Board of Directors

30 September 2020, 13:30 to 15:30
By videoconference

Agenda

9. Apologies for absence

Information

Robert Armstrong

10. Declarations of interest

Information

Robert Armstrong

11. Minutes of previous meeting

Approval

Robert Armstrong

Minutes - Public board - Jul 2020.pdf (7 pages)

12. Chair and Chief Executive's update

(Verbal update)

Information

Robert Armstrong/Silas Nicholls

13. Committee chair's reports

(Verbal item)

- Audit Committee, I Haythornthwaite
- Finance and Performance Committee, M Guymer
- People Committee, L Lobley
- Quality and Safety Committee, T Warne

Information

Committee chairs

14. Performance report

Discussion

H Richardson/M Fleming/S Arya

Performance report.pdf (4 pages)

15. Finance report

Information

Ged Murphy

Public finance report.pdf (2 pages)

16. Workforce risk assessment update, including BAME and clinically extremely vulnerable staff

Discussion

Alison Balson

Workforce risk assessment update.pdf (5 pages)

17. Safe staffing report

Information

Helen Richardson

Safe staffing report.pdf (12 pages)

18. Review of COVID-19 risk appetite statement

Decision

Paul Howard

Review of risk appetite statement.pdf (5 pages)

19. Board assurance framework

Discussion

Robert Armstrong

BAF - September 2020.pdf (10 pages)

20. Consent agenda

20.1. Register of Clinical Ethics Group referrals

Information

CEG referrals.pdf (3 pages)

20.2. Changes to Standing Financial Instructions

Approval

SFI report.pdf (6 pages)

20.3. Terms of reference for the Finance and Performance Committee

Approval

F&P ToRs.pdf (6 pages)

20.4. Workforce Race Equality Standard and Workforce Disability Equality Standard

Approval

WRES and WDES report.pdf (19 pages)

20.5. Statutory, mandatory and recommended posts

Information

Statutory, mandatory and recommended posts.pdf (9 pages)

21. Date, time and venue of next meeting

25 November 2020, by videoconference

Information

Robert Armstrong

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

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

HELD ON 29 JULY 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
	Mrs L Lobley	Non-Executive Director
	Mr G Murphy	Acting Chief Finance Officer
	Mr R Mundon	Director of Strategy and Planning
	Mr S Nicholls	Chief Executive
	Ms H Richardson	Chief Nurse
	Prof T Warne	Non-Executive Director
In attendance:	Mrs N Guymer	Deputy Company Secretary
	Mr P Howard	Director of Corporate Affairs
	Mrs L Sykes	Public Governor (observer)
	Mr K Collum	Freedom to Speak Up Guardian (for item 116/20 only)

107/20 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.

108/20 Apologies for absence

Apologies for absence were received from Mr I Haythornthwaite, Non-Executive Director.

109/20 Declarations of interest

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

110/20 Minutes of the previous meeting

The minutes of the previous meeting held on 24 June 2020 were **APPROVED** as a true and accurate record.

With regard to the action log, the Director of Strategy and Planning advised that he was awaiting a document which provided an overview of the revised governance structure, which he would forward to Mrs Lobley on receipt.

111/20 Chief Executive's opening remarks

The Chief Executive provided a verbal report and noted the planning that is ongoing to restart the elective care programme, with the intention of returning to near-normal levels by the end of August or early September 2020. He noted that some services were currently being delivered from alternative locations and that it would be necessary to revisit this in the near future as a result.

The Chief Executive also highlighted the many innovations that had been introduced as a result of the global COVID-19 pandemic and confirmed the intention to move some of these, such as video-based appointments, to a more business as usual approach going forward. Whilst he noted that this approach would not be appropriate for all patients, he nonetheless noted the amount of positive feedback that had been received from patients and staff alike. The Board noted the refurbishment work that had been commenced in two operating theatres on the Royal Albert Edward Infirmary site over recent weeks and a summary of the benefits of the works was provided.

The Chief Executive also commented on the work of the Healthier Wigan Partnership in focusing on system-wide recovery efforts and how increased support could be provided to social care; in particular to nursing and residential homes in the borough. The Board noted that the foundation trust is an anchor organisation in the borough and as a result it has a role to play in using its purchasing and spending power to help improve the local economy and to support the employment opportunities for the local population.

Particular note was made of the ongoing level of investment in the foundation trust and the Chief Executive referred the Board to recent videos of the work on the Community Assessment Unit which had been shared online. He confirmed that the work was progressing well and that the build phase is expected to be completed in early October with the unit expected to become operational in early-to-mid-November in time to help with the traditional winter pressures. He also confirmed that building works in A&E were due to conclude in the coming weeks.

Mrs Lobley commented that the junior doctor cohort had been particularly impacted by the changes implemented as a result of the pandemic and suggested that the Board's thanks be passed on to them as they move onto their next placement within the organisation. In response, the Medical Director confirmed that he and the Chief Executive had met with the junior doctors recently to convey their thanks for their hard work and flexibility. Mrs Lobley also highlighted the vast array of additional skills and experience that redeployed staff will have obtained and suggested the need to capture this information in a way that allows it to be useful in the event of a second wave of the virus. In response, the Director of Workforce confirmed that a redeployment group had been established to oversee the issue and that a standard operating procedure had been developed based on staff feedback. She noted that staff had shared their experiences of redeployment, both positive and negative, and that an onboarding passport was in the process of being developed to support redeployed staff. The benefits of staff remaining

in contact with their redeployment area during a return to their substantive post were acknowledged.

The Board received and noted the verbal update.

112/20 Committee chairs' reports

Prof Warne opened this item by summarising the business transacted at the Quality and Safety Committee meeting held on 8 July 2020. He noted that the meeting had been the first under the new arrangements which the Board had agreed earlier in the year and which had been delayed in implementation as a result of temporary changes to committee arrangements in March 2020. He commented on the fact that the divisional leadership teams had been in attendance as had been intended and that the new reporting format had been shared with the committee and had been well received.

Prof Warne noted that the committee had received the outcomes of a recent Ofsted report arising from an adult safeguarding review of the local authority and noted the planned action to address social work caseloads as well as noting the recent review of adult and child safeguarding governance processes. In addition, revised quality priorities had been presented to the committee and minor changes had been made following discussion to include a number of outcomes and challenges identified during the management of the COVID-19 pandemic. The final version would therefore be presented to the August meeting of the committee.

The Quality and Safety Committee had also considered progress against an action plan arising from a review by the Royal College of Ophthalmology as well as a report following a never event. Good levels of assurance had been received. Prof Warne advised the Board that full assurance had not been received in relation to mortality but commented that this would be discussed later in the agenda. He advised that partial assurance had been provided, based on the actions in place to address the Summary Hospital-level Mortality Indicator ("SHMI").

Mr Guymer noted that the next meeting of the Finance and Performance Committee would be taking place in August 2020 but noted the approval of the Microsoft N365 business case since the last meeting as well as confirming the ongoing work in relation to the development of a balanced scorecard approach to performance reporting.

Mrs Lobley confirmed that the next meeting of the People Committee would take place in September 2020.

The Board received and noted the verbal updates.

113/20 Performance report

A copy of the report had been circulated with the agenda and the Chief Nurse opened by confirming that the complaints process had been recommenced after it had been paused as a result of a national directive.

The Chief Operating Officer commented on the operational metrics within the report and noted that, like other NHS organisations, the foundation trust had moved into phase

one of the national pandemic plan which had resulted in all activity being paused, with the exception of those in response to life- or limb-threatening conditions. In line with the plan, the foundation trust had recently recommenced its elective programme based on clinical priority and confirmed that, as part of phase three of the national pandemic response, activity was being reinstated in accordance with a national model. She noted that national planning guidance was currently awaited and advised that plans would be reviewed on receipt of the guidance and revised as necessary. The Chair noted that the performance report would be similarly revised following a review of the planning guidance.

In response to a question from Mrs Lobley, the Chief Operating Officer described the waiting times in diagnostic services and commented that endoscopy had been impacted the greatest on a national scale as a result of it being deemed an aerosol-generating procedure. Although the foundation trust had the lowest turnaround time in Greater Manchester at 23 weeks, the Greater Manchester Chief Operating Officers' network had been tasked to identify additional capacity where possible for the benefit of all organisations in the system. The Chief Operating Officer also described the approach to management of cancer patients through the Greater Manchester cancer hub. Mrs Lobley requested that assurance on this latter point be sought via the Quality and Safety Committee at an appropriate point in time.

With regard to the people metrics within the report, the Director of Workforce noted the high level of compliance reported against risk assessments for COVID-19 but advised that the foundation trust had recently taken the decision to increase the number of staff subject to risk assessment; particularly in relation to black, Asian and ethnic minority (BAME) staff. She confirmed that progress is reported to NHS England and NHS Improvement and that improvement trajectories had been agreed, given that the recent changes had impacted on the level of compliance.

The Board received the report and noted the content.

114/20 Safe staffing report

The Chief Nurse presented a report which had been circulated with the agenda to summarise the safe staffing position across the organisation for the months of April, May and June 2020. She noted that the trajectory for reducing Band 5 vacancies had previously been shared with the Board and confirmed that this had been impacted by the pandemic; particularly in relation to the planned use of international staff. She also highlighted the positive reduction in the number of vacancies in the district nursing team. In response to a suggestion from the Chair, it was noted that the matter would be considered by the Quality and Safety Committee at an appropriate point in time.

The Board received the report and noted the content.

115/20 Mortality report

The Medical Director presented a report which had been circulated with the agenda to summarise the current position in relation to mortality. He noted the focus on SHMI as a metric relevant to the whole systemin Wigan Borough and described the work that

has been undertaken to try and improve this. He noted that he would be meeting with colleagues from Wigan Borough CCG to set out a system-wide approach to the management of SHMI.

In response to a question from Mrs Lobley, the Medical Director advised that he is confident that a sufficient level of resource is in place to improve sepsis performance and noted that, as SHMI data is correct as at February 2020, it is likely that the impact of this improvement would be felt in future months' data. The Medical Director agreed to share the quality performance indicators for the Accident and Emergency Department which demonstrate an improvement in sepsis performance within the department.

ACTION: Medical Director

In response to a question from Dr Elliot, the Medical Director highlighted the fact that SHMI does not take account of those patients in receipt of palliative care. The Chief Operating Officer reminded the Board that SHMI is seen as the responsibility of all organisations and noted that the Healthier Wigan Partnership has the end of life pathway as a primary focus.

The Board received the report and noted the content.

116/20 Freedom to Speak Up Guardian's report

The Freedom to Speak Up Guardian joined the meeting and presented his report which had been circulated with the agenda. He summarised a number of key issues arising from the contacts that have been received, including the need to ensure good visibility of leaders and the work that has been undertaken around ensuring good psychological safety within the organisation. He confirmed that a number of drop-in sessions would be offered across the organisation over the coming months.

In response to a question from Prof Austin, the Freedom to Speak Up Guardian described the escalation processes available to individuals who are unhappy with the responses that they have received to their concerns. The Director of Workforce also noted the planned approach to providing further enhanced support via Freedom to Speak Up Ambassadors within the organisation over the coming months.

The Board received the report and noted the content.

The Freedom to Speak Up Guardian left the meeting.

117/20 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 Guardian of Safe Working's report be received and noted.

2. THAT the finance report be received and noted.

3. THAT the Audit Committee terms of reference be **APPROVED**.

4. THAT the modern slavery statement be **APPROVED**.

5. THAT the COVID-19 risk appetite statement remains appropriate.

118/20 Date of the next meeting

The next meeting of the Board of Directors will be held on 30 September 2020 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.
29 Jul 2020	115/20	Mortality report	Share the quality performance indicators for the Accident and Emergency Department which demonstrate an improvement in sepsis performance within the department.	Medical Director	30 Sep 2020	Verbal update to be provided.

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	WWL M5 Scorecard
Presented to:	Board of Directors
On:	30 September 2020
Presented by:	Chief Nurse, Chief Operating Officer and Medical Director
Prepared by:	Data, Analytics and Assurance Department
Contact details:	BI.Performance.Report@wwl.nhs.uk

Executive summary

This paper is an interim report as Data, Analytics and Assurance continue to automate the production of a Balanced Scorecard with supporting commentary.

Link to strategy
Patient
Partnership
Workforce
Site and Service

The WWL Way

Risks associated with this report and proposed mitigations

Financial implications
None currently highlighted.

Legal implications
None identified.

People implications
None identified.

Wider implications

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

Report

WWL Balanced Scorecard:

Overall Trust Performance - Balanced Scorecard from 1 April to 31 August 20.

QUALITY & SAFETY

	Month	ON/OFF Track	Why?
Protecting Patients Metrics			
Number of Serious Incidents	M5	Off Track	7 Incidents in month, 29 YTD
Never Events	M5	Off Track	0 Incident in month, 1 YTD
Patient Safety Incident Reporting	M5	On Track	983 in month, 4092 YTD
National Patient Safety Alerts (CAS)	M5	On Track	1 in month, 1 YTD
Infection Prevention and Control (Grouped)	M5	Off Track	3 / 6 in month, 5 / 6 YTD; No Metrics Off Track
SHMI Rolling 12 months	M1 2021	Off Track	Latest position: 117.68
Patient Experience (Grouped)		*Not currently collected*	

ACTIVITY & EFFECTIVENESS

	Month	ON/OFF Track	Why?
A&E Performance (Single)	M5	Off Track	93.2% M5, 94.8% YTD; Target 95%
Cancer Performance (Grouped)	*M4*	*Off Track*	*4 / 8 in month, 4 / 8 YTD, Metrics Off Track*
RTT Performance (18 Weeks)	*M4*	*Off Track*	*44.0% M4; Target 92%*
RTT Performance (52 Weeks)	*M4*	*Off Track*	*303 patients waiting 52+ weeks*
Diagnostics Patients waiting under 6 weeks	*M4*	*Off Track*	*66.99% M4; Target 99%*
Recovery plan	M5	On Track	At aggregate level

PEOPLE

	Month	ON/OFF Track	Why?
Protecting Patients Metrics			
Safe care / e-roster (nursing & AHPs) - RN	M5	On Track	99.0% M5, 108.3% YTD; Target 95%
Safe care / e-roster (nursing & AHPs) - Unregistered	M5	On Track	135.5% M5, 127.9% YTD; Target 95%
Absence SITREP	M4	To be agreed	5.88% M4, 6.34% YTD
Absence - Covid related	*M3*	*To be agreed*	*6.8% M3, 15.2% YTD*
Mandatory Training	M5	Just below target	M5 90.0% YTD 90.1%; Target 95%
Protecting Staff Metrics			
Risk stratification - Shielded		*To be agreed*	
RIDDOR reporting & investigation status		*To be agreed*	

FINANCE

Financial Position (£000s)	In Month Actual £000's	In Month Plan £000's	In Month Var £000's	Year to Date Actual £000's	Year to Date Plan £000's	Year to Date Var £000's	Full Year Plan £000's
Income	34,954	30,499	4,455	176,741	157,070	19,670	385,376
Expenditure	(33,882)	(31,295)	(2,587)	(171,463)	(156,927)	(14,536)	(380,308)
Surplus / Deficit	(13)	(1,883)	1,870	(49)	(5,290)	5,241	(7,971)
Cash Balance	65,504	38,159	27,345	65,504	38,159	27,345	14,849
Capital Spend	551	2,305	1,754	5,183	9,022	3,839	23,000
Reported position : M5							

Note : Showing August data where available. *Details in italics where latest month details have not been signed off.*

Overall Trust Performance - Balanced Scorecard from 1 April to 31 August 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 August 2020, the Trust reported 7 incidents to StEIS (Strategic Executive Information System), which was a reduction on the previous month; no Never Events. These incidents included 4 Hospital Acquired Pressure Ulcers (same as last month) and 1 Community Acquired Pressure Ulcer (compared to 3 last month). The Trust's overarching Pressure Ulcer Improvement Plan has been finalised and approved by the Chief Nurse. 5 Trust cases of Clostridium Difficile infection. No obvious connection between the cases and all have been sent for further typing. Work continues in addressing environmental issues through audit and the deep clean programme. Antibiotic prescribing rounds are being increased post COVID-19. *WWL have not received any National Patient Safety Alerts (CAS) during the July 20.* **Patient Experience** In August, there were 2 formal complaints which were due a response, both of which were sent within the timescales agreed, equating to 100%. The main theme for Complaints and concerns received during August were in respect of clinical treatment, communication, appointments, attitude of staff (covid preventative measures), loss of property, and discrimination/equality (1). No new cases were called for review by the PHSO during the month of August. *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** **Protecting Staff Metrics**	**Financial Position (Variance)** The Trust is reporting a break even position in Month 5 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-19 pandemic. The national tariff payment by results system has been suspended for April to September 2020 and has been replaced by a block contract payment. It has been indicated that a financial envelope will be issued to the Greater Manchester ICS from October to the end of the financial year. In Month 5, the Trust planned a deficit of £1.9m and therefore by reporting a breakeven position is £1.9m favourable to plan. Year to date, the Trust is £5.3m favourable to plan. Cash is £65.5 at the end of Month 5 which is £64.6m better than plan. This is due to the block payment and the projected top up for September being received in advance. Capital spend is £5.1m year to date plus a further £6.5m incurred in respect of COVID-19 associated projects of which £5.8m has been reimbursed via PDC. Please see the monthly finance report for further commentary.	FINANCE

Title of report:	Monthly Trust Financial Report – Month 5 (August 2020)
Presented to:	Board of Directors
On:	23 September 2020
Presented by:	Ged Murphy [Acting Chief Finance Officer]
Prepared by:	Heather Shelton [Head of Financial Management]
Contact details:	T: 01942 77 (3759) E: heather.shelton@wwl.nhs.uk

Executive summary

	In Month			Year to Date		
	Actual £000's	Plan £000's	Var £000's	Actual £000's	Plan £000's	Var £000's
Income	34,954			176,741		
Expenditure	(33,882)			(171,463)		
Financial Performance	0			0		
Cash Balance	65,504			65,504		
Capital Spend	847			11,717		

Key Messages:

- NHSI/E have been very clear to NHS organisations that financial governance must remain during the COVID-19 pandemic. Informing the Public of the Trust's financial position is part of our governance and assurance process and as such the Financial Board Report will continue to be produced and issued.

- 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 5 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-19 pandemic.

- Cash is £65.5m at the end of Month 5.

- Capital spend is £11.7m year to date. This includes £6.5m on COVID-19 associated projects which will be fully reimbursed via non-interest bearing PDC.

Title of report:	Workforce risk assessment update
Presented to:	Board of Directors
On:	30 September 2020
Presented by:	Director of Workforce
Prepared by:	Vikki McManus, Strategic HR Lead
Contact details:	T: 01942 773832 E: vikki.s.mcmanus@wwl.nhs.uk

Executive summary

This report is presented to provide the Board with an update in relation to the development and progress of our workforce risk assessment process with specific focus on the developments in relation to risk assessments for colleagues from a Black, Asian, Ethnic Minority (BAME) group and those staff who are clinically extremely vulnerable, required until 1 August to shield. The detail of this report was considered by the People Committee at its meeting on 22 September 2020 and therefore a summary report only has been provided for the Board's information.

Throughout the COVID-19 pandemic the Trust has designed a process to ensure that risk assessments are obtained and completed for all staff. The process has developed over time and in order to provide both internal assurance and relevant statistical data externally, it is now a two-part process. Part 1 is required by all staff to provide an initial assessment of a staff member's risk status against those attributes and conditions where evidence suggests a person may be at increased risk should they contract coronavirus. Where the Part 1 assessment indicates an individual is at risk, Part 2 is completed to ensure that consideration is given to those risks, provides guidance to both the manager and the staff members and identifies appropriate mitigations to reduce the risk. Occupational Health and HR colleagues continue to work together, alongside other stakeholders to ensure that the latest medical and national information is incorporated into the risk assessment process.

NHS updates recently provided pay protection guidance for those staff who are temporarily redeployed. The Trust has agreed we will apply our local Job Security and Change policy and pay protection provisions and additionally allow all staff who have been redeployed due to a COVID-19 risk assessment to be eligible for 12 months pay protection, including those with less than two years' service.

Through COVID-19 workforce group discussions to support managers and staff reaching an effective resolution and work plan for any staff member considered at increased risk, an escalation process has been defined which includes support from a senior panel. Each division is reviewing those cases where return to work plans have not been agreed and with attendance from senior HR, OH, IPC and staff side will consider appropriate resolution routes.

Significant work has taken place since March this year to ensure there are effective processes in place to support our staff and their health and wellbeing. The COVID-19 workforce group and associated teams within divisions, OH and HR continue to drive risk assessments forward whilst remaining agile and responsive to the latest advice and guidance.

Whilst there are questions that continue to arise as part of the risk assessment process the Trust has remained consistent in its approach to find positive routes for resolution and protect employment where at all possible.

Link to strategy

There is no direct link to the organisation's strategy.

Risks associated with this report and proposed mitigations

Consideration is currently being given to the organisation's approach to allowing staff to retain a role within their substantive site should they wish to whilst recognising and accepting their risk factors fully. This matter continues to be considered and escalated to senior groups for consideration and a consistent approach across staff groups.

Financial implications

There are potential financial implications due to pay protection requirement for redeployed staff for 12-month period and if staff remain in unfunded supernumerary roles.

Legal implications

Potential legal implications would be considered on a case-by-case basis.

People implications

The risk assessment process has both positive and negative health and wellbeing implications for staff members.

Wider implications

Links to operational and service delivery due to undetermined disruption for workforce and services. Largest staff groups affected by risk assessments and associate staff movements are predominantly within our clinical services which imply a direct impact on patients.

Recommendation(s)

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

Report

Introduction

This report identifies the current risk assessment process and progress across the Trust in ensuring that all staff have an appropriate risk assessment in place and an associated work plan to support their personal risk and any mitigations to reduce risk to their health. The report explores the developments over the pandemic period in supporting specific 'at risk' groups; those staff members who are from a Black, Asian, Minority Ethic (BAME) background; plus those staff who are considered as clinically extremely vulnerable and were required to shield until 1 August 2020.

Risk assessment process

Throughout the COVID-19 pandemic, the Trust has designed a process to ensure that risk assessments are obtained and completed for all staff. The process has developed over time and in order to provide both internal assurance and external statistical data, it is now a two-part process. Part 1 is required by all staff to provide an initial assessment of an individual staff members risk status against those attributes and conditions where evidence suggests a person may be at increased risk should they contract coronavirus. Where the Part 1 assessment indicates an individual is at risk Part 2 should be completed to ensure that consideration is given to those risks; provides guidance to both the manager and the staff members; plus identifies appropriate mitigations to reduce the risk.

The HR and OH department have amended the Part 1 and Part 2 templates throughout the pandemic in response to any new and emerging evidence/national advice.

BAME staff

At the commencement of the pandemic this group of staff were requested to consider their individual risk against the original high risk categories only, alongside all other ethnic groups i.e. if they had any specific medical conditions, were over the age of 70 or were pregnant. Throughout the pandemic, however, emerging medical evidence suggested that BAME individuals are at increased risk when contracting the virus. There are nuances with the ethnic groups however as a whole individuals from a BAME background are at higher risk than those with a white ethnicity.

NHSE/I have provided consistent advice, guidance and instruction and therefore the risk assessment process was modified to ensure that all BAME staff have both part 1 and part 2 of the risk assessment completed. Less clear has been any specific advice in relation to what mitigations should and could be put in place that are appropriate, over and above current PPE recommendations for this group of staff. The Trust has applied a pragmatic approach and managers and individuals are requested to have a holistic discussion around not only the team members' ethnicity but any other additional risks, plus any personal stress or concerns about their role and risk status in order to define an appropriate work plan.

The medical staff group has the highest percentage of BAME staff members. The Trust has also worked with our Lead Employer to ensure that new and existing trainees hosted by WWL have appropriate risk assessments and agreed work plans in place.

BAME percentage of staff across staff groups as at 1 September 2020

Division	BAME staff	Total staff	% of BAME staff against total in group	% risk assessments completed
TRUST TOTAL	455	6066	7.5%	83%
Medical &Dental	245	425	57.6%	78%
Nursing & Midwifery Reg.	77	1651	4.7%	83%
AHPs	19	484	3.9%	80%
Estates & Ancillary	23	420	5.4%	100%
Admin &Clerical	34	1404	2.4%	97%

Clinically extremely vulnerable (shielding) staff

In March 2020 the government classed some people as clinically extremely vulnerable and therefore at high risk of serious illness from coronavirus (COVID-19) infection. Those people or their parents should have received a letter advising them to shield from the Department of Health and Social Care, their GP or hospital clinician. Shielding required those individuals to remain at home and stringently socially distance themselves from other members of their household. Across the Trust approximately 200 staff were reported as being required to shield.

As at 3 June 2020 it was determined that approximately 90 of those staff were able to work from home. The redeployment team remained active, alongside divisional managers and the HR team, to try to locate work for shielding staff. There have been a number of executive-led engagement events with the shielding staff. Themes from those sessions identified a significant level of concern and isolation from within the group, including limited communication and engagement from the Trust and their managers. Actions have been taken forward to retain/improve contact and communication during the pandemic with this group. This has been essential as the government advice has been updated in the last couple of months.

On 23 June 2020 the government released information advising that should infection rates continue to decrease that shielding would be paused from 1 August. In light of this information the Trust published guidance for managers to support return to work considerations and plans for any shielding team members. On 1 August the shielding requirement was paused. Homeworking is still recommended where possible, however if not available then individuals were told they could go to work providing the business was defined as COVID-safe.

Significant work commenced to ensure that all Trust sites were assessed against the COVID-safe/secure recommendations. Estate, IPC, Governance and Divisional management teams alongside HR and OH support have worked to ensure the sites are safe, in accordance to their operational status, so that individual risk assessments can be completed and safe work plans put in place.

Redeployment

Where redeployment from a substantive post has been required, divisional managers have redeployed staff across their services and divisions and linked with the Trust redeployment team

where a temporary role has not been identified. The Trust has a senior-led redeployment group in place to consider and operationalise the longer-term requirements in redeploying staff against pandemic and operational requirements.

Further discussions with HR representatives have identified queries in regard to those staff who are currently redeployed into a supernumerary post. There is a risk that long term there would be a number of unfunded posts across the Trust. The scale of this is not known currently at this time. The escalation process and COVID-19 Workforce group has been the methodology to consider these issues to support resolution.

Escalation process

The divisional management teams have been proactive to resolve and define appropriate work plans for those staff who are considered at increased risk. Where challenges, questions or barriers remain to define and agree an appropriate work plan providing effective mitigation of risks the route to resolution has been defined in a personal risk assessment flowchart. Each divisional senior team with HR rep have reviewed their outstanding cases and where resolution is not identified are arranging a panel, where support is provided by senior HR, OH, IPC and staff side representatives alongside operational/clinical management and the individual staff member to determine a resolution.

Remaining considerations/risks

One overarching consideration for the Trust is in relation to the approach to allowing staff to retain a role within their substantive site should they wish to whilst recognising and accepting their risk factors fully. This matter continues to be considered and escalated to senior groups for consideration and a consistent approach across staff groups.

Conclusion

Significant work has taken place since March this year to ensure there are effective processes in place to support our staff and their health and wellbeing. The COVID-19 workforce group and associated teams within divisions, OH and HR continue to drive risk assessments forward whilst remaining agile and responsive to the latest advice and guidance.

Whilst there are questions that continue to arise as part of the risk assessment process the Trust has remained consistent in its approach to find positive routes for resolution and protect employment where at all possible.

Title of report:	Safe Staffing Report
Presented to:	Board of Directors
On:	30 September 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 with assurance of the ongoing monitoring of nurse staffing levels across inpatient areas in line with national requirements. For completeness this report also includes adult and children's community services.

This report covers the time period July and August 2020. Inpatient areas have returned to pre-COVID staffing levels and fill rates reported within the report are against the Trust agreed staffing requirements.

The Board is asked to note:

- Registered nurse vacancies remain high, most significantly at B5 level. The greatest risk with respect to B5 vacancy factor remains within the division of Medicine. In part this can be attributed to the investment in nursing establishments agreed by the Board in the financial year 19/20.
- There has been a sustained reduction in District Nursing vacancies remain 14% as in the previous report as compared with 24% previously.
- The recent restrictions on international recruitment remain in place and continue to delay the plan to minimise band 5 vacancies by September 2020. The trajectory for recruitment is therefore being recast taking into account the current labour B5 turnover rates with the intention of minimising vacancies by the end of the financial year. This trajectory remains dependent on the lifting of constraints to international travel.
- Staff have continued to return to their substantive roles during the COVID recovery phase.
- The impact of residual vacancies and sickness absence levels is reflected in fill rates in August.
- There has been an increase in the use of temporary staffing to back fill vacancies unfunded capacity and sickness.

- 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 are no Registered Midwifery vacancies.
- The number of reported serious pressure ulcers remain a concern, whereas community services saw an improving trend in Q4 19/20 and Q1 20/21 and the bedded areas of the Trust also seeing an improvement in Q4 19/20, these improvement have not been sustained and further work is required to embed the pressure ulcer improvement plan across all areas.

Link to strategy

Delivery of safe care

Risks associated with this report and proposed mitigations

- Registered nurse vacancies particularly at B5 level within the division of Medicine and resulting high use of temporary staff.
- The requirement to staff unfunded capacity and impact of use of temporary staff.
- Roster reviews have been initiated to ensure there is an appropriate balance of substantive and temporary staffing to provide safe care, and there is increased focus on local induction of temporary staff.
- Community have had an improving trend in pressures ulcers in Q4 19/20 and Q1 20/21.
- The bedded areas of the Trust saw an improvement in Q4 19/20, however these improvement have not been sustained and further work is required to embed the pressure ulcer improvement plan across all areas.

Financial implications

Temporary staffing costs related to high vacancy levels

Legal implications

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

People implications

- Potential impact on staff wellbeing associated with vacancy rates, escalation of areas and the resumption of services during COVID recovery.
- Impact on staff due to redeployment to alternative work area due to need to maintain patient safety during Covid pandemic.
- Brilliant Basics campaign to assist in addressing the cultural issues identified within the report with respect to accountability, delegation of duties and professional responsibilities of registered staff.

Wider implications

- Increased scrutiny from Commissioners and Regulators

Recommendation(s)

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

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 (Appendix 1), 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 during the phased reinstatement of services in accordance with the risk stratification agreed by Gold Command.

During this reporting period E roster staffing levels returned to the agreed ratio of registered nurses to 1:8 within bedded areas of the Trust in accordance with the COVID Recovery Plan.

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

At the end of August 2020 the Trust had 350 WTE nurse vacancies; 272 WTE are registered nurse vacancies (Appendix 2 Table 2).

Of these 180 WTE are at B5 level with the greatest number of vacancies (98.61 WTE) being within the Division of Medicine (Appendix 2 Table 3); this represents a reduction of 5.45 WTE B5 vacancies since the last report. 63.97 WTE posts are associated with the uplift in staffing as approved by Trust Board in response to the nursing establishment review.

There is a plan in place to reduce Band 5 vacancies to zero by the end of the current financial year which involves international recruitment, proactive recruitment of final year students and a targeted and generic recruitment events. Turnover at Band 5 level has on average been 4-5 staff/month, however in August there were 11 leavers from the Trust. Of the leavers no reason for leaving was provided to HR in the documentation supplied. As a consequence the trajectory for recruitment is currently being reviewed and refreshed by the Deputy Chief Nurse and Deputy Director of HR.

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

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

Within the Community Division there are 41.6 WTE registered nurse vacancies Bands 5 to 8a; this represents an overall vacancy factor of 17% (15% adult services, 2% childrens services).

40.6 WTE vacancies are within Adult Services of which the greatest proportion,17.5 WTE, are within District Nursing Services. The vacancy factor within District Nursing Teams is 14% which is unchanged from the previous report received by the Board. Staffing gaps are being mitigated by utilising other professional groups to augment the service, and the block booking of bank and agency staff. Patient safety issues have been identified with regards to the increase in StEIS reportable pressure ulcers discussed later in this report.

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

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

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 throughout July and August.

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

The number of nursing red flags reported remained low in July 2020 but has marginally increased in August 2020. In July this is to be expected given the fill rates reflected earlier in the report, however fill rates on some wards have deteriorated in August as staff have returned to their substantive areas following the resumption of services and the impact of vacancies has become more apparent (Appendix 2 Table 4).

1 red flag was raised on the Coronary Care Unit in August 2020 indicating that there were less than 2 registered nurses 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.

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

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

The quality metrics provided within Appendix 1 demonstrate an increase in the number of harms across the Trust from pressure ulcers.

The number of reported serious pressure ulcers remain a concern, whereas community services saw an improving trend in Q4 19/20 and Q1 20/21 and the bedded areas of the Trust also seeing an improvement in Q4 19/20, these improvement have not been sustained and further work is required to embed the pressure ulcer improvement plan across all areas.

7 Pressure ulcers were escalated to StEIS in July 2020; 3 Unstageable and 1 Category 3 pressure ulcer from bedded areas of the Trust (Orrell, MAU, Ward A and Ince Wards), and 2 unstageable and 1 Category 3 pressure ulcer that developed whilst under the care of the Community Division.

A further 5 pressure ulcers were reported to StEIS in August 2020; 4 category 3 pressure ulcers developed whilst patients were being cared for in the bedded areas of the Trust (Langtree, Standish and 2 on Ince Ward), the 5th category 3 pressure ulcer developed whilst under the care of 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. A refreshed Trust Wide Pressure Ulcer Improvement Plan has been refreshed.

A 50% reduction target in avoidable Category 3 and 4 Pressure Ulcers has been agreed by Quality and Safety Committee as an objective within the Trust Quality Accounts. Whilst there has been some improvement in the level of Registered Nurse oversight of pressure ulcers, there remains inconsistency in practice across the Trust which suggests this practice change is not yet fully

embedded. Safety huddles have been introduced across the bedded areas of the Trust augmented by Matron spot checks of documentation and coaching conversations with staff.

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

9 CDT's have been reported in July and August 2020 bringing the Trust total to 19 against an annual trajectory of 20; 3 of these have been subject to internal review, the remaining reviews are scheduled to be undertaken in September. From the reviews completed there have been no identified lapses in care.

A Trust Wide CDT Reduction Plan is in place and focuses on the areas of learning identified from reviews i.e delays in sampling and isolation of the patient, and use of Personal Protective Equipment (PPE).

In addition the Trust recommenced the deep clean programme in July 2020.

There were no falls reported where moderate or severe harm occurred within the reporting period.

It should be noted:

Fill rates within inpatient areas for registered and unregistered staff throughout July and August reflects the redeployed multi professional staff that remained within services until all areas of the elective programme was recommenced.

In August Standish Wards fill rate is reflected against a roster requirement for 10 beds rather than the 28 actually open, and therefore is artificially inflated (Appendix 2). This will be corrected in the next report.

4.0 ACTIONS BEING TAKEN

The B5 vacancy reduction plan is being reviewed and refreshed to reflect current labour turnover rates.

Partnership working with NHS Professionals (NHSP) to recruit an additional 30 WTE registered staff on consistent 6 month assignment to assist in augmenting clinical teams where there are high vacancy rates within the Division of Medicine, of these 10.32WTE have been recruited to.

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

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

5.0 RECOMMENDATIONS

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

Appendix 1: Safe Staffing Exception Reports
July 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	117.6%	143.9%	4.2	199.9%	148.5%	8.0	6.35%	0.05%	7.57%	0		0/3				
Astley	116.0%	166.3%	4.2	138.8%	132.3%	6.1	5.66%	4.74%	15.94%	0		0/1		1/2		
Bryn North	114.4%	101.1%	4.0	151.8%	131.5%	7.3	0.00%	Unable to report vacancies as there is no budget recorded for this department		0		0/4	2/0	0/1		
Bryn South	158.1%	106.9%	5.1	177.9%	142.4%	8.2				0		0/2		1/4		
Coronary Care Unit	101.5%	100.0%	8.0	787.6%	0.0%	4.8	3.92%	29.23%	27.91%	0			1/0	1/1		
Highfield																
Ince	123.2%	101.4%	4.0	130.5%	167.2%	6.0	1.61%	25.70%	44.46%	0		0/3	0/1	0/3		
Pemberton	101.4%	112.9%	5.6	177.1%	132.8%	6.5	6.57%	6.50%	9.01%	0	1	0/3				
Shevington							10.48%	16.19%	30.32%							
Standish	114.4%	97.8%	3.5	159.1%	146.4%	6.5	11.24%	12.97%	38.67%	0		0/4	2/2	0/2		
Winstanley	131.3%	124.8%	7.1	113.9%	104.6%	8.0	1.92%	3.49%	18.79%	0		0/1		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	95.6%	94.3%	61.1	87.8%	0.0%	6.4	9.17%	0.00%	0.00%	12						
Langtree	99.8%	100.2%	3.3	178.8%	247.0%	4.8	10.93%	5.29%	32.02%			0/3		0/2		
Orrell	118.9%	98.0%	3.6	149.2%	130.9%	6.0	3.33%	8.36%	13.18%			0/5		0/3		
Swinley	114.8%	88.2%	3.3	153.8%	197.3%	4.1	3.68%	10.19%	22.69%			1/2		0/1		
Maternity Unit	103.7%	98.8%	16.8	116.0%	100.0%	5.0	1.10%	0.00%	0.00%					0/1		
Neonatal Unit	93.0%	93.9%	21.6	163.7%	0.0%	5.1	5.65%	1.28%	0.00%							
Rainbow	73.9%	80.7%	10.1	128.6%	109.7%	5.5	15.67%	0.00%	0.00%	1				0/2		

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	109.2%	97.7%	3.6	134.1%	142.5%	5.73	15.90%	22.04%	37.03%	0		0/1		0/2		
Ward A	140.8%	94.7%	7.0	154.3%	161.9%	9.53	10.14%	17.56%	12.81%	0		0/5				
Ward B	123.7%	121.0%	5.5	169.0%	102.4%	5.99	9.87%	18.28%	21.79%	0						
JCW	0.0%	0.0%	0.0	0.0%	0.0%	0.0	12.90%	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	96.0%	116.6%		151.0%	208.5%		4.06%	22.98%	32.77%	0		1/2				
A&E Paeds	119.0%	97.0%					2.68%	11.18%	11.18%	0						
A&E NP's	85.9%	0.0%		66.3%	0.0%											
CDW	87.6%	100.0%		133.5%	194.2%		6.08%	28.31%	31.35%	0		0/1				
Lowton	108.6%	98.0%		158.1%	168.9%		3.99%	9.13%	26.21%	0	1	0/3		0/2		
Medical Assessment Unit	94.4%	113.6%		115.0%	127.4%		4.64%	13.26%	28.79%	0	2	0/3		0/1		

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

August 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	105.7%	157.4%	3.9	188.0%	160.7%	7.6	4.19%	3.07%	14.57%			0/5		0/2		
Astley	114.0%	87.8%	3.2	123.7%	46.5%	3.9	9.48%	4.74%	15.94%			0/2				
Bryn North	110.4%	99.3%	3.6	138.6%	140.4%	6.3	0.00%	Unable to report vacancies as there is no budget recorded for this department			1	1/3	1/0	0/2		
Bryn South																
Coronary Care Unit	99.1%	101.9%	7.8	452.4%		4.4	10.55%	31.31%	27.91%	1				0/1		
Highfield																
Ince	118.4%	93.1%	3.4	121.6%	178.4%	5.3	3.78%	23.81%	41.13%			0/3	0/2			
Pemberton	88.5%	100.1%	4.7	159.9%	118.2%	5.6	2.38%	1.19%	1.74%		1	0/1				
Shevington	76.8%	80.2%	3.8	101.6%	87.1%	6.0	9.77%	16.27%	30.49%		1	0/2	1/0	0/3		
Standish	244.6%	173.5%	3.7	281.4%	258.7%	4.8	9.40%	15.52%	40.42%			1/5	0/1	0/2		
Winstanley	92.6%	110.4%	5.1	109.4%	108.1%	7.4	6.89%	7.21%	22.77%		1	0/3		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	88.7%	88.9%	31.3	98.4%		4.1	6.44%	0.00%	0.00%	9	1			0/1		
Langtree	87.0%	101.4%	3.3	164.1%	253.6%	5.0	7.48%	10.39%	22.60%	2		0/5	0/1	0/1		
Orrell	104.2%	102.9%	3.4	158.4%	130.5%	5.9	1.82%	1.84%	0.00%	4				0/7		
Swinley	101.6%	100.2%	3.2	144.4%	177.0%	3.8	9.29%	12.88%	26.96%					0/1		
Maternity Unit	101.3%	94.1%	18.1	122.0%	97.6%	5.7	2.13%	0.00%	0.00%							
Neonatal Unit	96.1%	97.6%	19.2	132.3%		3.5	5.10%	1.28%	0.00%							
Rainbow	78.9%	82.2%	11.3	113.1%	99.6%	5.3	10.09%	0.00%	0.00%					0/1		

	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	93.8%	104.3%	3.2	132.9%	141.0%	5.52	16.64%	24.34%	41.72%	2		0/1		0/5		
Ward A	55.3%	37.5%	8.1	60.3%	73.9%	11.31	8.41%	17.56%	12.81%			0/1				
Ward B	122.5%	170.1%	4.9	190.1%	134.1%	5.87	9.27%	16.56%	16.51%			0/4		0/1		
JCW							11.16%	10.76%	18.01%							

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	91.4%	116.7%		146.5%	203.4%		2.84%	24.48%	35.03%			0/2		1/0		
A&E Paeds	97.4%	100.5%					0.80%	11.18%	11.18%							
A&E NP's	84.3%	1.7%		51.6%												
CDW	80.9%	83.9%		113.7%	191.3%		8.13%	28.48%	31.35%							
Lowton	77.6%	108.9%		158.5%	149.8%		5.36%	7.56%	26.25%	3		0/4				
Medical Assessment Unit	79.7%	103.5%		108.7%	114.3%		9.36%	14.95%	28.79%			0/4				

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

Appendix 2

	June 2020		July 2020		August 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	**1**	**13**	**1**	**1**	**6**	**4**

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

Month	Registered WTE	Unregistered WTE
June	264.77	85.95
August	272.1	78.48

Table 2. Nurse Vacancies June to August 2020 Trust Wide)

	June 2020	August 2020
Specialty	B5 vacancies	
Medicine	104.06	98.61
Surgery	34.62	28.36
Specialist Services	22.66	35.14
Community Services	16.99	17.2
Corporate	1.7	0.69
Total	**180.03**	**180**

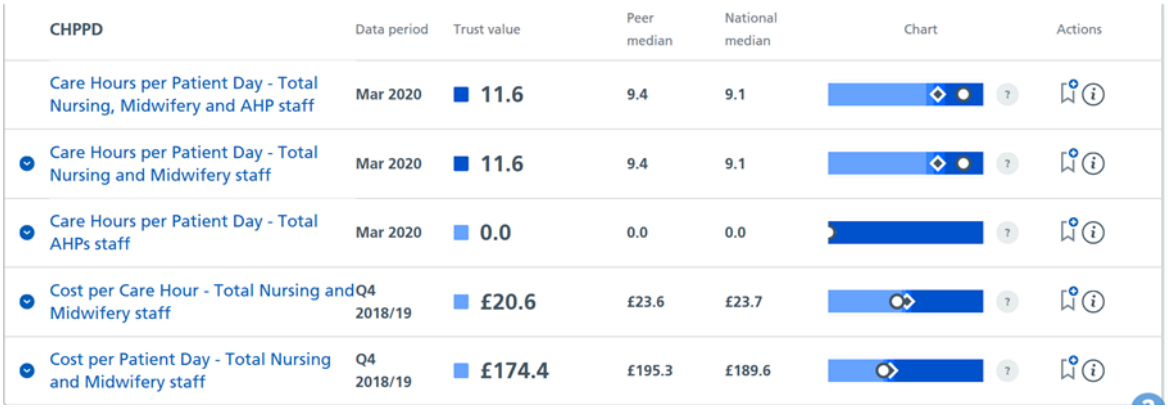
Table 3. B5 Nurse Vacancies June to August 2020 by Division

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

Table 4. Nursing Red Flags June to August 2020

Red Flag Category	No. of Incidents June 2020	No. of Incidents July 2020	No. of Incidents August 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 June to August 2020.



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

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

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Review of COVID-19 risk appetite statement
Presented to:	Board of Directors
On:	30 September 2020
Presented by:	Director of Corporate Affairs
Prepared by:	Paul Howard, Director of Corporate Affairs
Contact details:	T: 01942 822027 | E: paul.howard@wwl.nhs.uk

Executive summary

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

The Executive Team considered the risk appetite statement at its meeting on 8 September 2020 and recommends a number of changes, as set out below:

1. That the appetite for financial risk in respect of meeting statutory duties be reduced from significant to high;

2. That the appetite for risk in making investments which may grow the size of the organisation be increased from moderate to high; and

3. That the appetite for risks which may compromise our compliance with statutory duties or regulatory requirements be reduced from high to moderate.

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

Link to strategy

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

Risks associated with this report and proposed mitigations

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

Financial implications

There are no financial implications arising out of this report.

Legal implications

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

People implications

There are no people implications in this report.

Wider implications

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

Recommendation(s)

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

COVID-19
Risk appetite statement

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Introduction

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

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

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

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

Underlying principles

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

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

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

Our risk appetite

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

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

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

This statement was approved by the Board of Directors at its meeting on ~~25 March 2020~~ 30 September 2020.

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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.

Patients:

Every patient receives the best possible care

Executive lead(s):	Chief Nurse Medical Director	**Reviewing committee:**	Quality and Safety Committee	**DELIVERY CONFIDENCE** **CURRENT MONTH:**	**WEIGHTED DASHBOARD** **MONTH:** 2.35 **YTD:** 3.22
Strategic importance:	Provision of safe, effective, high-quality and evidence based care is at the heart of everything we do.				
Sources of assurance:	▪ Scrutiny by Quality and Safety Committee ▪ Scrutiny by Board of Directors ▪ Use of internal and external auditors ▪ Escalation of emerging risks ▪ Divisional performance reviews ▪ REMG			**ROLLING TREND:** Aug 2020 · Mar 2020 · Jan 2020 · Nov 2019	**ROLLING TREND:** Aug 2020: 2.27 · Mar 2020: 2.08 · Jan 2020: 2.23 · Nov 2019: 1.73

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

PATIENTS: WEIGHTED DASHBOARD

Performance	Measure	Result	1 (Green)	2 (Amber-Green)	3 (Amber)	4 (Amber-Red)	5 (Red)	Weight	Month	Year	Source
Harm free care	%VTE Assessments undertaken within 24 hours of admission (indicative data)	**96.31%M 96.17%Y**	≥95%	94% - 90%	89%-85%	84%-80%	<80%	**1**	1 x 1 = 1	1 x 1 = 1	Perf. Report (Aug 2020)
Harm free care	No. Serious Falls	**0 MTD 2 YTD**	0 MTD		1 YTD	2 or 3	>3	**2**	1 x 2 = 2	2 x 2 = 6	Perf. Report (Aug 2020)
Patient Safety	% of 'red sepsis' patients receiving antibiotics within 1 hour in A&E	**85.7%**	≥95%	94% - 90%	89%-85%	84%-80%	<80%	**1**	3 x 1 = 4	---	A&E Monthly Audits
Patient Safety	No. of Never Events	**1 MTD 2 YTD**	0				1	**3**	5 x 3 = 15	5 x 3 = 15	Perf. Report (Aug 2020)
Patient Safety	100% compliance with appropriate frequency of observations	**70.7%**	100%	99-95%	94-90%	89-80%	<80%	**1**	5 x 1 = 5	---	NEWS quarterly Audits (3,6,9,12)
Infection Control	No. of MRSA	**0 MTD 0 YTD**	0				1	**3**	1 x 3 = 3	1 x 3 = 3	Perf. Report (Aug 2020)
Infection Control	No. of C. diff Lapses in Care	**2 MTD 4 YTD**	0	1	2 MTD	3	>4 YTD	**2**	2 x 2 = 6	4 x 2 = 6	Perf. Report (June 2019)
Patient Experience	% of patients recommending WWL for care	**92%**	≥95%	94% - 90%	89%-85%	84%-80%	<80%	**2**	2 x 2 = 4	---	Monthly FFT (2020)
Patient Experience	% of patients feeling involved with decisions about their discharge	**90.77%**	≥95%	94% - 90%	89%-85%	84%-80%	<80%	**1**	2 x 1 = 2	---	Perf. Report (2020)
Patient Experience	% of complaints responded to within the timescale agreed with the patient	**100%M 32.86%Y**	≥95%	94% - 90%	89%-85%	84%-80% MTD	<80% YTD	**1**	1 x 1 = 1	5 x 1 = 5	Perf. Report (Aug 2020)
Mortality	HSMR	**117%M 103.9% Y**	≤100	101-105 YTD	106-110	111-115	>115 MTD	**3**	2 x 3 = 6	5 x 3 = 15	Perf. Report (Mar 2020)
Mortality	SHMI	**117.7%**	≤100	101-105	106-110	111-115	>115	**1**		5 x 1 = 5	Perf. Report (April 2020)
Mortality	No. of PFDs	**0**	0	1	2	3	>4	**2**	1 x 2 = 2	1 x 2 = 2	Perf. Report (Aug 2020)
Medicines Management	% of critical medicines prescribed within 24 hours of admission or before the patient is transferred to a new area	**90%**	100%	99-95%	94-90%	89-80%	<80%	**1**	3 x 1 = 3	---	Pharmacy (Aug 2020)
Medicines Management	% of completed medicines reconciliation within 24 hours	**91%**	100%	99-95%	94-90%	89-80%	<80%	**2**	3 x 2 = 6	---	Pharmacy (July 2020)
Total									(54/23)	(58/18)	
Average									2.35	3.22	

Metrics highlighted in grey have been unreportable this month.

People:
Everyone has the opportunity to achieve their purpose

Executive lead(s):	Director of Workforce		**Reviewing committee:**	People Committee	**DELIVERY CONFIDENCE**			**WEIGHTED DASHBOARD**	
Strategic importance:	Every member of staff has the opportunity to achieve their purpose. Safe and effective workforce to meet service needs							**MONTH:** 3.75	**YTD:** 3.75
Sources of assurance:	▪ Scrutiny by Workforce Committee ▪ Scrutiny by Board of Directors ▪ Use of internal and external auditors	▪ Escalation of emerging risks ▪ Exec-to-exec meetings ▪ REMC			**ROLLING TREND:**			**ROLLING TREND:**	
					Jan 2020	Nov 2019	Sep 2019	Jul 2019	
								3.75	4.00	4.00	4.00
								Jan 2020	Nov 2019	Sep 2019	Jul 2019

Individual risks	Original Score	Mitigations	Current score
HR 84 - Ability to recruit and retain to required staffing levels for service delivery and service development plans	20	Recruitment & retention plan and trajectory International recruitment campaign – supported by NHSEI funding bid process Workforce plan Programmes of work to improve the experience of work	20
HR104 - Failure to achieve Trust sickness absence target of 4% which impacts on staffing levels in clinical areas, agency spend and effective service provision	20	Implementation of Empactis absence management system (business case approved). Psychological support programmes and 12 month proof of concept enhanced stepped approach Health & well-being staff group leads and network of champions in place	20
HR82 - Declines in safety culture and staff confidence in reporting errors, near misses and incidents	16	Psychological safety work programme commenced – diagnostic completed and action plans developed for implementation	16

HR101 - Wally' intranet provision	16	Single sign on now in place. Content review and relaunch scheduled aligned to functionality upgrade. Script issues to manage leavers being progressed between IM&T and service provider. ESR data cleanse commenced to support Active Directory automatic interface with ESR	16
HR109 - Quality of appraisals	16	Review of My Route Plan complete. Implementation support and toolkit developed. Launch in September / October	16
HR112 - Not meeting Inclusion and Diversity requirements	12	EDI strategic framework agreed. New strategy to be developed: • Improving diversity of workforce to meet population needs • Improving experience of work • Reducing inequalities Potential for Borough wide EDI objectives	16
HR115 - Organisational Staff Engagement Levels	16	New approach to the use of the Your Voice Survey. Building staff experience into the people accountability and performance framework. Leadership development, focussed on compassionate leadership ethos. Full relaunch and embedding of the WWL Behaviour Framework	16
HR127 - There is a risk that, due to the impact of Covid-19 and the requirement for social distancing, staff members will become non-compliant in modules of training that are only delivered face to face and will not be able to retake the necessary training, resulting in potential safety implications for staff, patients and the organisation.	15	Move to virtual where possible. Face to face delivery requirements to be fully reviewed and recovery plan to be brought to Education Governance in November	16
HR126 - Inability to make critical workforce decisions around planning / availability / training to meet the needs of services due to current lack of accurate data.	15	ESR data cleanse commenced. Creation of transactional people services function, with a focus on self service where possible. Business cases approved for implementation of e-rostering throughout the Trust and Empactis absence management. Interactive workforce dashboard in development	15

NARRATIVE

Employment essentials

- Virtual recruitment event in development for October / November
- EDI strategic framework agreed at People Committee
- Workforce data flows work progressing. First version dashboard developed in draft – positive feedback from operational management teams
- ESR data cleanse work commenced to facilitate implementation of workforce information systems (e-roster & Empactis absence management)
- Transactional People Services function to be created, pulling together payroll, recruitment workforce data, absence management, e-rostering and temporary staffing
- Covid second surge workforce plan developed, taking into account learning from wave one especially linked to redeployment)

Steps 4 wellness

- Recruitment to clinical psychologist roles to deliver 12 month proof of concept service
- More than 90 well-being champions now in place across the Trust
- Psychological well-being programme aligned to wave 2 escalation triggers
- Risk assessment compliance now around 95%

Go Engage

- Your voice survey approach changed to active divisional feedback and support (business partnering approach)
- Psychological safety work programme – diagnostic and action planning completed. Moving to implementation.

WWL Route Planner

- My Route Plan 2020 has been re-designed and is heavily focused on well-being, personal development and behaviours. Multi-source feedback included. Roll out plan and implementation toolkits in place to help improve quality of the appraisal
- 360 feedback process started for all 8c+ and medical leaders. 360 is behaviour focussed and has been mapped to the WWL Behaviour framework
- Learning Needs Analysis completed for HEE upskilling funding
- Increased placement capacity bid successful
- Face to face core skills delivery framework and requirements scheduled for November Education Governance Committee

PEOPLE: WEIGHTED DASHBOARD

Performance	Measure	Result	1 (Green)	2 (Amber-Green)	3 (Amber)	4 (Amber-Red)	5 (Red)	Weight	Month	Year	Source
Go Engage	Friends and family test (work)	69.04%	≥95%	72-94%	68-71%	64-67%	≤63%	2	3 x 2 = 6	3 x 2 = 6	Workforce team
Employment Essentials	Turnover	8.72%		8.01-8.5%	8.51-9%	9.01-9.9%	≥10%	1	3 x 1 = 3	3 x 1 = 3	Workforce team
Employment Essentials	Leavers with less than 12 months' service	18.16%	≤10%	11-14%	15-20%	21-24%	≥25%	1	3 x 1 = 3	3 x 1 = 3	Workforce team
Route Planner	PDR completion	77.9%	≥95%	86-94%	78-85%	73-77%	≤72%	1	4 x 1 = 4	4 x 1 = 4	Workforce team
Steps 4 Wellness	Energy levels	3.47	≥4.00	3.7-3.99	3.61-3.69	3.47-3.6	≤3.46	1	4 x 1 = 4	4 x 1 = 4	Workforce team
Go Engage	Cultural enabler score	32.67	≥36	35.01-35.9	34.01-35	33.61-34	≤33.6	2	5 x 2 = 10	5 x 2 = 10	Workforce team
Total								8	30	30	
Average									3.75	3.75	

Performance:
We aim to be in the top 10%

Executive lead(s):	Chief Operating Officer Chief Finance Officer	**Reviewing committee:**	Finance and Performance Committee	**DELIVERY CONFIDENCE**	**WEIGHTED DASHBOARD**
Strategic importance:	Delivery of operational and finance performance underpins clinical care, facilitates the patient journey and enhances the patient experience, and affects the organisation's financial performance.				**MONTH:** 3.3 **YTD:** 3.18
Sources of assurance:	▪ Scrutiny by Finance and Performance Committee ▪ Scrutiny by Board of Directors ▪ Use of internal and external auditors ▪ Escalation of emerging risks ▪ Divisional performance reviews ▪ REMC			**ROLLING TREND:**  Aug 2020 Mar 2020 Feb 2020 Jan 2020	**ROLLING TREND:** 3.30 2.35 2.88 2.72 Aug 2020 Mar 2020 Feb 2020 Jan 2020

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

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

NARRATIVE

Currently on track

PERFORMANCE: WEIGHTED DASHBOARD

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

Performance	Measure	Result	1 (Green)	2 (Amber-Green)	3 (Amber)	4 (Amber-Red)	5 (Red)	Weight	Month	Year	Source
4-hour standard	95% of patients should be admitted, transferred or discharged within 4 hours of arrival at A&E	93.26% M 94.81% Y	≥95% YTD	94.9-90% MTD	89.9-80%	79.9-70%	≤70%	2	2 x 2 = 6	1 x 2 = 2	BI (July 2020)
12-hour operational standard	No patient requiring emergency admission will wait 12 hours in A&E	0 M 0 Y	0 M & YTD				1	2	1 x 2 = 2	1 x 2 = 2	BI (Aug 2020)
Ambulance handover standard	All handovers between ambulance and A&E must take place within 15 mins with none waiting >60m	> 60m M > 60m Y	≤ 15 mins	15-30 mins		30-59 mins MTD	>60 mins M & YTD	1			BI (2020)
Cancer treatment times	85% should wait no more than 62 days from urgent referrer to first definitive treatment	76.6% M 78.13% Y	≥85%				≤84.9% M &YTD	2	5 x 2 = 10	5 x 2 = 10	BI (July 2020)
18-week RTT	92% on incomplete RTT pathways (yet to start treatment) should wait no more than 18 weeks	43.96% M 57.52% Y	≥92% YTD				≤91.9% M & YTD	1	5 x 1 = 5	5 x 1 = 5	BI (July 2020)
52-week RTT	Zero tolerance for patient waits over 52 weeks on an incomplete pathway	303 M 303 Y	0				≥1	2	5 x 2 = 10	5 x 2 = 10	BI (July 2020)
Diagnostic waiting times	99% of service users waiting for a diagnostic test should receive it within 6 weeks of referral	68.56% M 44.92% Y	≥99%				≤98.9%	1	5 x 1 = 5	5 x 1 = 5	BI (Aug 2020)
Paper switch off programme	By 1 Oct 2018, NHS E-referral will be used for all relevant consultant-led first OPD appointments	Complete	100%				≤99.9%	1	1 x 1 = 1	1 x 1 = 1	Complete
Control total achievement	Forecast position: Achieve finance control total before PSF	Forecast 4 quarter	Achieve 4 quarters	3 quarters	2 quarters	1 quarter	0 quarters	4			Forecast
Control total achievement	Forecast position: Achieve A&E control total trajectory	No longer applicable	Achieve 4 quarters	3 quarters	2 quarters	1 quarter	0 quarters	2	---	---	Forecast
Use of resources risk rating	Forecast position: Achieve use of resources risk rating as per plan	Forecast 4 quarter	Achieve 4 quarters	3 quarters	2 quarters	1 quarter	0 quarters	4			Forecast
Transformation	SAVI delivery against target	% M % Y	Achieved	Fail by <10%	Fail by 10-20%	Fail by 20-30% YTD	Fail by >30% MTD	3			Finance report ()
IT	Completion of agreed IT priorities in line with plan	91% M	100%	90-99% MTD	80-89%	70-79%	≤70%	2	2 x 2 = 4	---	IT department
Total								13	43(/13)	35(/11)	
Average									**3.3**	**3.18**	

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

Partnerships:
We work together for the best patient outcomes

Executive lead(s):	Director of Strategy and Planning	**Reviewing committee:**	Board of Directors	**DELIVERY CONFIDENCE**	**WEIGHTED DASHBOARD**
Strategic importance:	Effective partnership working underpins our strategic direction				MONTH: 2.08 YTD: 2.08
Sources of assurance:	▪ Scrutiny by committee ▪ Scrutiny by Board of Directors ▪ Use of internal and external auditors	▪ Escalation of emerging risks ▪ Exec-to-exec meetings ▪ REMC		ROLLING TREND: Jan 2020, Nov 2019, Sep 2019, Jul 2019	ROLLING TREND: 2.67 (Jan 2020), 2.75 (Nov 2019), 2.88 (Sep 2019), 2.96 (Jul 2019)

Individual risks	Original Score	Mitigations	Current score
Lack of Tier 4 CAMHS beds	16	Likely to be recalibrated as no current escalations and fed into discussions on new mental health provider	16
Non-achievement of KPIs relating to cellular pathology	16	Shared Services Board re-established. A recovery plan has been agreed to create additional capacity. Still concerns about performance – audit to be put in place. GM action to create pathology network	16
Unable to effectively implement Population Health within Wigan	16	Likely to be recalibrated. Reliant on GraphNet which is now approved but delayed	16

NARRATIVE

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

PARTNERSHIPS: WEIGHTED DASHBOARD

Performance	Measure	Result	1 (Green)	2 (Amber-Green)	3 (Amber)	4 (Amber-Red)	5 (Red)	Weight	Month	Year	Source
Transformation	Support to BIG projects	Fully provided	Fully provided	Mostly provided	Mild problems	Moderate problems	Major problems	2	---	---	Self-assessment
Research	Numbers recruited against target	Target complete	Target complete	Ahead of target	On track	Off target	Way off target	1	1 x 1 = 1	1 x 1 = 1	R&D report
Bolton partnership	Progress on 8 key projects	Major concerns	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	3	---	---	Self-assessment
Locality partnership	Locality plan performance matrix	Mild concerns	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	2	---	---	Self-assessment
Locality partnership	Transformation of hospital care	Almost on track	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	3	2 x 3 = 6	2 x 3 = 6	Self-assessment
Locality partnership	Healthier Wigan partnership score	Almost on track	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	2	2 x 2 = 4	2 x 2 = 4	Self-assessment
Locality partnership	Community services transfer	Fully on track	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	3	1 x 3 = 3	1 x 3 = 3	Self-assessment
NW Sector p/ship	Highlight report for NWSP	Mod. concerns	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	1	3 x 1 = 3	3 x 1 = 3	Self-assessment
GM partnership	Combined theme 3 status	Mod. concerns	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	2	---	---	Self-assessment
GM partnership	Orthopaedic theme 3 status	Fully on track	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	3	---	---	Self-assessment
GM partnership	Cardiology theme 3 status	Almost on track	Fully on track	Almost on track	Mild concerns	Moderate concerns	Major concerns	2	---	---	Self-assessment
SLAs	Compliance	55%	>95%	95-80%	80-60%	60-40%	<40%	2	4 x 2 = 8	4 x 2 = 8	SLA database
Total								24	25/12	25/12	
Average									**2.08**	**2.08**	

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Register of referrals received by the Clinical Ethics Group
Presented to:	Board of Directors
On:	30 September 2020
Presented by:	Not applicable – consent agenda
Prepared by:	Paul Howard, Director of Corporate Affairs
Contact details:	T: 01942 822027 | E: paul.howard@wwl.nhs.uk

Executive summary

It was agreed at the Pandemic Assurance Committee meeting on 13 May 2020 that a high-level summary of cases referred to the Clinical Ethics Group would be reported to the Board at each meeting. The attached table summarises the referrals that have been received from the group since its inception and is presented for information only.

Link to strategy

There is no direct link to the organisation's strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

There are no financial implications arising out of this report.

Legal implications

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

People implications

There are no people implications in this report.

Wider implications

The establishment of a Clinical Ethics Group is intended to support decision-making.

Recommendation(s)

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

Register of referrals made to the Clinical Ethics Group
23 April 2020 to 23 September 2020

Ref.	Date of referral	Time of referral	Urgent or routine referral	Date CEG convened	Time CEG convened	Summary of case	CEG recommendation	Issues escalated to management
CEG-001	1 May 2020	2045hrs	Urgent	1 May 2020	2120hrs	Request for elderly parents to be allowed to visit patient receiving end-of-life care where death was considered to be imminent. Balancing risk to the visitors against desire to visit their relative.	Recommended that visiting be permitted provided risks are explained and PPE is available and can be provided.	Noted that there are conflicting visiting policies in existence. Management to address and have one single policy.
CEG-002	3 May 2020	0942hrs	Retrospective for assurance	7 May 2020	0800hrs	Request to review the care of a now deceased patient, with particular reference to the DNACPR decision-making.	Noted that the referral did not require consideration of ethics in the current sense but comments on the case provided to the Medical Director by way of peer review. No concerns around decision-making or documentation identified.	Nil
CEG-003	3 Jun 2020	0900hrs	Retrospective for assurance	4 Jun 2020	0800hrs	Request to consider the use of best interests around antibody testing for patients without the capacity to consent	Matter referred to the Executive Scrutiny Group with feedback from the Clinical Ethics Group	To be considered by Executive Scrutiny Group
CEG-004	29 Jul 2020	1815hrs	Retrospective for assurance	6 Aug 2020	0800hrs	Request to consider applicability of duty of candour in a historic case.	Clinical Ethics Group view on the case was provided to the referring clinician.	Nil

Title of report:	Standing Financial Instructions
Presented to:	Board of Directors
On:	30 September 2020
Presented by:	Acting Chief Finance Officer
Prepared by:	Shirley Martland, Head of Financial Services and Payroll
Contact details:	T: 01942 773786 Ext: 3786

Executive summary

As a result of COVID-19 and the requirement to be flexible and timely when dealing with issues arising as a result of the pandemic, the Board of Directors at its meeting of 25 March 2020 approved a number of changes to the Trusts Standing Financial Instructions (SFIs).

For information a copy of the changes implemented can found in Appendix 1.

A further change to the SFIs was implemented to reduce the administration burden around approval of business cases and to reflect direction from NHSI that revenue business cases should be suspended.

Details of these changes can be found in Appendix 2.

The Trust is moving back to operating business as usual, and it is therefore appropriate to rescind the schedule of changes whilst retaining the revised business case process.

Link to strategy

None

Risks associated with this report and proposed mitigations

There is a risk that COVID infections could increase to such an extent that warrants the previous changes to expenditure processes to be re-instated. This would be addressed via Board approval.

Financial implications

No impact on financial position but impact on change to financial process and procedure.

Legal implications

None

People implications

None

Wider implications

None

Recommendation(s)

The Board is requested to rescind the previous changes to SFIs around revenue expenditure whilst maintaining the revised business case process.

WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST

("the Foundation Trust")

COVID-19 SCHEDULE TO STANDING FINANCIAL INSTRUCTIONS

Application of this Schedule

This Schedule was approved by the Board of Directors of Wrightington, Wigan and Leigh NHS Foundation Trust ("Board") at its meeting on 25 March 2020 with retrospective application to 1 March 2020.

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

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

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

Interpretation

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

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

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

General statement of intent

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

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

Effect of this Schedule

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. BUSINESS CASE AND TENDER PROCESS

1.1 Introduction

1.1.1 The Trust's business case process has been established to ensure there is full involvement from any party within the organisation that could be affected by the intended direction of travel. Auditability, governance and financial principles are critical to ensure there is no unforeseen service, quality or financial consequences from our investment decisions.

1.2 Revenue expenditure

1.2.1 NHSI have stated that until further notice non-COVID-19 expenditure should not increase and Trust's should suspend all business cases seeking increased revenue spend.

1.2.2 In exceptional circumstances the Executive team may decide that a revenue business case can be considered. The standard business case template is still required, complete with all signatures.

1.2.3 Should the Trust approve it may also be necessary to seek NHSI's approval.

1.3 Capital expenditure

1.3.1 Capital schemes for the year have been categorised as follows:

Category 1: Strategic schemes requiring approval

Category 2: Strategic schemes with revenue implications

Category 3: Schemes already approved as part of the capital allocation for the year.

Business cases will approved in accordance with the following table:

Type of Business Case	ETM	Finance and Performance Committee	Board of Directors
Revenue only	£500k	£1m	>£1m
Capital - category 1	£500k	£1m	>£1m
Capital - category 2 with revenue implications	£500k	£1m	>£1m
Capital - category 2 with no revenue implications	Not required		

1.4 Role of the approving entities

1.4.1 ECC, Finance and Performance Committee and the Board of Directors will take the decision to approve a business case taking into consideration strategic direction, priorities and affordability.

1.4.2 The business case process does not replace the Trust's tendering process which must be followed when purchasing goods or services.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Finance and Performance Committee terms of reference
Presented to:	Board of Directors
On:	30 September 2020
Presented by:	Not applicable – consent agenda
Prepared by:	Paul Howard, Director of Corporate Affairs
Contact details:	T: 01942 822027 | E: paul.howard@wwl.nhs.uk

Executive summary

The terms of reference of the Finance and Performance Committee are appended to this report. They were supported by the Committee when it reviewed them on 19 August 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 arising out of this report.

Legal implications

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

People implications

There are no people implications in this report.

Wider implications

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

Recommendation(s)

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

Appendix

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

FINANCE AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

1.1. The Finance and Performance 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 amendment at future Board meetings.

1.2. The Committee is authorised by the Board to act within its terms of reference. 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 instruct professional advisors and 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.

1.4. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. MAIN PURPOSE

2.1. The Committee will enable the Board to obtain assurance around the financial and performance elements of the foundation trust's business.

2.2. Its key duties are as follows:

Finance

(a) Reviewing and endorsing the foundation trust's annual financial plan prior to presentation to the Board for approval;

(b) Monitoring the foundation trust's in-year performance against the agreed financial plan at divisional and organisational level;

(c) Reviewing and monitoring the strategic five-year capital programme and the annual capital budgets and recommend these to the Board for approval;

(d) Reviewing the cash position of the foundation trust and the related treasury management policies;

(e) To consider and recommend the borrowing strategy for consideration by the Board;

(f) To identify and review external financing arrangements or vehicles, e.g. borrowing, joint ventures or PFI;

(g) Monitoring delivery of the Service and Value Improvement programme;

(h) Monitoring the detailed monthly income and expenditure position of the foundation trust, and reviewing the robustness of the risk assessments underpinning financial forecasts; and

(i) Assessment of the working capital position of the foundation trust, including reviewing the 12-month rolling cash flow forecast and investment portfolio of the foundation trust.

(j) Receiving updates on estates and facilities key performance indicators and other matters relevant to the Trust's performance;

(k) Receiving updates on procurement key performance indicators and other matters relevant to the Trust's performance;

Performance

(l) To review the performance quadrant of the overall balanced scorecard performance report and to seek assurances around deliverability of key performance standards;

(m) To consider the adequacy of forecasting models used in relation to operational performance;

(n) To consider investment or divestment in services;

(o) To monitor delivery against the IT investment plan;

(p) To monitor the foundation trust's operational performance against planned trajectories and seek assurances around any necessary corrective planning and action; and

(q) To seek assurance that the underpinning systems and processes for data collection and management are robust and provide relevant, timely and accurate information to support the operational management of the organisation.

Risk

(r) Consideration of all relevant risks within the Board Assurance Framework as they relate to the remit of the Committee and escalate any issues to Board as required.

Business cases

(s) On the recommendation of the Trust Management Committee, the Committee shall consider:

(i) For approval, any business case over £500,000 and up to a value of £999,999;

(ii) For recommendation to the Board of Directors any business case of £1m or more.

The Committee shall consider business cases in line with the Trust's strategic direction, priorities and affordability.

2.3. The Committee will also provide information to the Audit Committee, when requested, to assist that Committee in ensuring good structures, processes and outcomes across all areas of Governance.

3. MEMBERSHIP

3.1. The membership of the Committee shall consist of:

(a) Three Non-Executive Directors, one of whom shall be Chair;

(b) Chief Finance Officer;

(c) Chief Operating Officer; and

(d) Director of Strategy and Planning.

3.2. The Committee will be deemed quorate on the attendance of two Non-Executive Directors and one Executive Director.

3.3. In the event that the Chair is not able to attend a meeting, one of the other Non-Executive Directors shall take the chair.

4. SECRETARY

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

5. ATTENDANCE

5.1. The following participants are required to attend meetings of the Committee:

(a) Governor; and

(b) Director of Transformation

5.2. The Committee may be attended by any other person who has been invited to attend a meeting by the Committee so as to assist in deliberations.

6. FREQUENCY OF MEETINGS

6.1. Meetings shall be held every two months. There will be six meetings a year.

6.2. Additional meetings may be held on an exceptional basis at the request of the chairperson or any three members of the Committee.

7. MINUTES AND REPORTING

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

7.2. Once approved by the Committee, the minutes will be presented to the board for information.

7.3. The Committee will report to the Board after each meeting.

7.4. The following groups shall report to the Committee:

(a) Site and Service Investment Group

(b) Research and Development Group

8. PERFORMANCE EVALUATION

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

9. REVIEW

9.1. The terms of reference of the Committee shall be reviewed by the Board when required, but at least annually.

Title of report:	Workforce Race Equality Standard and Workforce Disability Equality Standard report
Presented to:	Board of Directors
On:	30 September 2020
Presented by:	Director of Workforce
Prepared by:	Joanne O'Brien, Assistant HR Business Partner
Contact details:	-----

Executive summary

As a public sector NHS organisation the Trust is required to collect data and report a range of Equality & Diversity measures which include the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

The aim of the Workforce Race Equality Standard (WRES) is to improve the experience of Black and Minority Ethnic (BME) staff in the workplace. This includes employment, promotion and training opportunities. It also applies to BAME people who want to work in the NHS. Additionally, this applies to BAME staffs' experience of the employee relations process.

The WDES is mandated through the NHS Standard Contract the WDES enables NHS Trusts and Foundation Trusts to better understand the experiences of their disabled staff. It supports positive change for existing employees, and enables a more inclusive environment for disabled people working in the NHS. Like the Workforce Race Equality Standard on which the WDES is in part modelled, it also allows the ability to identify good practice and compare performance regionally and by type of trust.

This report summarises the Trust`s latest) Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) information.

WRES (Workforce Race Equality Standard)

The data highlights as at 31 March 2020 the Trust`s BAME representation was 8% compared with 3% BAME for the Wigan Borough. 90% of Trust Staff declared their ethnicity with 42% of the Trust's BAME workforce situated within the Medical & Dental Staff Group.

The data highlights that White staff experience higher levels of bullying , harassment and abuse from the Public/Service Users and staff whilst BAME staff experience higher levels from their

Managers. However overall there has been an improvement in this data when comparing it to the previous year's figures.

There has been a significant deterioration in the figures from 2019 of BAME staff reporting that the Trust provides equal opportunities for careers progression or promotion, from 81.8% in 2019 to 58.3% in 2020.

The figures show that BAME staff were 1.62 times more likely than white staff to enter a formal disciplinary process which is a deteriorating position on the previous year's data at 0.66.

Workforce Disability Equality Standard (WDES)

The data highlights as at 31 March 2020 that there was 2.5% of the Workforce declared that they were living with a disability, compared to 16% for the Wigan Borough. There is still a large amount of undeclared data and this remains relatively static since 2019 at 29.09%.

The data highlights that Disabled staff experienced higher levels of bullying , harassment and abuse from the Public/Service Users, Staff and Managers. There was an overall improvement in these figures from 2019 with the exception of disabled staff experiencing bullying, harassment and abuse from colleagues.

Data shows that staff believing that the Trust provides equal opportunities for career progression or promotion was lower for disabled (83.7%) staff than non-disabled staff (85.8%), however this is an improving picture from 2019.

Figures show that 56% of Disabled staff stated that their employer had made adequate adjustment(s) to enable them to carry out their work, however this is a deterioration in figures compared to last year's at 60.5%.

The data shows that the likelihood of Disabled staff member entering a formal capability process is 9.2% times more likely than non- disabled staff (this does not include ill health capability)

Link to strategy

The WRES and WDES are integral to the Trust`s People Strategy and actions including improvement trajectories are to be included within the revised Inclusion & Diversity Strategy which is currently in the draft stages.

Risks associated with this report and proposed mitigations

It is noted there are possible risks of adverse publicity being generated due to the Trust`s WDES and WRES returns and in addition this could negatively impact upon the engagement of disabled and BAME staff who may feel unfairly treated and disengaged.

Whilst it is recognised these risks exist it is noted there has been no adverse publicity generated to date in response to the publishing of the Trust`s previous WDES and WRES returns. In addition there is not yet any qualitative data that suggests engagement levels have been adversely impacted linked specifically to the Trust`s WRES and WDES returns.

There are possible risks of employment tribunal claims relating to discrimination arising from the areas identified for improvement within the WDES and WRES metrics.

Actions and improvement trajectories are in development to respond to the areas where improvement is required and this will support a reduction in risk moving forward.

Financial implications

The potential financial impact resulting from the WDES and WRES is the risk of any employment claim awards relating to discrimination and unlike other tribunal claims such as unfair dismissal there is no limit on the compensation that can be awarded in discrimination claims.

Legal implications

The Equality Act 2010 requires all employers to demonstrate equality of opportunity for staff, as measured against nine Protected Characteristics, including Race & Disability. The Public Sector Equality Duty, contained within the Equality Act 2010, requires all public sector organisations to publish equality performance data on an annual basis; and the NHS Standard Contract requires all provider organisations to publish information on disability equality in the form of the WDES summary

People implications

WRES & WDES has been implemented as the best means of helping the NHS as a whole to improve its performance on workforce race and disability equality. Research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety.

Wider implications

There is considerable evidence that the less favourable treatment of BAME and Disabled Staff in the NHS, through poor treatment and opportunities, has a significant impact on staff well-being, patient outcomes and on the efficient and effective running of the NHS and that the measures needed to address such discrimination will benefit patient care and organisational effectiveness.

Recommendation(s)

To approve the publication of the Trust's Workforce Race Equality Standard (WRES) report and Workforce Disability Standard (WDES) report (appended to this report).

Appended report- for publishing

Workforce Race Equality Standard (WRES) report and Workforce Disability Standard (WDES) report

Background

As a public sector NHS organisation the Trust is required to collect data and report a range of Equality & Diversity measures which include the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standards (WDES).

This report summarises the Trust`s latest Workforce Disability Equality Standard (WDES) and the Workforce Race Equality Standard (WRES).

1 Workforce Race Equality Standard (WRES)

2.1 Information on the WRES

In 2016 NHS organisations through the NHS standard contract were required to implement the Workforce Race Equality Scheme (WRES). The aim of the Workforce Race Equality Standard (WRES) is to improve the experience of Black and Minority Ethnic (BME) staff in the workplace. This includes employment, promotion and training opportunities. It also applies to BME people who want to work in the NHS. Additionally, this applies to BME staffs' experience of the employee relations process. This can be achieved by taking positive action to eliminate discrimination, harassment and unfair treatment of BME staff in the workplace.

2.2 WRES: Key themes for the Trust

Appendix 1 includes a full copy of the Trust`s 2020 WRES submission which relates to data from 1 April 2019-31 March 2020. The data collection is extensive and is drawn from a range of sources including the Electronic Staff Record (ESR), the Trust`s recruitment system TRAC and a number of National staff survey indicators.

Key points to note are:

- The Trust`s BME representation is currently 8% compared with 3% BME for the Wigan Borough
- A high level of staff have self-reported their ethnicity at 90% declared data.
- White staff were 1.52 more likely to be appointed from shortlisting compared with BME applicants which is a deteriorating position from previous year's data at 1.25.
- BME staff were 1.62 times more likely than white staff to enter a formal disciplinary process which is a deteriorating position on the previous year's data at 0.66.
- In the 2019 staff survey 10% of BME staff report bullying & harassment or abuse from patients, relatives or the public compared with 21.2% of white staff. This is an improving position from previous year's results where 34.6% of BME staff reported bullying & harassment or abuse.

- In the 2019 staff survey higher levels 20% of BME staff report bullying & harassment or abuse from managers compared with 10% of white staff. This is an improvement compared to previous year's results which were BME staff 26.9% and White staff 16.8%.
- In the 2019 staff survey higher levels 15.8% of BME staff report bullying & harassment or abuse from staff compared with 16.7% of white staff. This is an improvement compared to previous year's results which were BME staff 20% and White staff 17.6%.
- 58.3% of BME staff believe the Trust provides equal opportunities for career progression or promotion compared with 87.3% of white staff. This is deteriorating position on the previous year's results which were 85% of BME staff and 81.8%.
- 5% of BME staff report experiencing discrimination at work from abuse from patients, relatives or the public compared with 4.2% of white staff which is a slight deterioration of previous year's figures of BME Staff 4% & White Staff 2.9%.
- 20% of BME staff report experiencing discrimination at work from a Manager/Team Leader or other Colleagues compared with 4.6% of white staff which is a slight deterioration of previous year's figures of BME Staff 11.5% & White Staff 6.6%.

2 Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) that will enable NHS organisations to compare the experiences of Disabled and non-disabled staff.

The WDES is mandated through the NHS Standard Contract and it is restricted to NHS Trusts and Foundation Trusts for the first two years of implementation. The implementation of the WDES enables NHS Trusts and Foundation Trusts to better understand the experiences of their disabled staff. It supports positive change for existing employees, and enables a more inclusive environment for disabled people working in the NHS. Like the Workforce Race Equality Standard on which the WDES is in part modelled, it also allows the ability to identify good practice and compare performance regionally and by type of trust.

There are 10 WDES metrics, which cover such areas as the Board, recruitment, bullying and harassment, engagement and the voices of Disabled staff. The statutory information was required to be published in August 2020 on a public facing website.

3.1 WDES : Key themes for the Trust

Appendix 2 includes a full copy of the Trust`s 2020 WDES submission which relates to data from 1 April 2019 - 31 March 2020. The data collection is extensive and is drawn from a range of sources including the Electronic Staff Record (ESR), the Trust`s recruitment system TRAC and a number of National staff survey indicators.

Key points to note are as follows:-

- Non disabled staff are 1.76 times more likely of being appointment from shortlisting compared to Disabled staff.
- The % of disabled staff who experience harassment, bullying and or abuse from their Line Manager, Colleagues & Patients is higher than that for non-disabled staff.

	2019		2020	
	Disabled	Non Disabled	Disabled	Non Disabled
% of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months	27.8%	19.1%	26.7%	14.2%
% of staff experiencing harassment, bullying or abuse from managers in the last 12 months	18.8%	17.3%	16.4%	10.6%
% of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	25.0%	16.1%	26.7%	14.2%

- The % of staff believing that the Trust provides equal opportunities for career progression or promotion was lower for disabled (83.7%) staff than non-disabled staff (85.8%), this is an improvement on the previous year's figures for Disabled Staff (77.1%) and Non-Disabled Staff (83%).
- The % of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties was higher for Disabled (40.4%) staff than Non-Disabled staff (21.9%) this is a deterioration on previous year's figures of Disabled Staff (36.4%) and Non-disabled staff (23.3%) .
- The % staff saying that they are satisfied with the extent to which their organisation values their work is lower for Disabled staff (46%) compared to Non-Disabled staff (51.3%) this is an improvement on previous years' figures of Disabled Staff (38.5%) and Non-disabled staff (43.5%).
- 56% of Disabled staff stated that their employer has made adequate adjustment(s) to enable them to carry out their work, this is a deterioration compared to last year's figures of 60.5%.
- The likelihood of Disabled staff entering the formal capability process is 9.2 times more likely than non-disabled staff.
- There are no reported disabled staff for voting or non-voting Board members.

3 Actions in response to the WDES & WRES

The WRES and WDES are integral to the Trust`s People Strategy and actions including improvement trajectories are to be included within the revised Inclusion & Diversity Strategy which is currently in the draft stages.

All actions in relation to WDES & WRES will be incorporated within the Trust's EDS Action Plan.

Appendix 1 - Workforce Race Equality Standard

Name of organisation:
Wrightington, Wigan and Leigh NHS Foundation Trust

2 Date of report

March/2020

3 Name and title of Board lead for the Workforce Race Equality Standard

Name and title of Board lead for the Workforce Race Equality Standard :
Alison Balson, Director of Workforce

4 Name and contact details of lead manager compiling this report

Name and contact details of lead manager compiling this report:
Joanne O'Brien, 01942 244000

5 Names of commissioners this report has been sent to

Complete as applicable:
Sally Forshaw

Workforce Race Equality Standard reporting template

6 Name and contact details of co-ordinating commissioner this report has been sent to

Complete as applicable.:
Sally Forshaw
Director of Quality & Safety,
Wigan Borough CCG,
Wigan Life Centre,
College Avenue,
Wigan, WN1 1NJ

sally.forshaw@wiganboroughccg.nhs.uk

7 Unique URL link on which this report and associated Action Plan will be found

Unique URL link on which this Report and associated Action Plan will be found:
http://www.wwl.nhs.uk/Equality/wres.aspx

8 This report has been signed off by on behalf of the board on

Name::
Alison Balson

Date 28th August 2020

Background narrative

9 Any issues of completeness of data

Any issues of completeness of data:
BME data recorded on ESR is good quality and we are able to report against a range of indicators. However, our central electronic recording of training data includes internal training only and so we are unable to report on all training undertaken. Therefore, we are currently unable to provide data on the relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff (Section 20).

10 Any matters relating to reliability of comparisons with previous years

Any matters relating to reliability of comparisons with previous years:
None.

Self reporting

11 Total number of staff employed within this organisation at the date of the report:
Total number of staff employed within this organisation at the date of the report:

6282

12 Proportion of BME staff employed within this organisation at the date of the report?
Proportion of BME staff employed within this organisation at the date of the report:

8%

13 The proportion of total staff who have self reporting their ethnicity?

The proportion of total staff who have self–reported their ethnicity:

99%

14 Have any steps been taken in the last reporting period to improve the level of self reporting by ethnicity?
Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity:
Woven Reports are reviewed on a monthly basis and any gaps are duly followed up.

15 Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity?
Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity:
Response rate is high so no current concerns.

Workforce data

16 What period does the organisation's workforce data refer to?
What period does the organisation's workforce data refer to?:
01 April 2019 to 31 March 2020

Workforce Race Equality Indicators

17 Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.

Data for reporting year:

Clinical / Non-Clinical	WRES Banding	BME	White
Clinical	Band 1	2	59
	Band 2	24	1077
	Band 3	23	202
	Band 4	4	196
	Band 5	77	826
	Band 6	23	820
	Band 7	9	509
	Band 8a	5	123
	Band 8b		14
	Band 8c	1	9
	Band 8d		3
	Medical & Dental Consultant	1	2
	VSM		1
	Medical & Dental Consultant	126	79
	Medical & Dental Non-Consultant Career Grade	69	26
	Medical & Dental Trainee Grades	71	46
	AP30		1
	MQ00		1
	WQ00		8

Non	Band 1	1	17

Clinical	Band 2	5	562
	Band 3	24	396
	Band 4	14	324
	Band 5	4	131
	Band 6	4	88
	Band 7	3	78
	Band 8a	2	44
	Band 8b		33
	Band 8c		8
	Band 8d	1	9
	Band 9		8
	VSM		6
	AP30		4
	CRRW		
	WQ00		3

Data for previous year:

Clinical	Band 1	4	294
	Band 2	20	797
	Band 3	2	126
	Band 4	3	129
	Band 5	46	687
	Band 6	20	545
	Band 7	6	344
	Band 8a	4	82
	Band 8b	1	10
	Band 8c		5
	Band 8d		2
	Medical & Dental Consultant	1	2
	Medical & Dental Consultant	118	76
	Medical & Dental Non-Consultant Career Grade	76	33
	Medical & Dental Trainee Grades	95	52
	AP30		4
	WQ00		7

Non Clinical	Band 1	4	89
	Band 2	14	434
	Band 3	8	269
	Band 4	8	293
	Band 5	2	112
	Band 6		58
	Band 7	4	66
	Band 8a	2	48
	Band 8b		25
	Band 8c		5
	Band 8d	1	10
	Band 9		7
	VSM		6
	AP30		6
	CRRW		
	WQ00		2

The implications of the data and any additional background explanatory narrative:
The Trust's BME representation is currently 8% compared to 2.8% BME for the Wigan Borough. A large percentage of BME employees are within clinical staff groups and in particular the Medical & Dental staff group. There are no areas of concern from the data at the present time.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:
There are no concerns from the data at the present time.

18 Relative likelihood of staff being appointed from shortlisting across all posts.

Data for reporting year:
White staff were 1.52 times more likely to be appointed from shortlisting compared to BME applicants.

Data for previous year:
White staff were 1.25 times more likely to be appointed from shortlisting compared to BME applicants.

The implications of the data and any additional background explanatory narrative:
There has been a slight deterioration seen since 2019. Further analysis of the recruitment data will be undertaken at a more granular level to identify any particular areas of concern.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:
The Trust's Equality Objectives for the forthcoming year include a specific focus on further reducing inequalities experienced by staff and applicants from a BME background by, currently

reviewing recruitment training for Interview Panellists for Consultant Recruitment and developing a BME mentoring programme.

19 Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.

Data for reporting year:

BME staff were 1.62 times more likely than white staff to enter a formal disciplinary process.

Data for previous year:
BME staff were 0.66 times more likely than white staff to enter a formal disciplinary process.

The implications of the data and any additional background explanatory narrative:
There has been a significant deterioration since last year's submission.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:
The Trust will undertake a granular level review of the 2019/20 disciplinary cases to identify if there are any specific of concern. The Trust has now introduced an Executive Scrutiny Review Panel for Disciplinary Cases whereby all cases are reviewed prior to any formal process being agreed

20 Relative likelihood of staff accessing non-mandatory training and CPD.

Data for reporting year:
N/A

Data for previous year:
N/A

The implications of the data and any additional background explanatory narrative:
See Question 9 - Background Narrative.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:
New IT Training system introduced to include the new national mandatory training modules which may be able to provide the information required for this metric.

Workforce Race Equality Indicators

21 KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

Data for reporting year:

White: 10%
BME: 21.2%

Data for previous year:

White: 19.50%
BME: 34.60%

The implications of the data and any additional background explanatory narrative:
There has been a significant decrease in BME staff experiencing harassment, bullying or abuse from patients, relatives or the public within this year's results.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:
The trust implemented a just culture programme which included a focus on any bullying/harassment, civility saves lives. A BME Listening Event is planned and it is planned to set up a Staff Network.

22. KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

Data for reporting year:

White:16.7%
BME:15.8%

Data for previous year:

White: 17.6%
BME: 20%

The implications of the data and any additional background explanatory narrative:
Significantly reduced % rate of BME experiencing discrimination at work within this year's results compared with last year.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:
Focus Groups have been held on a regular basis to gain feedback from staff around any areas of concern. We will continue to review internally reported Dignity At Work related Grievances to establish any trends/hotspots requiring further action.

23 KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.

Data for reporting year:

White:87%
BME: 58%

Data for previous year:

White: 81.0%
BME:85%

The implications of the data and any additional background explanatory narrative:
Significant decrease in % of BME staff believing the Trust provides equal opportunities within this year's results.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:
Promotions data is included within the annual inclusion & diversity report and this will be triangulated with the staff survey feedback. Associated actions to be built into EDS action plan.

24 Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.

Data for reporting year:

White: 4.6%
BME: 20%

Data for previous year:

White: 6.60%
BME: 11.50%

The implications of the data and any additional background explanatory narrative:
Significant increase in the % of BME staff reporting discrimination at work from Manager/Team Leader or other colleagues.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:
BME Listening Event will be held in order to look at the bullying and harassment from managers/colleagues to identify any actions.

25 Percentage difference between the organisations' Board voting membership and its overall workforce.

Data for reporting year:

White:
93.8% of the Trust Board membership was White compared with 90.8% of the Trust workforce.

BME:
7.1% of the Trust Board membership was BME compared with 8% of the Trust workforce.

Data for previous year:
White:
92.9% of the Trust Board membership was White compared to 90.6 % of the workforce

BME:
7.1% of the Trust Board membership was BME compared to 8.4 % of the workforce

The implications of the data and any additional background explanatory narrative:
Small differential between the percentage BME Trust Board membership when compared to the Trust workforce.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:
None at present.

26 Are there any other factors or data which should be taken into consideration in assessing progress?

Are there any other factors or data which should be taken into consideration in assessing progress?:
The Trust has run several BME focus groups over a number of years and these sessions have been extremely beneficial in enabling proactive engagement with BME staff and key actions have been incorporated into the EDS action plan in response to feedback obtained.

The Trust reports on other BME data items such as PDR, leavers, flexible working applications and promotions within its Annual Inclusion & Diversity Monitoring Report.

27 Organisations should produce a detailed WRES action plan, agreed by its board. It is good practice for this action plan to be published on the organisation's website, alongside their WRES data. Such a plan would elaborate on the actions summarised in this report, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other workstreams agreed at board level, such as EDS2. You are asked to provide a link to your WRES action plan in the space below.

Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other workstreams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.:
The Trust's EDS Action Plan focuses on actions associated with this year's WRES.

Appendix 2 - Workforce Disability Equality Standard (WDES)

Trust information
1 Name of organisation:

Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust

2 Date of completing this report:

31/08/20

3 Name, job title and email address of the lead compiling this report:

Joanne O'Brien

Job title:
Joint I & D Lead

Email address::
joanne.m.o'brien@wwl.nhs.uk

4 Name of the clinical commissioning group (CCG) that the trust's 2020 WDES annual report (metrics data and action plan) will be sent to:

Name of the clinical commissioning group (CCG) that the trust's 2020 WDES annual report (metrics data and action plan) will be sent to::
Sally Forshaw
Director of Quality & Safety,
Wigan Borough CCG,
Wigan Life Centre,
College Avenue,
Wigan, WN1 1NJ

5 Unique URL link or existing web page on which the trust's 2020 WDES annual report (metrics data and action plan) will be published:
Unique URL link or existing web page on which the trust' 2020 WDES annual report (metrics data and action plan) will be published:
https://www.wwl.nhs.uk/Equality/WDES.aspx

6 Date of board meeting at which the trust's 2020 WDES annual report (metrics data and action plan) were, or will be, ratified
Day/month/year::
30/09/2020

7 Does your trust participate in any programmes or initiatives that are focused on disability equality and inclusion?
Yes

If yes, please provide details:

The Trust has held annual Disability Focus Groups over the past 4 years with the aim of engaging with trust staff living with a a disability. A Listening Event is planned for 2020. Associated actions identified from the focus groups have been built into the EDS Action Plan.

Metric 1 - Workforce representation

8 Did your trust's 2020 data for WDES Metric 1 include any of the following groups of staff? 1) Bank staff, 2) Agency staff, 3) Apprentices 4) Subsidiary group staff:
No
If yes, please detail which staff groups::

9 Do your staff have access to the ESR self-service portal?
Yes

10 Please share any examples of actions taken in the last 12 months to increase the disability declaration rates in your trust:
Please share any examples of actions taken in the last 12 months to increase the disability declaration rates in your trust::
To improve the levels of undeclared disability data, the Trust undertook a communication campaign with staff to raise awareness and provided step by step
guides for employees to change their details via ESR.

Metric 2 - Shortlisting
11 What level of Disability Confident accreditation does your trust currently hold? (Level 1, 2 or 3):
Level 2

12 Does your trust use the Guaranteed Interview Scheme?
Yes

13 Please share any examples of actions that the trust has taken in the past 12 months to improve the recruitment of Disabled staff:
Please share any examples of actions that the trust has taken in the past 12 months to improve the recruitment of Disabled staff :
None

Metric 3 - Capability
14 Did your trust experience any issues with providing the data for Metric 3, which was voluntary last year and mandatory this year?
No
If yes, please provide details::

Metric 4 - Harassment, bullying and abuse
15 Please summarise any actions taken in the last 12 months to reduce harassment, bullying and abuse in relation to Disabled staff:
Please summarise any actions taken in the last 12 months to reduce harassment, bullying and abuse in relation to Disabled staff:

The Trust plans to triangulate the staff survey data against other data sets in order to identify specific areas of concern. Actions will be developed and
included within the EDS Action Plan.

The Trust launched its just culture programme this included will a focus on any bullying / harassment, civility saves lives, embedding within performance
management frameworks and a zero tolerance programme in relation to physical and verbal abuse of employees.

Metric 5 - Career promotion and progression

16 Does your trust provide any targeted career development opportunities for Disabled staff?

No

If yes, or planned, please provide further details::

Not currently

Metric 6 - Presenteeism

17 Has your trust planned any targeted actions to reduce presenteeism?

Yes

If yes, or planned, please provide examples::

Yes – The Trust offer phased return to work for employees who are off work for 4 weeks or more. The Trust also consider s temporary and longer term flexible working options with regards to reducing hours or changes to shift start/finish times.
We are intending to purchase a health & well-being app and attendance management system that has an evidence base to reduce presentism, by improving overall well-being.

Metric 7 - Staff satisfaction

18 Has your trust planned any targeted actions to increase the workplace satisfaction of Disabled staff?

Yes

If yes, or planned, please provide examples::

Yes – The Trust has offered staff opportunity to attend the annual disability focus groups in order to discuss key issues affecting staff living with a disability. Many of the issues/ideas from these focus groups are taken as actions and incorporated within the EDS Action Plan. A listening event is being planned for 2020.

Metric 8 - Reasonable adjustments

19 Does your organisation have a reasonable adjustments policy?

Yes

20 Are costs for reasonable adjustments met through centralised or local budgets within the trust?

Local

21 Please summarise any actions taken in the last 12 months to improve the reasonable adjustments process?

Please summarise any actions taken in the last 12 months to improve the reasonable adjustments process:

A guidance document for Managers in supporting staff with underlying health issues has been updated to include utilisation of the NHS Employers Health
Passport.

Metric 9 - Disabled staff engagement
22 Does your trust have a Disabled Staff Network (or similar)?
No
Yes

23 Was your trust's 2019/20 WDES action plan co-developed with Disabled staff?
Yes
If yes, please provide details on how Disabled staff were involved::
Through feedback via Focus Groups and representatives from our I & D Operational Group

Metric 10 - Board representation
24 Please describe any challenges that your organisation has experienced in collecting and reporting data for this metric:
Please describe any challenges that your organisation has experienced in collecting and reporting data for this Metric::
None

25 Name and job title of the Board lead for the Workforce Disability Equality Standard:
Name and title of Board lead for the Workforce Disability Equality Standard::
Alison Balson, Director of Workforce

26 Please summarise any actions taken in the last 12 months to improve Board representation:
Please summarise any actions taken in the last 12 months to improve Board representation::
Unfortunately there will be a delay in this information, this will be updated in due course.

Supplementary
27 Are there plans for your trust to merge with another trust in the next 12 months?
No
If yes, please provide details::
28 Do you have any further comments about the WDES data collection 2020?
Do you have any further comments about the WDES data collection 2020? :
No of the issues/ideas from these focus groups are taken as actions and incorporated within the EDS Action Plan. A listening event is being planned for 2020.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Statutory, mandatory and recommended posts
Presented to:	Board of Directors
On:	30 September 2020
Presented by:	Not applicable – consent agenda
Prepared by:	Paul Howard
Contact details:	T: 01942 822027 | E: paul.howard@wwl.nhs.uk

Executive summary

There are a number of posts set out in legislation that a foundation trust is required to have. Additionally, there are a number of posts that are required by regulators or which have been recommended as a result of inquiries, investigations or as best practice.

A table summarising the various requirements and the respective post holders is attached to this report as appendix 1.

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

The content of this report covers legal requirements for foundation trusts and serves to provide assurance that all statutory requirements have been satisfied.

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 receive the report and note the content.

Appendix 1

Post	Description	Required by	Post holder
STATUTORY POSTS			
Accounting Officer	The Chief Executive must be designated as the Accounting Officer	Schedule 7, paragraph 16(1)(a) to the National Health Service Act 2006	Silas Nicholls, Chief Executive
Director of Infection Prevention and Control	An individual with overall responsibility for infection prevention and control and accountable to the registered provider in NHS provider organisations.	Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance	Helen Richardson, Chief Nurse
Responsible Officer for Revalidation	A medical practitioner, at the time of appointment and for the preceding 5 years, who must remain a medical practitioner during the course of their appointment. Duties set out in the regulations	The Medical Profession (Responsible Officers) Regulations 2010	Nayyar Naqvi, Responsible Officer
Executive lead for safeguarding	A senior board level lead to take leadership responsibility for the organisation's safeguarding arrangements	Section 11, Children Act 2004 and Working Together to Safeguard Children 2015 (mandatory guidance)	Helen Richardson, Chief Nurse
Authorised Officer in relation to removing person causing nuisance or disturbance	Any English NHS staff member authorised to exercise powers which are conferred or an authorised officer in respect of English NHS premises	Section 120, Criminal Justice and Immigration Act 2008	Jason Carr, Security and Car Parking Manager
Accountable Emergency Officer	Board-level director responsible for EPRR with executive authority and responsibility for ensuring that the organisation complies with legal and policy requirements and to provide assurance to the Board.	Section 252A National Health Service Act 2006	Mary Fleming, Chief Operating Officer
Accountable officer for controlled drugs	A fit, proper and suitably experienced person who satisfies the requirements as to seniority, reporting arrangements and activities	Section 8 The Controlled Drugs (Supervision of Management and Use) Regulations 2013	Mike Parks, Chief Pharmacist

Post	Description	Required by	Post holder
Chair	There must be a Chair of the organisation	Schedule 7, paragraph 16(1)(a) to the National Health Service Act 2006	Robert Armstrong, Chair
Chief Executive	There must be a Chief Executive of the organisation	Schedule 7, paragraph 16(1)(a) to the National Health Service Act 2006	Silas Nicholls, Chief Executive
Designated Individual	Duty to secure that suitable people and suitable practices are used in the course of carrying out the licensed activity and that the conditions of the licence are complied with.	Human Tissue Act 2004	Helen Richardson, Chief Nurse
Data Protection Officer	To inform and advise on legal obligations, on the carrying out of data protection impact assessments, to act as the point of contact for the ICO and to monitor compliance with personal data policies.	Section 69 Data Protection Act 2018; General Data Protection Regulation	Natalie Baxter, Head of Information Assurance and DPO
Chief Finance Officer	There must be a finance director on the board	Schedule 7, paragraph 16(1)(a) to the National Health Service Act 2006	Ged Murphy, Acting Chief Finance Officer (to 30 Sep 2020) Ian Boyle (from 1 Oct 2020)
Registered medical practitioner or dentist as a director	One of the executive directors must be a registered medical practitioner or dentist	Schedule 7, paragraph 16(2) to the National Health Service Act 2006	Sanjay Arya, Medical Director
Registered nurse or registered midwife as a director	One of the executive directors must be a registered nurse or midwife	Schedule 7, paragraph 16(2) to the National Health Service Act 2006	Helen Richardson, Chief Nurse
Nominated individual	Responsible for supervising the management of the carrying on of CQC regulated activities.	Regulation 6, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	Helen Richardson, Chief Nurse
Named doctor for safeguarding children	To support other professionals in their agencies to recognise the needs of children. This should be explicitly defined in job descriptions.	The Children Act 1989 and 2004; Working Together to Safeguard Children 2015 and 2018 (statutory guidance)	Vineeta Joshi, Paediatric Consultant

Post	Description	Required by	Post holder
Designated Doctor for Safeguarding Children	To support other professionals in their agencies to recognise the needs of children. This should be explicitly defined in job descriptions. To provide Safeguarding Supervision to the Named Doctor for Safeguarding Children.	The Children Act 1989 and 2004; Working Together to Safeguard Children 2015 and 2018 (statutory guidance)	Shirley Castille (provided via CCG commissioning arrangements)
Named Doctor for safeguarding adults	To support other professionals in their agencies to recognise the needs of adults. This should be explicitly defined in job descriptions.	The Care Act 2014	Stephen Guilliford, Medical Consultant
Named nurse for safeguarding adults	To support other professionals in their agencies to recognise the needs of children. This should be explicitly defined in job descriptions	The Care Act 2014	Anna Svarc, Named Nurse for Safeguarding Adults
Named nurse for safeguarding children	To support other professionals in their agencies to recognise the needs of children. This should be explicitly defined in job descriptions	The Children Act 1989 and 2004; Working Together to Safeguard Children 2015 and 2018 (statutory guidance)	Linda Cuniffe, Named Nurse for Safeguarding Children
Named midwife for safeguarding	To support other professionals in their agencies to recognise the needs of children. This should be explicitly defined in job descriptions	The Children Act 1989 and 2004; Working Together to Safeguard Children 2015 and 2018 (statutory guidance)	Sharon Heap, Named Midwife for Safeguarding
Responsible Person	To ensure the correct processing of blood or blood components, including storage and distribution and providing information as required	Blood Safety and Quality Regulations 2005	PAWS
Medical Physics Expert (Nuclear medicine)	An individual with the knowledge, training and experience to act or give advice on matters relating to radiation physics applied to exposure	Ionising Radiation (Medical Exposure) Regulations 2017	Emma Birch and Christie Theodorakou, Medical Physics Experts
Radiation protection supervisor	To secure compliance with the regulations in respect of work carried out in areas made subject to local rules.	Section 14(4) Ionising Radiation Regulations 1999 and Health and Safety Executive	Lee Unsworth (lead RPS, with specific RPSs for different modalities)
Superintendent pharmacist	A pharmacist who has been notified to the registrar	Section 71 Medicines Act 1968	Mike Parks, Chief Pharmacist

Post	Description	Required by	Post holder
MANDATORY POSTS			
Caldicott Guardian	A senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly	Health Service Circular HSC 1999/012	Sanjay Arya, Medical Director
Guardian of Safe Working	To oversee work schedule review process and to address concerns relating to hours worked and access to training opportunities	2016 terms and conditions of service for doctors and dentists in training	Shams Khan, A&E Consultant
Accredited Security Management Specialist	Focal point for the local delivery of professional security management work carried out to a high standard within a national framework	Direction to NHS bodies on Security Management Measures 2004	Jason Carr, Security and Car Parking Manager
Accredited Local Counter-Fraud Specialist	Responsibilities set out in the directions from the Secretary of State.	Directions to NHS trusts and Special Health Authorities in respect to Counter Fraud 2017	Collete Ryan, Fraud Specialist Manager
Senior Responsible Officer for EU Exit/UK End of Transition	Board-level individual responsible for providing information returns to NHSI, reporting EU Exit-related problems and ensuring that business continuity plan incorporates potential 'no deal' exit implications	EU Exit Operational Readiness Guidance 21 December 2018 and Professor Keith Willett letter of 16 September 2020 (Gateway reference 001559)	Mary Fleming, Chief Operating Officer
Senior Information Risk Owner	Executive director or member of the senior management board with overall responsibility for an organisation's information risk policy, accountable and responsible for information risk across the organisation.	David Nicholson letter dated 20 May 2008 (Gateway reference 9912)/Data Security and Protection Toolkit	Ged Murphy, Acting Chief Finance Officer Richard Mundon, Director of Strategy and Planning from 1 Oct 2020
Senior Independent Director	To provide a sounding board for the Chair and to serve as an intermediary for other directors when necessary. Should be available to governors if they have concerns that contact through the normal channels of chairperson, chief executive, finance director or secretary has failed to resolve or for which such contact is inappropriate.	Provision A.4.1 NHS Foundation Trust Code of Governance	Lynne Lobley, NED

Post	Description	Required by	Post holder
Named nurse for looked after children	A registered nurse with additional knowledge, skills and experience that has a particular role with looked after children and is the lead professional for these children	Looked After Children: Knowledge, Skills and Competences of Health Care Staff (Intercollegiate Role Framework March 2015)	Michelle Nicholls, Named Nurse for Children in Care
Company Secretary	The secretary of the foundation trust or any other person appointed to perform the duties of secretary	Foundation Trust Constitution	Paul Howard, Director of Corporate Affairs
Resuscitation Officer	Responsible for coordinating the teaching and training of staff in resuscitation. One WTE per 750 members of clinical staff is recommended.	Resuscitation Council (UK) Quality Standards for cardiopulmonary practice and training	Janet Woods, Solaman Rashid and Matt Sawyer
Medication error lead	A board-level director to have the responsibility to oversee medication error incident reporting and learning	Patient Safety Alert NHS/PSA/D/2014/005 MHRA/NHS England March 2014	Sanjay Arya, Medical Director
UK Visa and Immigration Authorising Officer	Senior and competent person responsible for the actions of staff and representatives who use the Sponsorship Management System	UK Visas and Immigration	James Baker, Deputy Director of Human Resources
RECOMMENDED POSTS			
Learning from Deaths Champion	To ensure that processes are robust, focus on learning and can withstand external scrutiny, that quality improvement becomes and remains the purpose of the exercise and that the information published is a fair and accurate reflection of achievements and challenges	National guidance on learning from deaths (National Quality Board, March 2017)	Martin Farrier, Associate Medical Director
Sustainability Improvement Champion	An person to take responsibility for leading the spread efforts and helps to ensure the sustainability of interventions already implemented.	Sustainable Development Unit guidance	Tony Warne, NED

Post	Description	Required by	Post holder
NED Lead for Freedom to Speak Up	A nominated non-executive director to receive reports of concerns directly from employees (or from the Freedom to Speak Up Guardian) and to make regular reports on concerns raised by staff and the organisation's culture to the Board	Freedom to Speak Up Review 2015	Clare Austin, NED
NED lead for mortality	To have oversight of the mortality process	National guidance on learning from deaths (National Quality Board, March 2017)	Steven Elliot, NED
NED lead for safeguarding	To ensure appropriate scrutiny of the organisation's safeguarding performance and to provide assurance to the board of the organisation's safeguarding performance. Core competencies around training and understanding set out in the guidance	Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff, Fourth Edition, January 2019, p.61	Rhona Bradley, NED
NED lead for end of life care	A lay member of the board with specific responsibility or a role for end of life care.	End of Life Care Audit - Dying in Hospital 2016	Steven Elliot, NED
NED lead for EPRR	To support the Accountable Emergency Officer to endorse assurance to the board that the organisation is meeting its obligations with respect to EPRR and relevant statutory duties under the Civil Contingencies Act 2004 and the National Health Service Act 2006 (as amended)	NHS England Core Standards guidance for Emergency Preparedness, Resilience & Recovery (EPRR), p.17	Robert Armstrong, Chair
NED lead for procurement	A non-executive director to sponsor the procurement function	NHS Procurement: Raising our Game, p.19 (DHSC gateway reference 17646)	Mick Guymer, NED
Designated board member for Maintaining High Professional Standards (MHPS)	Representations may be made to the designated Board member in regard to exclusion, or investigation of a case if these are not provided for by the NHS body's grievance procedures. The designated Board member must also ensure, among other matters, that time frames for investigation or exclusion are consistent with the principles of Article 6 of the European Convention on Human Rights.	Maintaining High Professional Standards in the Modern NHS (2003)	Clare Austin, NED

Post	Description	Required by	Post holder
NED lead for resuscitation	A non-executive director given designated responsibility on behalf of the board to ensure that a resuscitation policy is agreed, implemented and regularly reviewed within the clinical governance framework	Health Service Circular 2000/028	Lynne Lobley, NED
Wellbeing Guardian	To look at the organisation's activities from a health and wellbeing perspective and act as a critical friend, while being clear that the primary responsibility for our people's health and safety lies with Chief Executives or other accountable officers.	NHS People Plan	Ian Haythornthwaite, NED
MRI responsible person	A person with day-to-day responsibility for safety in the MRI centre	MHRA guidance	Barry Burgess, Cross-Sectional Imaging Manager
Freedom to Speak Up Guardian	A person appointed by the organisation's Chief Executive to act in a genuinely independent capacity	Freedom to Speak Up Review, Feb 2015	Kyle Collum, FTSUG
Freedom to Speak Up Executive Lead	At least one nominated executive director to receive and handle concerns	Freedom to Speak Up Review, Feb 2015	Alison Balson, Director of Workforce
Medication Safety Officer	A person notified to the Central Alerting System to support local medication error reporting and learning and to act as the main contact for NHS England and MHRA.	Patient Safety Alert NHS/PSA/D/2014/005 MHRA/NHS England March 2014	Kim Ferguson, Medicine Safety Officer
WWL POSTS			
NED for FOI internal reviews	To provide an independent perspective to internal freedom of information reviews	Internal approach	Mick Guymer, NED