Board of Directors

Wed 27 January 2021, 13:30 - 15:20

via Videoconference

Agenda

0 min

9. Declarations of interest

Information *Robert Armstrong*

0 min

10. Minutes of previous meeting

Approval *Robert Armstrong*

Minutes - Public board - Nov 2020.pdf (10 pages)

10 min

11. Chair and Chief Executive's Report

Information *Robert Armstrong/Silas Nicholls*

(Presentation)

15 min

12. Situation Report

Discussion *Silas Nicholls*

(Verbal)

15 min

13. Committee Chair's Reports

Discussion *Commitee Chairs*

(Verbal)

5 min

14. Board Assurance Framework

Approval *Robert Armstrong*

BAF - People - Jan 2021.pdf (4 pages)
BAF - Partnerships - Jan 2021.pdf (2 pages)
BAF - Patients - Jan 2021.pdf (2 pages)
BAF - Performance - Jan 2021.pdf (2 pages)

15 min

15. Performance Report

Discussion *Morag Olsen/Mary Fleming/Sanjay Arya*

Performance Report.pdf (4 pages)

15 min

16. Infection Prevention and Control Board Assurance Framework

Discussion *Morag Olsen*

- Infection Prevention and Control Board Assurance Framework.pdf (30 pages)

10 min

17. Ockenden Report

Discussion *Morag Olsen*

- Ockenden Review Dec 2020 12 IEA TEMPLATE v3 1.pdf (1 pages)
- Ockenden Review Dec 2020 12 IEA TEMPLATE v3 2.pdf (4 pages)
- Ockenden Review Dec 2020 12 IEA TEMPLATE v3 3.pdf (1 pages)
- Assessment and assurance tool v1.1.pdf (24 pages)

15 min

18. Bi-Annual Staffing Review

Discussion *Morag Olsen*

Presentation

0 min

19. Consent Agenda

19.1. Review of Risk Appetite Statement

Information

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

19.2. Finance Report

Information

- Board Report 20-21 December month 9 Public.pdf (2 pages)

10 min

20. Questions from the public

Discussion *Robert Armstrong*

0 min

21. Date, time and venue of next meeting

The next Board of Directors to be held in public will be on 31 March 2021

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

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

HELD ON 25 NOVEMBER 2020, 2PM

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
	Mr I Boyle	Chief Finance Officer
	Lady R Bradley DL	Non-Executive Director
	Dr S Elliot	Non-Executive Director
	Ms M Fleming	Chief Operating Officer
	Mr M Guymer	Non-Executive Director
	Mr I Haythornthwaite	Non-Executive Director
	Mrs L Lobley	Non-Executive Director
	Mr R Mundon	Director of Strategy and Planning
	Mr S Nicholls	Chief Executive
	Mrs M Olsen	Interim Chief Nurse
	Prof T Warne	Non-Executive Director
In attendance:	Miss H Holding	Deputy Company Secretary (Minutes)
	Mr P Howard	Director of Corporate Affairs
	Prof S Ranote	Med Director for Mental Health & Clinical Integration
	Mrs L Sykes	Public Governor (Observer)

155/20 Chair and quorum

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

156/20 Apologies for absence

No apologies for absence were received.

157/20 Declarations of interest

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

158/20 Minutes of previous meeting

The minutes of the previous meeting held on 30 September 2020 were **APPROVED** as a true and accurate record. Confirmation was provided that all actions on the action log had been completed.

159/20 Staff Story

The Board of Directors received a short video in which two staff members, Sue and Brendan, detailed their experience at the foundation trust throughout the COVID-19 pandemic.

Sue detailed her experience as a redeployed member of the pharmacy administration team. She outlined that despite being tired as a result of the impact that the pandemic has had, staff remain caring, compassionate and committed to providing patient care. Sue relayed her personal experience with COVID-19, in that she had tested positive for the virus and was admitted to the trust as a patient.

Brendan detailed his experience as a porter on the wards. He outlined his experience on a ward with regard to challenges he faced with regard to wearing personal protection equipment (PPE). Brendan outlined that he now feels safe on the wards after he raised the difficulties that he had experienced with the Director of Workforce as part of a Wellbeing Walkabout, at which time the issue was resolved.

The Director of Workforce outlined how the two stories brought together the fears, anxieties and worries that staff have had throughout the pandemic. She detailed that a shared commitment to do the right thing and provide high quality compassionate care for patients is consistent throughout all staff. Using Brendan's story as an example, she emphasised the impact that can be had from what could be considered to be a small action. The Medical Director agreed, and noted the impact that the goodwill of staff had on the NHS throughout difficult times.

The Chief Operating Officer agreed that the staff stories presented were representative of the fears and anxieties of staff throughout the foundation trust. She reflected on concerns that staff had at the start of the first wave of the COVID-19 pandemic around the availability of PPE and recommended that reassurance is provided that a shortage of PPE will not be an issue.

Prof Austin was pleased to note how the presentation highlighted the focus that staff have for caring for patients. In the instance of Brendan's story, she questioned whether the correct lines of open communication are in place for staff to feel safe raising their concerns. The Director of Workforce felt that those channels are in place. Staff can raise concerns through line managers, and members of the executive team and senior manager team are visible and undertake regular Wellbeing Walkabouts. Further, there are over 100 wellbeing champions in place that staff can talk to at any time. The Director of Workforce confirmed for Prof Austin that the uptake of staff utilising psychological wellbeing services is high.

On behalf of the Board, the Chair thanked Sue, Brendan and all the staff at the foundation trust for their commitment and hard work since the start of the pandemic.

160/20 Chair and Chief Executive's update

The Chief Executive provided a verbal update on the current situation at the foundation trust with regard to second wave of the pandemic. Positive cases have exceeded worst case scenario modelling from the start. Nationally, the NHS has reverted back to Level 4. Gold and Silver Command and Control structures are in place across Greater Manchester. The Chief Executive emphasised that despite the challenges faced, the ability to ensure continuation of care at the foundation trust for every patient is a testament to all staff, and that the success has come at the cost of immense strain on all both professional and personally.

The Chief Executive welcomed the Chief Finance Officer, Mr Ian Boyle, the Director of Mental Health and Clinical Integration, Dr Sandeep Ranote and Mrs Morag Olsen, Interim Chief Nurse to their first formal Board of Directors meeting.

The Board of Directors heard that verbal feedback following a recent visit from NHS England and Improvement (NHSE/&I) had been positive. NHSE*I have recognised the high standard of cleanliness, the use of PPE and clear communications across WWL. The Infection Prevention and Control (IPC) Team are working to introduce measures of recommended improvement, such as the provision of isolation pods.

The first virtual Annual Members Meeting took place in October 2020, which had been a success. The meeting is accessible to watch on the WWL Website. The Annual Report and Annual Accounts have also now been published and can also be accessed on the website.

The Chief Executive thanked Mr Howard Gilmore and Mrs Karen Taylor-Smith for their contribution on the Council of Governors, and welcomed Mr Phil Woods, Mr Andrew Savage and Ms Shelly Sephton.

A drive has been made across the foundation trust to increase the uptake of flu vaccinations. The Director of Strategy and Planning confirmed that 100% of the Board of Directors and 48% of frontline staff have had their flu jabs to date. The Chief Executive anticipated that the first tranche of a COVID-19 vaccination will be available in December 2020.

The bi-annual staffing review has been delayed to January 2021, as further guidance is expected to be released which will support the process.

The Chair provided an update following the attendance of several governors at a Clinical Commissioning Group (CCG) hosted event. The event looked at feedback around the initial implementation of the GP triage pilot for walk-in patients. 70% of those surveyed stated that they had waited less than 60 minutes for an appointment, and overall experience had been good or very good.

The Board of Directors received and noted the verbal update.

161/20 Situation Report

The Chief Operating Officer presented a verbal summary of the COVID-19 pandemic situation report. The Board of Directors heard that the transmission rates across the Wigan Borough escalated from containment to red throughout October and November 2020, with Wigan having one of the highest rates of transmission in Greater Manchester and the UK. Despite the news across the Wigan Borough that the transmission rate is stabilising, the foundation trust continues to see high occupancy rates and expects to operate at this high level for some time.

The Chief Operating Officer detailed that the second wave of the pandemic has felt worse that the first wave in many ways. The impact on capacity has been significant, and demand has remained steady on critical care and on the CPAP ward. There has been an increase in COVID-19 positive patients admitted to general and acute beds, who occupy up to 30% of occupied beds. The foundation trust has consistently had a bed occupancy rate of 97% throughout the pandemic.

Staff have been redeployed throughout the foundation trust in response to needs identified in response to the pandemic. Unfortunately, there have been a higher number of staff absences relating to COVID-19 on this occasion.

In August 2020, the foundation trust achieved 80% of activity against the Elective Recovery Plan which was submitted to NHSE&I. Unfortunately, the impact of the second wave has resulted in the centralisation of elective surgery to one site. The Chief Operating Officer confirmed that elective patients continue to be treated in priority order, and clinically urgent patients are seen first.

The Director of Workforce provided a verbal update around the asymptomatic testing of staff that had commenced the previous day. Staff in patient facing roles have been issued with asymptomatic test kits, and an additional 600 kits are expected to be provided to all students and agency staff. To date, 2000 kits have been issued, and out of 386 tests only 7 staff have been identified as positive.

Lady Bradley noted the update that the second wave had been challenging. In response to a question around plans for long COVID-19 conditions, the Medical Director detailed plans for a COVID-19 clinic that would oversee patients experiencing symptoms beyond three months. In addition, virtual COVID-19 clinics have been established to allow regular monitoring of patients where admissions can be avoided. The Medical Director for Mental Health and Clinical Integration confirmed that three long COVID-19 clinics will be established across the North West. She added that the mental health approach to COVID-19 is crucial, ensuring that the systematic impact it has is encompassed with a holistic approach.

The Board of Directors received the report and noted the content.

162/20 Committee Chairs' Report and Board Assurance Framework

Prof Warne opened this item and provided an update following the Quality and Safety Committee meeting in October 2020, at which time the committee discussed the impact of redeployment both on staff and on services. Quality accounts and the national patient safety action plan were approved at the meeting. Prof Warne informed the Board of Directors that the board assurance framework rating remains at 'amber', and will be reviewed at the meeting in December 2020.

My Haythornthwaite provided an update following the Audit Committee meeting in November 2020. The committee considered the internal audit progress report, and discussions focused around the potential impact on the internal audit opinion at the end of the financial year. The committee received assurance that good progress is being made against the identified actions. Mr Haythornthwaite detailed the committee's review and approval of the charity's annual report and accounts, and the updates received from counter fraud. The legal service annual report was also presented to the committee.

The Finance and Performance Committee is due to meet at the start of December 2020, at which time it will review its board assurance framework. Mr Guymer informed the Board of Directors that the committee will also review the risks which score 20 or higher, and the progress made against the action plans which are in place to mitigate the same. He reminded the Board of Directors that finance controls across the NHS have been managed nationally during the first six months of the year as a result of the COVID-19 pandemic.

Mrs Lobley provided an update with regard to the People Committee. The committee is due to meet at the start of December 2020. Mrs Lobley detailed the emphasis on the committee agenda around staff health and wellbeing, psychological support, redeployment and recruitment challenges. A workforce dashboard has been developed to manage staff risk assessments with regard to COVID-19. The board assurance framework remains 'red' as a result of the recruitment challenges.

The Board of Directors received the report and noted the verbal updates provided.

163/20 Performance report

The Interim Chief Nurse opened this item by noting that the foundation trust had reported 11 serious incidents in the previous period. Of these, two incidents related to COVID-19 outbreaks, one related to an unsafe discharge, three had been escalated as a result of hospital acquired pressure ulcers.

The Interim Chief Nurse was pleased to report to the Board of Directors that there have been no cases of MRSA for 626 days.

Throughout September, 19 complaints have been received. To date, 13 of those complaints have been replied to, and replies are being actioned for the remaining.

The Chief Operating Officer noted the positive progress made against the elective recovery plan throughout August 2020, and the foundation trust remained on track for cancer performance. As updated earlier in the meeting, the elective recovery programme is being maintained as a restrictive programme at present as a result of the redeployment of staff.

The Medical Director drew attention to the positive update that hospital standardised mortality ratio remain below 100.

The Chair recognised the impact had by the staffing issues and the pressure of general and acute beds at 97% occupancy.

The Board of Directors received the report and noted the content.

164/20 Staff Health and Wellbeing Report

The Director of Workforce presented a report which had been circulated with the agenda and provided an update on staff health and wellbeing. She alluded to the staff story which had highlighted the need for sustained and prolonged psychological wellbeing support for staff.

The foundation trust has an established staff health and wellbeing programme (Steps 4 Wellness) which includes both physical and mental health. Steps of Support (SOS) is the branding for the foundation trust's psychological support programmes. SOS is a stepped programme of support designed by clinical psychologist to meet the needs of staff during and beyond the COVID-19 pandemic. Following the approval of investment for a psychological support team, positions have been recruited to.

Recent enhancements to the programme include the implementation of the Schwartz Rounds and the development of Leadership Support Circles to build on reflective supportive approaches.

The Director of Mental Health and Clinical Integration detailed her involvement in staff health and wellbeing by ensuring that psychological services are more accessible for staff.

The Chief Executive emphasised the need to ensure that the basics are in place where staff feel pressured and tired, which is reflective in the number of unplanned absences.

The Chair expressed thanks to all those involved in supporting the staff health and wellbeing programme.

The Board of Directors received the report and noted the content.

165/20 Infection Prevention and Control Board Assurance Framework

The Interim Chief Nurse presented the Infection Prevention and Control (IPC) Board Assurance Framework which had been circulated with the agenda. She informed the Board of Directors that a review of the IPC Board Assurance Framework has been undertaken with the IPC team, with a view to incorporating recently published guidance. A gap analysis has been undertaken as part of the review, and an executive director assigned to each area of development.

Prof Tony Warne confirmed for the Chair that the board assurance framework and gap analysis will be reported to the Quality and Safety Committee at its next meeting.

The Board of Directors received the report and noted the content.

166/20 Review of risk appetite statement

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

The Board of Directors received risk appetite statement as presented, and noted the content.

167/20 Safe Staffing Report

The Interim Chief Nurse presented a report which has been circulated with the agenda and provided the Board of Directors assurance of the ongoing monitoring of nurse staffing levels across inpatient areas.

Attention was drawn to the number of registered nurse vacancies which remained high, in particular, vacancies for Band 5 nurses within the division of medicine. The Interim Chief Nurse explained that exit interviews are being commenced with Band 5/6 leavers to establish what opportunities the foundation trust can create in instances where staff outline this as a reason for leaving.

A sustained reduction of district nurse vacancies remained at 14%.

The Interim Chief Nurse detailed that the recent restrictions on international recruitment continue to delay plans to minimise vacancies. As a result, the trajectory for recruitment is being revised, however remains dependent on the lifting of constraints to a national level.

The Board of Directors heard how many staff have been redeployed from services that have been redeployed from services that have been stood down to critical areas. The Interim Chief Nurse outlined that the combination of vacancies and sickness absence levels has proved challenging across the foundation trust throughout the second wave.

The Board of Directors received the report and noted the content.

168/20 Black, Asian and Minority Ethnic (BAME) Employment Profile in WWL

The Director of Workforce presented a report which was circulated with the agenda with regard to Black, Asian and Minority Ethnic (BAME) Employment Profile in the foundation trust. She detailed that it is nationally recognised that BAME employees are often underrepresented in decision making roles within the NHS. Furthermore, the national and Trust submitted Workforce Race Equality Standard demonstrates that BAME employees experience inequalities in their employment, whether that be access to development and career progression opportunities, their likelihood of being recruited to a position from being shortlisted and their likelihood to be subject to formal disciplinary processes. NHSE&I have set an improvement trajectory for each Trust in relation to BAME representation across the pay bands.

The Director of Workforce stated that the foundation trust should have an ambition to increase diversity at all levels, including senior leaders and at Board level.

The Board of Directors heard that the a new Equality, Diversity and Inclusion Strategy is being developed and will focus on ensure the foundation trust's workforce is diverse, representing the needs of the local population, improving the experience of work for people in protected groups and eliminating inequality in employment.

Prof Austin was pleased to note the holistic approach to equality and diversity. The Director of Workforce confirmed for Prof Austin that the foundation trust is working with its partners across the borough to implement a long term programme of change.

The Medical Director welcomed the update presented. He detailed his attendance on the foundation trust's BAME Group, and outlined how the lack of career progression for BAME employees is a regular theme of discussion. He emphasised the need to ensure that the non-medical workforce is also considered. The Medical Director detailed how the group do not wish to be referred to as BAME, and in place intend to rename the group FAME; Focus on All Minority Ethnic Groups.

The Director of Workforce defined the differences of positive action and positive discrimination for Dr Elliot. She detailed the positives in identifying change in recruitment processes and selection to be more inclusive, such as advertising vacancies in different parts of the community that are not widely represented at present. The Medical Director for Mental Health and Clinical Integration agreed that it is important to widen the equality of those applying for jobs at every level. She added that the workforce at the foundation trust has a higher representation of BAME employees than other organisations.

169/20 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 Quality Account 2019/20 be **APPROVED**.

2. THAT the Infection Prevention and Control Annual Report 2019/20 be received and noted.

3. THAT the register of Clinical Ethics Group referrals be received and noted.

4. THAT the monthly trust financial report for Month 7 (October 2020) be received and noted.

170/20 Date time and venue of the next meeting

The next meeting of the Board of Directors held in public will be held on 27 January 2021, 2.00pm by videoconference.

Action log

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
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People:
Everyone has the opportunity to achieve their purpose

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

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

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

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

NARRATIVE

Employment Essentials

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

Go Engage

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

WWL Route Planner

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

Steps 4 Wellness

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

PEOPLE: WEIGHTED DASHBOARD

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

Partnerships:
We work together for the best patient outcomes

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

Individual risks	Original Score	Mitigations	Current score
Lack of Tier 4 CAMHS beds	16	Ongoing discussions with mental health provider, but few options available. Considering alternative escalation routes. Has impacted on physical environment in Rainbow. Recent discussions with GM Mental Health as part of the transition plan	16
Non-achievement of KPIs relating to cellular pathology	16	Some performance issues remain, but the current focus is on testing and those turnaround times have significantly improved with new equipment at Salford. A sub-group is work through pathology risks in more detail and GM continues to pursue a pathology network through the PFB CSS sub-group and DoS.	16
Unable to effectively implement Population Health within Wigan	16	Likely to be recalibrated. Reliant on GraphNet which is now approved but delayed.	16

NARRATIVE

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

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

PARTNERSHIPS: WEIGHTED DASHBOARD

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

Patients:
Every patient receives the best possible care

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

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

PATIENTS: WEIGHTED DASHBOARD

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

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

Performance:
We aim to be in the top 10%

Executive lead(s):	Chief Operating Officer Chief Finance Officer	**Reviewing committee:**	Finance and Performance Committee	**DELIVERY CONFIDENCE**	**WEIGHTED DASHBOARD**
Strategic importance:	Delivery of operational and finance performance underpins clinical care, facilitates the patient journey and enhances the patient experience, and affects the organisation's financial performance.				MONTH: 4.23 YTD: 4.27
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:  Nov 2020 / Sep 2020 / Aug 2020 / Mar 2020	ROLLING TREND:  4.23 / 3.30 / 3.30 / 2.35 Nov 2020 / Sep 2020 / Aug 2020 / Mar 2020

Individual risks scoring ≥20	Original Score	Update	Current score
Funding allocation via Greater Manchester does not cover revenue expenditure with a shortfall each month from October 2020 of approximately £3m	20	The trust continue to ensure all costs incurred are essential to the delivery of services using the approved governance framework, and will seek to influence the GM ICS and NW region wherever possible to secure sufficient resources to cover its costs	20
Potential closure of RAEI theatre 1 and 2 following annual verification report	15	Refurbishment has progressed, and theatres are due to open on 8 February 2021 ahead of the projected timeframe.	20
Potential risk of Theatre 6 failure following next revalidation, resulting in one lamina flow theatre at RAEI	15	This will be impacted upon by the above, and the risk will be reviewed once theatres 1 and 2 have re-opened.	20
Patients with data entries under 'service lines' on SystemOne with no assurance that their pathways are being managed appropriately	15	Tameside and Stockport are creating a data set under GM.	20
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

Verbal update to be provided as part of the finance and performance chair's report

PERFORMANCE: WEIGHTED DASHBOARD

Performance data as at: **31 December 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	77.4% M 87.1% Y	≥95%	94.9-90%	89.9-80% YTD	79.9-70% Month	≤70%	2	4 x 2 = 8	3 x 2 = 6	BI (Dec 2020)
12-hour operational standard	No patient requiring emergency admission will wait 12 hours in A&E	102M c.200 Y	0				≥1 M & YTD	2	5 x 2 = 10	5 x 2 = 10	BI (Dec 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	72.09% M 77.22% Y	≥85%				≤84.9% M &YTD	2	5 x 2 = 10	5 x 2 = 10	BI (Dec 2020)
18-week RTT	92% on incomplete RTT pathways (yet to start treatment) should wait no more than 18 weeks	64.79% M 58.49% Y	≥92%				≤91.9% M & YTD	1	5 x 1 = 5	5 x 1 = 5	BI (Dec 2020)
52-week RTT	Zero tolerance for patient waits over 52 weeks on an incomplete pathway	1075 patients waiting 52 weeks +	0				≥1	2	5 x 2 = 10	5 x 2 = 10	BI (Dec 2020)
Diagnostic waiting times	99% of service users waiting for a diagnostic test should receive it within 6 weeks of referral	85.78% M 58.16% Y	≥99%				≤98.9%	1	5 x 1 = 5	5 x 1 = 5	BI (Dec 2020)
Paper switch off programme	By 1 Oct 2018, NHS E-referral will be used for all relevant consultant-led first OPD appointments	Complete	100%				≤99.9%	1	1 x 1 = 1	1 x 1 = 1	Complete
Control total achievement	Forecast position: Achieve finance control total before PSF	Forecast 4 quarter	Achieve 4 quarters	3 quarters	2 quarters	1 quarter	0 quarters	4	---	---	Forecast
Control total achievement	Forecast position: Achieve A&E control total trajectory	No longer applicable	Achieve 4 quarters	3 quarters	2 quarters	1 quarter	0 quarters	2	---	---	Forecast
Use of resources risk rating	Forecast position: Achieve use of resources risk rating as per plan	Forecast 4 quarter	Achieve 4 quarters	3 quarters	2 quarters	1 quarter	0 quarters	4	---	---	Forecast
Transformation	SAVI delivery against target	% M % Y	Achieved	Fail by <10%	Fail by 10-20%	Fail by 20-30% YTD	Fail by >30% MTD	3	---	---	Finance report
IT	Completion of agreed IT priorities in line with plan	85% M	100%	90-99% MTD	80-89%	70-79%	≤70%	2	3 x 2 = 6	---	IT department
Total								13	55(/13)	47(/11)	
Average									**4.23**	**4.27**	

- *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.*

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	WWL M9 Scorecard
Presented to:	Board of Directors
On:	27th January 2021
Presented by:	Chief Nurse, Chief Operating Officer and Medical Director
Prepared by:	Data, Analytics and Assurance
Contact details:	BI.Performance.Report@wwl.nhs.uk

Executive summary

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

Link to strategy
Patient
Partnership
Workforce
Site and Service

Risks associated with this report and proposed mitigations

The WWL Way

Financial implications
None currently highlighted.

Legal implications
None identified.

People implications
None identified.

Wider implications

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

Report: M9 WWL Balanced Scorecard 1 April – 31 December 2020

QUALITY & SAFETY

	Month	ON/OFF Track	Why?
Patient Safety (Safe)			
Never Events	*M7*	*On Track*	NE 0 in month 2 YTD
Number of Serious Incidents	*M7*	*Off Track*	SI - 12 Incidents in month, 52 YTD
Sepsis - Screening and Antibiotic Treatment (Grouped)		*Under development*	
Serious Pressure Ulcers (Lapses in Care)	*M7*	*Off Track*	PU - 2 Incidents in month, 22 YTD.
Serious Falls	*M7*	*On Track*	SF 0 in month 2 YTD
Infection Prevention and Control (Grouped)	*M7*	*Off Track*	5 / 6 in month, 5 / 6 YTD; Metrics Off Track
Clinical Effectiveness (Effective)			
SHMI Rolling 12 months	*M3 2021*	*Off Track*	*Latest position: 114.7*
National Patient Safety Strategy (Grouped)		*Under development*	
Patient Experience (Caring)			
Complaints Responses	*M7*	*Off Track*	59.4% M7, 51.8% YTD; Target 90%
Improved Discharge (Grouped)		*Under development*	
Patient Experience		*Not currently collected*	

ACTIVITY & EFFECTIVENESS

	Month	ON/OFF Track	Why?
A&E Performance (Single)	M9	Off Track	77.4% M9, 87.1% YTD; Target 95%
Cancer Performance (Grouped)	*M8*	*Off Track*	*5 / 7 in month, 2 / 7 YTD; Metrics Off Track*
RTT Performance (18 Weeks)	*M8*	*Off Track*	*64.79% M8, 58.49% YTD; Target 92%*
RTT Performance (52 Weeks)	*M8*	*Off Track*	*1075 patients waiting 52+ weeks*
Diagnostics Patients waiting under 6 weeks	*M8*	*Off Track*	*85.78% M8, 58.16% YTD; Target 99%*
Recovery plan	M9	*Off Track*	83% of 2019 Activity; Target 90%

PEOPLE

	Month	ON/OFF Track	Why?
Employment Essentials			
EDI - experience - disability	*M7*	*On Track*	*3.87, Q2, Experience score is comparable between disabled & non disabled staff*
EDI - experience - BAME	*M7*	*On Track*	*3.93, Q2, Experience score is comparable between BAME & White*
Job planning - Approved job plan within last 12 months (Consultants)	*M7*	*Off Track*	*13% M7 - Target 95%*
Job planning - Approved job plan within last 12 months (SAS Drs)	*M7*	*Off Track*	*6% M7 - Target 95%*
Turnover	*M7*	*On Track*	*8.06% M7, Target 10%*
Go engage			
Your voice scores (engagment enablers, feelings & behaviours)	*Q2*	*Off Track*	*3.77 Q2 Target 4, Q3 results not yet available*
Your voice response rate	*Q2*	*Off Track*	*19.22% Q2, Target 50%, Q3 results are not yet available*
Route Planner			
Apprenticeships - use of available apprenticeship levy	*M7*	*Off Track*	*Target £1,915,646, M7 cumulative actual £589,125*
CPD - allocation & use of HEE CPD funding	*M7*	*On Track*	*Aligned to spend £547k (M7), Target £711k by M12*
Steps for Wellness			
Flu vaccination - %age of front line staff vaccinated in current campaign	*M7*	*Off Track*	*41.07% M7, Target 85%+*
OH performance - Counselling	*M7*	*On Track*	*3.4 weeks M7, Target less than 4 weeks*
OH performance - Management referrals	*M7*	*On Track*	*13 days M7, Target less than 2 weeks*
Psychological well being - Stress related absence	*M7*	*Off Track*	*In-month 1.48%, Rolling 1,54% Target 1.5%*

FINANCE

Financial Position (£000s)

	In Month Actual £000's	In Month Revised Plan £000's	In Month Var £000's	Year to Date Actual £000's	Year to Date Revised Plan £000's	Year to Date Var £000's	Full Year Revised Plan £000's
Income	34,002	33,635	366	316,631	315,179	1,453	416,083
Expenditure	(35,471)	(35,710)	239	(315,990)	(315,201)	(788)	(423,991)
Surplus / Deficit	(2,445)	(3,127)	682	(8,937)	(9,595)	658	(20,637)
Cash Balance	67,986	49,065	18,921	67,986	49,065	18,921	11,583
Capital Spend	2,307	1,855	(452)	13,007	17,242	4,235	23,000

Reported position : M9

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

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

Balanced Scorecard from 1 April to 31 December 20 : Commentary

QUALITY & SAFETY	**Board are asked to note that further work is being undertaken to further strengthen the quality, safety and patient experience metrics within this report.** **Patient Safety (Safe)** *During the month of October 2020, the Trust reported 12 incidents to StEIS (Strategic Executive Information System), which was a slight increase on the previous month (n11); there were no Never Events. These incidents included 9 outbreaks of COVID, and 3 Hospital Acquired Pressure Ulcers. Notably, due to the increase in the number of COVID outbreaks NHSE/I attended the Trust to carry out a review, this took place on the 29 October 2020.* *Two cases of C.difficile infection assigned to the Trust. This represents a significant drop compared to recent monthly case numbers. Numbers of Trust associated bacteraemia cases remained low. There were no cases of MRSA bacteraemia* **Clinical Effectiveness (Effective)** **Patient Experience (Caring)** *This month there were 32 complaint responses due, of which 19 were sent within the timescales agreed with the complainant. This equates to 59%. There were one request for records by the PHSO (Ombudsman). The key issues identified as themes for October (including all formal complaints and concerns) were Medical treatment/management = 14. There are also concerns relating to the following : waiting for procedure/waiting list = 7, cancelled/rescheduled procedures = 4, delay in treatment = 3. Concerns relating to communication = 13, and loss of jewellery or damage to property = 3. Improving the timeliness of complaint responses is a quality priority in 2020/21.*	**See Operational Report**	ACTIVITY & EFFECTIVENESS
PEOPLE	**Narrative will be included in future reports.**	**Financial Position (Variance)** The Trust is reporting a £2.4m deficit in month and a £8.9m deficit year to date. The ICS top up and COVID allocation funding methodology for Month 7-12, which replaces the previous top up to balance approach, brings significant financial and strategic challenges for the Trust. The current year end exit rate of £20.6m deficit would erode the Trust cash balances to a forecast of c. £11m by the end of March 2021. This will impact on capital flexibilities and service development opportunities and will be subject to significant scrutiny by NHSI/E. The Trust deficit of £2.4m in month 9 is £0.7m favourable to the revised plan. Cash is £68.0m at the end of Month 9 which is £19.0m better than the revised plan. The adjusted cash position in month is £39.3m. This is due to the block payment for January (£28.7m) being received in advance to maintain liquidity in the provider sector. This will be recovered by the end of the financial year hence the step change in available cash. Capital spend is £13.0m year to date plus a further £5.7m incurred in respect of COVID-19 which has been reimbursed via PDC. Please see the monthly finance report for further commentary.	FINANCE

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

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Hospital onset (nosocomial) COVID infections and report on progress with the IPC Board Assurance Framework document
Presented to:	Board of Directors
On:	27 January 2021
Presented by:	Morag Olsen, Chief Nurse, Director IPC
Prepared by:	Rebecca Gerrard, Deputy Director IPC
Contact details:	T: [07798741695] E: [3115]

Executive summary

This paper provides an update on the Hospital onset (nosocomial) COVID infections and an updated version of the IPC BAF.
The numbers of patients who appear to be acquiring COVID in hospital has fallen.
PHE have issued new national guidance on IPC on 21 January 2021, this is yet to be assessed but is likely to result in changes to SOPs again.

Appendix 1 provides an update on the number of Hospital onset COVID-19 cases.

Appendix 2 contains the updated IPC Board Assurance Framework.

Link to strategy

IPC is integral to WWL strategy and there is currently an increased focus from regional and national teams.

The WWL Way

Risks associated with this report and proposed mitigations
Some of the actions required may have adverse reactions in other areas of patient care e.g. not moving cohorted patients more than once may result in more closed beds.
There is already a risk assessment titled 'There is a risk of inpatients developing hospital onset COVID-19 infection whilst at RAEI' scoring 20.
Also a risk assessment titled: 'There is a risk that WWL will not be able to comply with all the requirements in the 'Key Actions: IPC and testing' document published by NHS England/Improvement on 17/11/20'. This will need to be updated in light of the amended guidance.

Financial implications
Some actions will require significant financial resource to implement e.g. new cleaning regimes.

Legal implications
The Code of Practice on the prevention and control of infection links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People implications
Additional resource will be required in some areas e.g. cleaning to comply.
The current challenges associated with COVID-19 on top of the standard IPC workload is continuing to create additional ongoing pressure on the IPC team.

Wider implications
IPC is fundamental to the way all staff work and requires a Trust-wide approach.

Recommendation(s)
The Board are asked to accept this paper for information and be assured that action is being taken to enable compliance with the new guidance and reduce hospital onset COVID infection.

Report

The key IPC changes to be aware of in relation to COVID include:

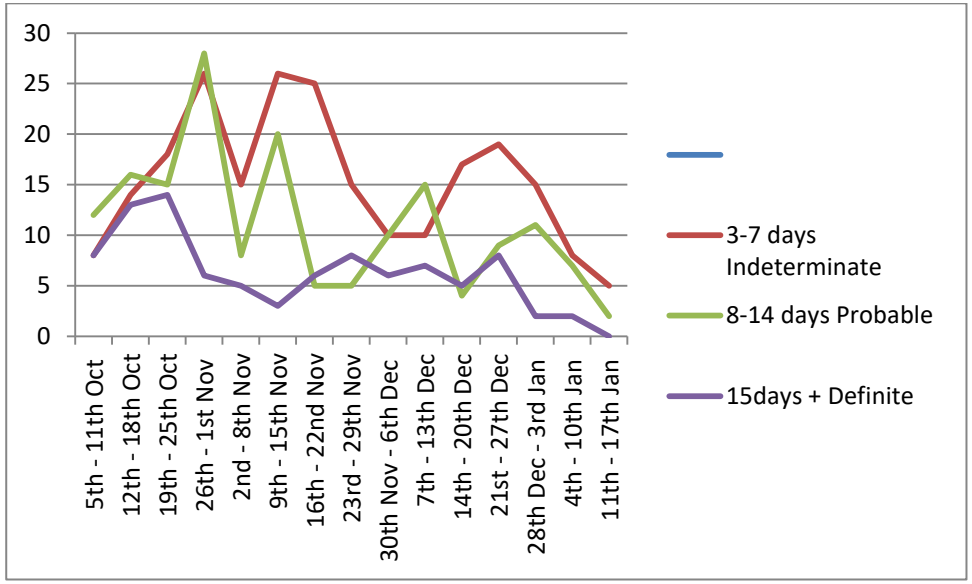
- PHE have issued new national guidance on IPC on 21 January 2021, 'COVID-19: Guidance for maintaining services within health and care settings – IPC recommendations'. This is yet to be assessed but is likely to result in changes to SOPs again.

- A written report has now been received following the NHSE visit in October 2020. The only recommendation yet to be actioned is to carry out an observational audit of behaviour at entrances (compliance with gel and mask wearing). Our meet and greet staff are being supported to be more pro-active in asking people to alcohol gel their hands and don a surgical mask if they've not already got one on.
- An updated version of the Key Actions document (dated 23 December 2020) has been issued. The main changes are:
    - They have removed the requirement for patients to be have 2 negative swabs before being moved to a negative ward
    - They have added that systems should be in place to measure compliance with hand hygiene, cleaning multiple times every day and the use of PPE.
    - There should be minimal movement of staff between COVID and non-COVID areas.
    - There should be minimal patient bed transfers for the duration of their admission unless clinically imperative.
    - The concept of 'bed, chair, locker' should be implemented to ensure patients are socially distanced from one another when sat out.
    - Sites with high nosocomial rates should consider testing COVID negative patients daily. (IPC have requested that the 2 outbreak wards swab patients at least 3 times per week.)
- National guidance (dated 24 December 20) now recommend lateral flow tests are carried out on all patients being admitted to hospital (not just symptomatic patients). An amended flow chart was approved by Silver Command on 12 January 21 and AED informed.
- Lateral flow kits can also be made available to maternity and neonatal departments to help screen mums and their support/partner but the logistics of carrying this out in large numbers is significant.
- The IPC COVID-19 e-learning module launched in December and is mandatory for all staff, but guidance has already changed so a new version has been written and is being uploaded.
- Patient flow continues to be a major challenge; Ops and IPC teams are liaising closely to manage patients safely.
- Swab turnaround times have improved since testing moved to Salford but can still be variable.
- There are COVID outbreaks now on both COVID negative wards (ASU and Swinley). Patients are now being swabbed 3 times per week on these wards. Outbreak meetings are held daily during the week.
- Additional cleaning is being carried out on Bryn North, ICU and the two wards that have COVID outbreaks.
- WWL are not now re-swabbing patients if there have been COVID positive in the last 90 days so long as they are asymptomatic.
- WWL is to pilot the use of clear plastic curtains (that sit parallel to the standard curtains at the head end of the bed, but can be left in situ at all times) in 2 wards at RAEI.

Appendices

Appendix 1: Hospital Onset COVID-19 Infections (HOCI):

Data for last 3 months is shown below. The number of probable and definite infections appears to be reducing.



Appendix 2: Infection Prevention and Control Board Assurance Framework (template version dated 15th October 2020) Updated 22 January 2021 – changes are highlighted

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes	• All patients attending A/E are screened for COVID-19 on registration with a risk assessment completed. Symptomatic and asymptomatic patients are segregated at this point. • Flow chart is in place Ward allocation of symptomatic, asymptomatic, positive and negative patients. • All patients within the community are contacted to	No gaps	N/A

	ensure a face to face visit is clinically required ensuring that staff do not mix visits for both symptomatic and asymptomatic patients. • Telephone advice lines are in place where visits are not required. • 18/1/21: All patients requiring admission undergo a lateral flow test now, as well as a PCR.		
• Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	• Microbiology results are obtained and documented in HIS before patients are moved to designated COVID-19 negative or positive ward. • If symptomatic but negative, patients are reassessed by medics. If COVID-19 still suspected patients stay on the ward and are retested which is all documented on HIS. • There is a Flowchart on Screening of admissions for COVID-19 infection' and in the Standard Operating Procedure on swabbing. • This is supported by frequent updates within the COVID-19 Newsletters. • 22/1/20: A new flow chart has been introduced to limit the number of times patients who have been a contact of a positive case can be moved and recohorted	No gaps	N/A
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	• National guidance is in use and documented on WWL intranet and in SOPs. • There is a flow chart on stepping patients down based on national guidance and this is included in the COVID-19 SOP. • Information, flowcharts and the rationale on swabbing practice has been provided to the council to share with the care homes.	None	N/A
• Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice	• Monitoring of IPC practices against key policies (including COVID-19) is included within IPC audit programme and includes environmental checklists, hand hygiene and PPE. • Monitoring of IPC practice is also included within	None	N/A

	matron's mini audits.		
• Monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	• PPE audit tool revised to incorporate new guidance	Limited audits undertaken to date in non-clinical areas	COVID Safety champions in each ward and department are being established
• Staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase	• Trust SOP in place. • Mass testing in line with national guidance/ roll out. • First mass asymptomatic staff testing programme implemented within the Trust end October 2020. • All staff now been offered lateral flow kits. • Test & Trace risk assessment process in place.	Multiple systems are currently in place that may be causing delays in communication transfer.	Development of one system for all staff through HR linked to IPC.
• Training in IPC standard infection control and transmission-based precautions are provided to all staff	• Mandatory training covers: - IPC level 1 and 2 - PPE All are undertaken via e-learning modules.	None	N/A
• IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training	• IPC measures in relation to COVID-19 form part of the above • COVID-19 module launched Dec 20 and is mandatory for all staff. 22/1/21: The programme is being reviewed and updated this month	None	NA
• All staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	• Multi-modal communications strategy has been implemented which includes poster, roller banner and newsletter campaign. • Defined SOP developed and implemented.	RCA review recommendations have changed the communication routes to reiterate importance	All managers use the 'just culture' framework for escalation of workforce incidents.

• All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	• PHE national guidance in place across the Trust • There is a PPE Store at each main site: PPE is delivered daily to wards and additional stock is available 24/7 if required. • A PowerPoint Presentation on PPE (along with a quiz to test learning) is on e-learning for all staff and is mandatory. • 22/1/21: The PPE e-learning programme is being reviewed and updated this month	None	N/A
• National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• All new guidance is acted upon in a timely manner • Where necessary SOP's are updated • Changes are communicated through the IPC team, newsletters and Divisional leads	Amended Key Actions issued 23 Dec 20 New National IPC guidance received 21/1/21	Risk assessment, gap analysis and reduction plan being updated All COVID SOPs will have to be reviewed and updated again
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• DIPC or Deputy present to the Board through the performance report or specific agenda items. • Quality and Safety committee review quarterly.	None	N/A
• risks are reflected in risk registers and the board assurance framework where appropriate	• Risk register • IPC BAF reviews	None	N/A
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Q&S sign off for IPC audit programme annually • IPC Committee monitors progress and establishes mitigating actions to be taken	None	N/A
• That Trust CEOs or the executive responsible for IPC approve and personally signs off, all data	• IPC check and validate data on HOCI that is downloaded from HIS before submission. CEO and DIPC are copied in so can check data. • Dec 20: Outbreak data now on IT system that all	None	NA

submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner**.**	relevant/designated staff can access.		
• ensure Trust Board has oversight of ongoing outbreaks and action plans.	• Outbreaks that meet StEIS criteria are reported through Safety Committees. • IPC report through IPC Committee up to the Quality and Safety Committee and monthly Performance report to Board • Regular IPC updates on COVID to the Board (last one was 16/12/20)	None	NA
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• Staff self-declaration for extremely vulnerable or high risk categories as defined by Public Health England. • Line manager risk assessment of the above individuals • All redeployed staff to undertake additional training to meet their needs • Where staff have been redeployed additional training has been provided. • PPE training is mandatory	None	N/A
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	• Domestic Response team and designated Domestics in place. • All Domestics are trained in the correct use of PPE and have been masked fit tested and issued with personal CorPro half mask.	None	N/A
• decontamination and terminal decontamination	• Domestic provision for the cleaning of isolation rooms and cohort areas follow PHE and National	None	N/A

of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	Guidance in place. • SOP in place in conjunction with IPC • Rapid Response Domestic team cover terminal cleans and work out of hours.		
• increased frequency at least twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	• A second tier clean is carried out in all isolation rooms and cohort areas to assist with the removal of bioburden as set out in national guidance • 11/1/21: Additional cleaning is being carried out on Bryn North (CPAP), ICU and the 2 wards that have COVID outbreaks.	None	NA
• cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	• SoChlor used at 1,000ppm is used for cleaning in all clinical areas. • Green disinfectant wipes are used in non-clinical areas and at mask stations to clean re-usable CorPro masks.	None	N/A
• Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning /disinfectant solutions/products as per national guidance	• Manufacturers guidance followed and available on the intranet and included in decontamination SOP	None	N/A
• 'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed	• IPC review Ward Housekeeping schedules • Compliance is audited via Matron and IPC Spot audits and reported to IPC Committee. • Disinfectant wipes are recommended for non-	Amended 'Key actions' guidance calls for all high touch surfaces and items to be decontaminated	A Business case is being drawn up for cleaning by Facilities.

rails should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids	clinical area PCs and phones. Wipes also available on 'cleaning stations' at ward entrances/exits for re-usable half masks. • SOP's in place for all Facilities staff • Environmental cleaning audits in place and reported to the IPCC	multiple times every day	For nursing equipment the Ward Cleaning Schedules have been revised and re-issued – they are yet to be audited.
• electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards should be cleaned a minimum of twice daily	• Decontamination SOP in place. • Green disinfectant wipes are used in non-clinical areas and at mask stations to clean re-usable CorPro masks.	Limited audits undertaken to date in non-clinical areas	COVID Safety champions in each ward and department are being established
• rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	• Limited designated PPE doffing areas. • All clinical areas undergo decontamination of the environment at least twice daily. • Outbreak reviews monitored.	None	N/A
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	• Linen system managed in line with PHE and National guidance • SOP available on the Intranet • External contractor performance against the contractual requirements	None	N/A
• single use items are used where possible and according to single use policy	• Single Use SOP in place • Single Use is included in mandatory level 2 IPC training. • Patient Safety Alerts communicated through internal Newsletters, Governance Team and changes to individual policies	None	N/A
• reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance	• Strategic and Operational Decontamination Groups in place • Decontamination SOP both WWL wide and at departments levels in place • All reusable equipment is decontaminated in line	Timely meeting of the Decontamination Group	Decontamination issues currently covered through IPCC.

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

	prescribing and new guidance as appropriate. • Antimicrobial audit in place		
• mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Mandatory reporting through the Board performance report • Mandatory reporting through the quarterly IPC paper to Quality and Safety Committee • Monthly reporting through Divisional Quality Assurance Groups	None	N/A
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
• **Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	• National guidance reviewed frequently with discussion at Board and Exec Team on restrictions • Changes communicated through Divisional Teams and via COVID Newsletter. • Visitor disclaimer in use.	None	N/A
• areas in which suspected or confirmed COVID-19 patients are being treated in areas clearly marked with appropriate signage and have restricted access	• Blue, yellow, green, cohort bay system in place across as GM with supporting SOP. • Entry to wards is via swipe which restricts unauthorised access. • Colour coded signs for all wards in place. • Signs include key instructions e.g. PPE required and who can enter. Also clear signage in ECC indicating symptomatic and asymptomatic patient areas.	Pace of change in COVID status of patients means that some wards may have bays with different designated areas	IPC attend bed management meetings and provide advice re patient moves 24/7
• information and guidance on COVID-19 is available on all trust websites with easy read versions	• Dedicated COVID tab on landing page of Trust Intranet with divided sections including PPE and IPC. • External website has clear information and advice on https://www.wwl.nhs.uk/	None	N/A
• infection status is communicated to the receiving organisation or department when a	• Infection status is communicated verbally before the patient is transferred and then in writing via a transfer form when the patient is moved.	None	N/A

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

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

to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care	requested to wear masks as they enter hospital. • There is an SOP on mask wearing. • Patients are asked to wear a mask where possible and where it is not interfering with their care e.g. oxygen masks. • There is an information leaflet for patients on masks approved at IPC Committee. • 22/1/20: WWL is to pilot the use of clear plastic curtains (that sit parallel to standard curtains) in 2 wards at RAEI.		least 2m apart and pull curtains if safe to do so. Additional posters distributed to remind patients.
• ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	• Seating rearranged or areas blocked off to ensure segregation. • Floor markings where required. • Hot clinic areas in the community have reduced and have clear signage. • Staff are not utilising patient entrances in order to reduce footfall • Perspex screens were present in AED reception. • Perspex screens required across the organisation reviewed and implemented.	None	N/A
• for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative	• COVID SOP in place. • Patient incident forms completed for all HOCI >8days that includes test and trace requirements • IPC carry out daily tracking to monitor patient moves. • IPC attend bed manager meetings each day. • Bay closure spreadsheet maintained by IPC.	No IT system to support tracking patients – currently done manually.	SOP reinforced at times of significant pressure. Business case submitted for IT surveillance system for IPC.
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly	• COVID SOP in place. • Patient Incident forms completed for those patients with hospital onset COVID-19 >8days that includes test and trace requirements	No IT system to support tracking patients – currently done manually.	SOP reinforced at times of significant pressure. Business case submitted for IT

re- tested and contacts traced promptly	• IPC carry out daily tracking to monitor patient moves. • IPC attend bed manager meetings each day. • Bay closure spreadsheet maintained by IPC		surveillance system for IPC.
• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	• In line with departmental SOPs, should patients attend who are symptomatic a risk assessment is undertaken. • All COVID departmental SOPs are sign off by IPC.	None	N/A
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	• Patient pathways have been risk-stratification and included within the Trust COVID-19 SOP. • Display posters and updates on the Trust intranet also available.	Due to constrictions on the Estate and the number of patients with COVID 19, currently we are not able to separate pathways at all times in all places.	Environmental risk assessments have been completed at ward and department level.
• all staff (clinical and non-clinical) have appropriate training, in line with latest national guidance to ensure their personal safety and working environment is safe	• Daily Trust Newsletter updating staff on the current position • IPC team accessibility • Divisional senior leaders, Exec team visible to staff • Where concerns are raised additional bespoke training is undertaken by the relevant individual to ensure staff comply. • A detailed IPC Checklist used to assess areas	None	N/A

	for the safe return of staff from isolating etc.		
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to Don and Doff it safely	• Don and doff posters are displayed in all wards and departments. • IPC check posters are present on ward visits. IPC advice is available 24/7. • The Professional Practice Team have supported IPC to carry out classroom training on donning & doffing. • Internal Patient Safety Notice was circulated Trust Wide via the Divisional Governance Leads in relation to the appropriate use and decontamination of reusable FFP3 masks. • Assurance was sought that this alert was circulated to all Ward and Departments has been received from all Divisions. • Don and doff guidance is included in the PPE e-learning module. • H&S and IPC advise and support was given Procurement for the purchase of PPE	None	N/A
• a record of staff training is maintained	• All mandatory training is recorded through personal passports and electronically through the Trust mandatory training system. • FFP3 mask fit training is organised by H&S and records are held centrally.	None	N/A
• appropriate arrangements are in place that any reuse of PPE in line with the MHRA CAS Alert is properly monitored and managed	• The alert was received and distributed • WWL has not experienced severe shortages of PPE and not had to instigate this guidance.	None	N/A
• any incidents relating to the	• The Procurement Group (includes medical	None	N/A

re-use of PPE are monitored and appropriate action taken	representation, IPC and H&S) monitor PPE stock. • All incidents investigated and documented in Datix • 20/1/21: To purchase some elbow length gowns for 1 month to promote hand hygiene in ICU as there is an outbreak of VRE amongst ICU patients.		
• adherence to PHE national guidance on the use of PPE is regularly audited	• IPC visit wards regularly. • IPC developed and piloted a new PPE audit tool in June. Results are fed back to clinical teams and included in IPC reports. • All key wards PPE compliance is audited monthly and fed into IPCC and the quarterly report to Board	None	N/A
• hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission	• A communication strategy has been developed to promote key principles to minimise COVID-19 transmission, including availability of hand hygiene products, face masks and promotion of social distancing	None	N/A
• hand hygiene facilities including instructional posters	• Instructional posters available at all alcohol hand gel stations throughout the hospital and ward/ department entrances. • Guidance is given to all elective patients within the patient information booklet	None	N/A
• good respiratory hygiene measures	• Facemasks are available at all hospital and ward/ department entrances. • Roller banners and posters are used to promote mask use and good respiratory hygiene	None	N/A
• maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care	• Roller banners and posters used to promote social distancing. • Trust SOPs clearly define the need to maintain 2 metres distance unless wearing PPE as part of	None	N/A

	patient care. • There are signs on doors to indicate the maximum number of people who should be in the room at any one point. • Floor marking are present in many outpatient areas and keep left signs in corridors		
• frequent decontamination of equipment and environment in both clinical and non-clinical areas	• Decontamination of the environment within clinical areas included within the Trust COVID-19 SOP. • Facilities audit compliance in clinical areas monthly that are reviewed by IPCC. • Cleaning schedules on the wards.	Unable to comply with Key actions on cleaning	Business case submitted for the additional resource required
• clear advice on use of face coverings and facemasks by patients/ individuals, visitors and by staff in non-patient facing areas	• Facemasks are available at all hospital and ward/ department entrances. • Roller banners and posters are used to promote mask use and good respiratory hygiene	None	N/A
• staff regularly undertake hand hygiene training and observe standard infection control precautions	• Hand hygiene training is mandatory • Hand hygiene audits take place monthly in all clinical areas and the results are monitored by IPCC and the Board	None	NA
• the use of hand air dryers should be avoided in all clinical areas.	• There are no hand dryers in any clinical areas at WWL. • Where hand dryers were available for the public these have been deactivated and replaced with paper towels.	None	N/A
• guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	• Hand hygiene posters are available from IPC and on intranet. • Laminated posters displayed in all areas	None	N/A
• staff understand the requirements for uniform laundering where this is not provided for on site	• National guidance has been followed with information for staff on laundering their uniforms • Staff have been updated through the COVID Newsletters	None	N/A

• all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE national guidance and other if they or a member of their household display any of the symptoms	• National guidance is being followed and available on the intranet. • Updates are included in the COVID Newsletters. • A drive through facility for staff testing at Leigh and at Wrightington and the phlebotomists can also swab staff as required at RAEI. • IPC liaise closely with H&S and Occupational Health as required. • Mass staff testing took place in October prior to the National scheme • December: Staff now have lateral flow kits for twice weekly testing	None	N/A
• a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital / organisation onset cases (staff and patients / individuals)	• An electronic laboratory reporting process (Queue) provides the IPCT with timely COVID-19 positive results. • An in-house COVID-19 App has been developed by the Trust BI Team that supports the collation, evaluation and summary of cases of COVID-19. • HOCI are reported via the daily nosocomial sitrep and summary directly to the Board bimonthly • Local PHE information on population transmission is circulated to EXEC's and IPC.	None	N/A
• positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	• Patient investigation templates are completed for patients who test positive for COVID-19 eight or more days after admission. • If the criteria for outbreak is met this is report to DIPC and NHSE/I • SOP in place that is monitored through IPCC	None	NA
• robust policies and procedures are in place for the identification of and management of outbreaks	• SOP for the identification and management of COVID-19 outbreaks that incorporates national guidance.	None	N/A

of infection	• This has been approved by the IPCC. • Daily outbreak meetings are held when necessary.		
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • restricted access between pathways if possible, (depending on size of the facility, prevalence / incidence rate low/high) by other patients/individuals, visitors or staff	• Patient pathways according to risk stratification have been defined and included within the Trust COVID-19 SOP which has been disseminated to all clinical teams. • Environmental risk assessments have been completed by wards and departments to establish safe flow of patients and staff	Due to the number of patients with COVID 19, currently we are not always able to separate pathways.	Tracking patients through the Bed management team, the number of transfers and outbreak occurrences to minimise risk. This is monitored and supported by IPC
• areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	• 'Zone' display posters developed and updates on the Trust intranet provided. • Entry to wards is via swipe which restricts unauthorised access.		
• patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	• Patients are currently cohorted on admission into symptomatic or non-symptomatic areas then wards. • Where a designated side room is available this would be used • Once the COVID result is known they are moved to either +ve or –ve ward. • There is an Operational flowchart and COVID SOP. • Reminder at senior meetings, in Newsletters • COVID SOP	A risk assessment has been undertaken	A paper is being prepared for the Board for Jan 2021
• areas used to cohort patients with suspected or confirmed COVID- 19 are compliant with the	• All bed spaces have been reviewed • Ward staff are requested to use privacy curtains between beds to minimise close contact where safe to do so; reminder in Newsletters and in	New National IPC guidance received 21/1/21	N/A

environmental requirements set out in the current PHE national guidance	COVID SOP. • IPC guidance on blue, green and yellow wards has been implemented and circulated to all wards • Reinforced through Newsletter • SOP covering all actions required • IPC environmental checklists are reviewed every time an outbreak is declared.		
• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• All previous IPC policies, SOPs and patient information leaflets are in place and up to date to identify and appropriately place patients. • Side rooms on non-COVID wards are used for patients requiring isolation for other reasons e.g. MRSA. • C.diff patients are managed on Pemberton ward. Bryn Ward (unusual layout) and Winstanley ward (COVID +ve ward) have separate SOPs. • Mandatory surveillance data is reported to IPCC and Trust Board.	New national CPE guidance published October	IPC reviewing and amending CPE SOP
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • ensure screens taken on admission given priority and reported within 24hrs	• There is a prioritisation system in place at Oldham virology lab which prioritises clinical specimens over staff screening samples but does not differentiate admission screens.	Admission screens are not differentiated.	Discuss with Salford Lab how this might be implemented. Lateral flow is carried out on symptomatic patients in ECC. 18/1/20: Lateral flow to be used on all patients to be admitted.
• regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time	• Dec 20: There is now an App that displays this data on a daily basis now. • Reporting times for results are highly variable and currently averages 39.5 hours	Audit suggests that samples routinely take greater than 24 hours from sampling to reporting.	Recommendations made to reduce transit time have been added to the COVID Reduction plan.

result is available	• 5/1/21: Testing now done at Salford and turnaround times are improving.	Report presented to IPCC in Nov.	Point of care testing is awaited.
• testing is undertaken by competent and trained individuals	• The Laboratories used are UKAS accredited	None	N/A
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	• Testing is performed in line with national guidance • Trust guidance is in line with NICE recommendations on testing for suspected COVID cases and for other infections. • The HIS tracking board highlights if swabs take longer than 48 hours and highlights when patients need re-swabbing. • System established for antibody testing • The swabbing team can be mobile and help to swab staff during outbreaks. • Testing is provided by Northern Care Alliance, monitoring of compliance is through contractual discussions	New Key Actions guidance recommends 'sites with high nosocomial rates should consider testing COVID negative patients daily'. New National IPC guidance received 21/1/21	11/1/21 – agreed to increase swabbing on outbreak wards to 3 times per week. SOPs and flowcharts may have to be amended and reissued
• regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	• NCA Virology lab as part of their accreditation system. • Errors reported to WWL Microbiologist should these occur.	None	N/A
• screening for other potential infections takes place	• National policy is followed for the screening of patients for MRSA and CPE.	New national CPE guidance been published in October	IPC updating CPE SOP.

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in	• IPC Policies and SOPs are approved at IPCC and are on the Intranet and kept up to date. • IPC and microbiology advice is available 24/7.	None	N/A

adhering to all IPC policies, including those for other alert organisms	• IPC level 1 and 2 e-learning is mandatory in line with national guidance		
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• All new guidance is acted upon in a timely manner • Where necessary SOP's are updated • Changes are communicated through the IPC team, newsletters and Divisional leads	New National IPC guidance received 21/1/21	N/A
• all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	• Trust adheres to national guidance and Waste Legislation. This is evidenced within the Trust's Waste Management Policy and Procedures under Category waste. Community staff also follow the Trust's Policies including the national guidance regarding the disposal of COVID-19 PPE within a patient's home environment. • The Clinical Waste Management Module is mandatory for all staff.	None	N/A
• PPE stock is appropriately stored and accessible to staff who require it	• PPE is distributed to the wards on a daily basis. The main PPE store is on the RAEI site and is accessible 24/7. Opening times are highlighted in COVID Newsletters. • PPE store also at Leigh and Wrightington. • In Community, PPE store well stocked and accessible to all teams	None	N/A
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported	• All staff requested to complete a self-declaration form confirming if they fall within the extremely vulnerable or high risk categories as defined by PHE. Where staff have been determined to fall within these groups, personal risk assessments have been completed by line managers with the support of Occupational Health. Records of the outcomes from the self-declarations forms logged and maintained within HR.	None	N/A

	• A comprehensive programme of support has been developed for all staff, including: Access to rest spaces with trained volunteers to provide a listening ear; in-reach support for teams when requested (e.g. at times of higher stress), training for managers in supporting staff; a 24/7 telephone helpline; staff counselling (including remotely); development of roles as clinical wellbeing leads and wellbeing champions; communications and information about self-care and sources of support. This is accessible by all staff, including those who are at-risk. Regarding those staff that are shielding, developing tailored support in addition to the above, in terms of accessing support remotely, and having access to information about supporting positive mental health when shielding. • Regular communications have been sent via senior managers; the HR team continue to be proactive and engaged with managers and individuals to obtain this information. • Home working supported for all staff where possible. • Staff vaccination programme began 23/12/20.		
• that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff	• Personal risk assessments have been completed by line managers with the support of Occupational Health. • Records of the outcomes from the self-declarations forms logged and maintained within HR.	None	N/A
• staff required to wear FFP3 reusable respirators undergo training that is	• Face fit testing is available across all acute sites and at one location in the community and is run by the H&S team.	None	N/A

compliant with PHE national guidance and a record of this training is maintained and held centrally	• All mask fit testers have been trained in line with national legislation. • A SOP has been developed and shared with all Testers. • Mask fit training records are held centrally. • Some staff cannot wear a close fitting FFP3 mask e.g. due to facial hair. There were 9 air powered hoods on site at RAEI and a further 11 were purchased and distributed to key areas. Face fit testing sessions are continuing on a regular basis to ensure staff are fit tested to the FFP3 masks currently available		
• staff who carry out fit test training are trained and competent to do so	• Fit test training is overseen by the Trust H&S team and conducted by staff who have been trained in line with national legislation and competent to do so	None	N/A
• all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	• Face fit testing sessions are continuing on a regular basis to ensure staff can receive fit test training in the FFP3 masks currently available	Face fit testing continues but the Central Register of staff tested indicates that not all staff are tested to a model that is currently in stock.	The Central Register has been shared with Divisions along with a request to prioritise staff who require retesting, initially those working in positive, symptomatic and asymptomatic, and where aerosol generating procedures are undertaken.
• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation	• Record of the fit test and result is given to the staff member and mask fit training records are held centrally by the H&S team.	None	N/A
• for those who fail a fit test, there is a record given to and held by trainee and centrally within the	• Individuals that fail a fit test are tested on an alternative model until options are exhausted. If a secure fit cannot be achieved staff are advised to use a mechanical respirator and hood. Records	None	N/A

organisation of repeated testing on alternative respirators and hoods	are kept by the individual and held centrally by the H&S team		
• for members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	• Included within the Respiratory Protective Equipment- Training Guidance SOP • Individuals that continue to fail fit tests and are unable to be provided with alternative respirators and hoods are provided with the opportunity for redeployment in line with Occupational Health and HR policies. • The Trust has a designated Redeployment team who oversee staff skill mix, knowledge and experience	None	N/A
• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health	• Documented records of staff redeployment are kept in line with Occupational Health and HR policies	None	N/A
• following consideration of reasonable adjustments e.g. respiratory hoods, personal re- usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	• Documented records of staff redeployment are kept in line with Occupational Health and HR policies	None	N/A
• Boards have a system in place that demonstrates how, regarding fit testing,	• A centrally held mask fit register is maintained and is available.	A member of the Board had weekly oversight of a summary of the register	Advice from the Director of Corporate affairs will be sought on

the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board		during the first wave.	the best mechanism for this regular review.
• consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent / emergency care pathways as per national guidance	• Healthroster system used for nurses. • Medical rotas for medical staff. • DDNs reviewed nursing staff rotas and all staff risk assessments now completed. Where safe and practicable staff are only moved between similar colour coded areas in response to acuity and dependency of patients. There has also been a reduction in the volume of temporary staff working across the Trust. Staff risk status is clearly recorded on e-roster. Head of E&F reviewed non-clinical staff allocation but it was not possible to achieve everywhere	Some staff do have to move between different areas on a daily basis. This includes circulating staff such as porters and phlebotomists. October – significant staff absent due to Covid/Mass testing necessities significant staff redeployment	Staff are trained in the use of PPE and carry hand gel. Guidance for circulating staff is included in colour coded ward guidance on ward entrances
• all staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas	• National guidance has been adopted and promoted. Staff reminded regularly via Newsletters and Posters. Also in COVID SOP. • Mask usage made compulsory for all visitors and staff is as per national guidance. • Office space has been redesigned to ensure social distancing e.g. in the Life Centre. • All community premises have been reviewed for social distancing and a number of work areas have been designated as no longer in use. Environmental checklists completed and risk assessments drawn up to support the return of shielding staff. Wards asked to include minimum numbers at staff handovers.	Learning from recent outbreaks identifies areas at risk are break and staff rooms	Action being taken to review all areas again and guidance reiterated to all staff via variety of communications. All staff are expected to wear masks on trust sites inside and outside action being taken to enact this.
• health and care settings are COVID-19 secure	• Space planning exercise undertaken at the start of the pandemic.	Lessons learnt form outbreaks have identified	Social distancing, care sharing rules re-

workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	• Maximum staff allowance per room assessments completed and supportive guidance provided to Departmental managers • Environmental risk assessments completed	that improvements are still required in social distancing within non-clinical areas, e.g. offices, break rooms.	emphasised through senior meetings and Trust Newsletter.
• staff are aware of the need to wear facemask when moving through COVID-19 secure areas	• Trust SOP for Masks in place and circulated to all departments. Regular reminders given at senior nursing and medical meetings for cascade, provided within Trust Newsletters and by the use of posters and roller banners.	None	None
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	• Staff absence is recorded for payroll purposes through e-roster and through e-SVLs. This means that data taken from ESR can be 4/6 weeks in arrears. In order to comply with the daily SITREP requirements, absence data is recorded either in spreadsheets submitted by Divisional representatives or from the e-roster. • E-roster is currently rolled out to the majority of nurses and some AHPs. Whilst there are still data quality issues, this is a more accurate reflection of absences. We do not have a shift by shift live record of staff absences. However, a small absence/ e-roster resource is now actively contacting wards and departments to ensure that absences are recorded on the e-roster for those within the scope of current provision. This covers most nurses and some AHPs. • Key actions are being progressed to mitigate this risk and to improve the availability of such data, including real time absence. • Well-being offers are widely available to staff members, with pro-active holistic well-being provision through our Steps 4 Wellness and occupational health services. Psychological support programmes are in place including access to well-being apps, EAP, SOS rooms with trained facilitators, critical incident debriefing and	Workforce data flows and the lack of accurate real time workforce data is on the corporate risk register (HR126), scoring 15.	Business case is being developed re Empactis absence management system

	departmental support programmes. There are nursing, AHP and medical well-being leads identified along with over 70 well-being champions within wards and departments. • The Trust continues to actively manage and support staff through attendance management procedures. The Strategic HR lead completes a monthly review of all long-term sickness absence cases with HR Business Partners. Staff have access to COVID-19 swab tests via a Trust drive through facility at Leigh along with tests through regional centres and home testing. All staff who require swab tests can be accommodated and this has been communicated through internal mechanisms. • December 2020 - All staff have been offered own lateral flow testing kit.		
• staff who test positive have adequate information and support to aid their recovery and return to work	• Flow charts based on national guidance outline the processes and time periods to follow and are on intranet. Staff are supported via managers during absence in accordance with all sickness absence. • HR advisors are available to staff and managers to seek advice and support where any individuals are concerned or have questions around returning to work or being absent due to COVID.		

Ockenden Review December 2020: 12 Urgent Clinical Priorities

Introduction

This document contains the 12 urgent clinical priorities identified in the letter dated 14th December 2020 from Amanda Pritchard, Ruth May and Prof Steve Powis to the NHS Trust and Foundations Trust Chief Executives sets out the immediate response required by all Trusts providing

Immediate Actions

Trusts should proceed to implement the full set of the Ockenden Immediate and Essential Actions. However, 12 urgent clinical priorities from the IEAs were identified which they are asking Trust Chief Executives to confirm they have implemented **by 5pm on 21st December 2020.**

These 12 priorities are taken from the 7 Immediate and Essential Actions:

1. Enhanced Safety
2. Listening to women and their families
3. Staff Training and working together
4. Managing Complex Pregnancies
5. Risk Assessment through Pregnancy
6. Monitoring Fetal well-being
7. Informed Consent

Confirmation of the Trusts compliance with these immediate actions signed off by the CEO, along with confirmation of sign off from the Chair of your local LMS to your Regional Chief Midwife, **by 21 December**. They are available to support Trusts with this request. The individual responses will form part of the presentation and discussion at the NHSEI Public Board in January 2021 when the report, and immediate and longer-term

Please note this template is for the response to the 12 Clinical Priorities for the 21st December 2020 submission. A further template will be circulated which will include all the actions from the 'Immediate and Essential Actions'.

Ockenden Review December 2020: 12 Urgent Clinical Priorities

Trust Name:	Wrightington Wigan and Leigh Teaching Hospital NHS FT
Tool completed by - Name:	Cathy Stanford, Fiona Bryant
Role:	Acting Div. Dir of Maternity and Neonates. Acting Assistant Chief Nurse
Contact email address:	cathy.stanford@wwl.nhs.uk fiona.bryant@wwl.nhs.uk

Essential Action		**Action required**	**Current status** *compliant, partially compliant, not compliant*	**Action to be taken if partially or not compliant**	**Lead**	**Timescale for completion**
Enhanced safety: Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.	1a)	A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly	Compliant	*The Maternity Service are aware of the 5 Quality Surveillance principles and have advised Trust Board of the requirement to have a Quarterly board review of Perinatal Safety. *The Transforming Perinatal Safety draft Resource pack has been received within the Trust and reviewed and the 3 primary drivers noted (Insight, Involvement and improve.) *There are aspects of the pack that cannot as yet be implemented until further standards and recommendations are published nationally and will be implemented upon receipt. *The Trust is committed to implementing the regional proposals that will be circulated in early 2021.	*Cathy Stanford, Acting Div. Director of Midwifery and Neonates. Head of Governance Maternity and Child Health. *Fiona Bryant, Acting Assistant Chief Nurse. *Papa Essilfie, Obstetric Consultant Governance Lead	Immediate
	1b)	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Partially Compliant	*All cases that meet the criteria are reported to HSIB, Each Baby Counts and MBRRACE. Going forward for all new SI's, these will be shared with the Trust board. *The trust will work with the LMS to ensure a process is commenced to share all serious incidents to optimise learning which can be shared across the system to prevent harm.	*Cathy Stanford, Acting Div. Director of Midwifery and Neonates. Head of Governance Maternity and Child Health *Fiona Bryant, Acting Assistant Chief Nurse.	Will commence Once WWL are in receipt of guidance from the LMS, a regular report upon maternity SIs (as per the Serious Incident Framework) will be submitted to Trust Board)
Listening to Women and their Families: Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to	2a)	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	Compliant	*Established Maternity Voice Partnership in place with BI-monthly meetings. *Feedback has been obtained on leaflets and visiting. *15 steps walk about undertaken by service users. *Patient stories have been circulated to staff to communicate the Voice of the Woman. *However it is recognised that greater involvement of service users' needs to be implemented, and lay representation on Directorate meetings sought.	*Anne-Marie Goodall, Out Patient Matron. *Cathy Stanford, Acting Div. Director of Midwifery and Neonates *Fiona Bryant, Acting Assistant Chief Nurse *MVP Chair	*New Chair has been appointed since last meeting. *Meeting to be scheduled in the early new year with the Chair and CCG leads to discuss how we can improve service user involvement and consider how we can increase diversity with the membership. *Further 15 steps challenge to be requested.

ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.	2b)	In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.	Compliant	*Non-Executive Director has been identified and in place. *Board Level Safety Champions in place in addition to Divisional level Safety Champions. *Triumvirate in place with bi monthly safety champion meetings.	Fiona Bryant, Acting Assistant Chief Nurse.	Role Descriptor for non-exec board safety champion has been received and has been circulated to relevant safety champions.
Staff training and working together: Staff who work together must train together.	3a)	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Compliant	*Daily Consultant Led ward round in place and second round has been implemented with On Call Consultant present and leading. This will be undertaken at 7pm prior to on call Consultant leaving the unit. *TW19-048 SOP 15 Maternity Communication and Hand Over of Care has been updated to reflect this. *Spot check audit undertaken.	*Shatha Attarbashi, Clinical Director *Papa Essilfie, Consultant Obstetrician *Amit Verma, Delivery Suite Lead Consultant	
	3b)	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.	Compliant	Full MDT programme of training in place and compliant with CNST current recommendations. MDT Face to face full day programme also developed ready. Maternity TNA updated to reflect current training requirements and core competencies	*Amit Verma, Delivery Suite Lead Consultant. *Keeley Jones, Practice Development Midwife. *Joanne Birch, CTG Champion Midwife	
	3c)	Confirmation that funding allocated for maternity staff training is ring-fenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving	Partially Compliant	Maternity incentive scheme refund is not currently ring fenced, although Funding has been received from year 1 to implement transitional care and employ Neonatal Nurses. *In year 2 the Maternity Service also received money to install a centralised CTG monitoring system to improve patient safety.	*Director of Finance. *Chief executive.	

		maternity safety				
Managing complex pregnancy: There must be robust pathways in place for managing women with complex pregnancies. Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.	4a)	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	Partially Compliant	*Consultant Leads in place for high risk women with complex medical conditions such as Hypertension & Cardiac problems, with designated medical antenatal clinics. *Diabetes and Endocrine leads in place with joint endocrine and obstetric clinics. *Mental Health lead in place working collaboratively with regional mental health team. *Lead has also been identified for -Multiple pregnancy -Previous pre term birth. *Pathways in place for referrals to Tertiary units for highly complex conditions such as HIV and Hepatic and Renal conditions.		*The name of the allocated Consultant lead for complex groups to be documented clearly within the records. *Work ongoing to improve continuity within Consultant led Clinics. *Audit of compliance has been undertaken and will be repeated and added to the audit calendar
	4b)	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Compliant	For Greater Manchester and Eastern Cheshire, it has been agreed that St Marys Hospital, Oxford Rd Campus will be the Maternal Medicine Centre via a hub and spoke model. Two physicians with special interest in Obstetrics have commenced Maternal Medicine training. Following a meeting held with the national policy team on 7th December, a proposal to agree funding through a system led commissioner model is to be taken through GM commissioning governance and to the joint commissioning board. Also a request has been made for pump prime funding in Q4, to initiate project support and clinical leadership	Greater Manchester and Eastern Cheshire, Strategic Clinical Network	When regional Maternal Medicine Centre via a hub and spoke model is in place this will likely be a regional referral pathway developed within the GM LMS.
Risk assessment throughout pregnancy: Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.	5a)	A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance	Partially Compliant	*Comprehensive Risk assessment completed at booking and updated during pregnancy . *All staff have been informed of the need to complete a risk assessment at each contact and prior to labour and delivery. *Communications have been sent to all staff. *Monitoring of compliance will be undertaken and review of the documentation to support this. *The Personalised Care and Support Plan (PCSP) is updated regular by named Midwives and this is monitored through the Maternity Information System(Euroking) for completion not content.	*Anne-Marie Goodall Out Patient Matron. *Fatima Abu Amna Antenatal Clinic Lead Consultant	Immediate implementation, however documentation tools need to be amended *Audits will be put in place for monitoring of compliance against NICE guidance recommendations

Monitoring fetal wellbeing: All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.	6a)	Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	Partially Compliant	*Carbon Monoxide (CO) monitoring has been suspended throughout the pandemic and is being re-introduced under risk assessment where appropriate and safe to do so. *Smoking cessation Midwife still in training. Service is due to start in mid-January. *Baby Clear Smoking intervention programme will be rolled out mid-January once all Midwives have completed training. * Pre term birth guidelines awaiting ratification following review of Regional Guideline. *Extreme pre term birth Regional guideline out for comments and review.	*Amit Verma, Delivery Suite Lead Consultant. Saving Babies Lives Consultant Lead *Sam Whelan, Saving Babies Live Champion Midwife. *CTG Champion Midwife (Joanne Birch) in place who leads on all CTG training in conjunction with the Obstetric Consultant lead. (Amit Verma)	*Funding to be received for 6 months 0.6 WTE to support saving babies lives care bundle implementation. *Funding will be utilised to support the smoking cessation service establish and provide training support for recognition of the growth restricted baby. * Case review to be undertaken to determine and act upon all themes related to pre-term birth (prediction, prevention and preparation) that are identified from investigation of incidents, perinatal reviews and examples of excellence
Informed consent: All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.		Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	Compliant	All leaflets to support informed choice and consent are published to the Trust Internet site.	*Clinical Guidelines Lead Consultant *Patient & Public Involvement Team. *Communications team	on-going

Ockenden Review December 2020: 12 Urgent Clinical Priorities

LMS Name:	
Tool completed by - Name:	
Role:	
Contact email address:	

			Overall LMS Position	**TRUST 1**	**TRUST 2**	**TRUST 3**	**TRUST 4**	**TRUST 5**	**TRUST 6**
Essential Action		**Action required**	**Current status -** compliant, partially compliant, not compliant *(drop down box available)*	**Current status -** compliant, partially compliant, not compliant *(drop down box available)*	**Current status -** compliant, partially compliant, not compliant *(drop down box available)*	**Current status -** compliant, partially compliant, not compliant *(drop down box available)*	**Current status -** compliant, partially compliant, not compliant *(drop down box available)*	**Current status -** compliant, partially compliant, not compliant *(drop down box available)*	**Current status -** compliant, partially compliant, not compliant *(drop down box available)*
Enhanced safety: Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.	1a)	A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly							
	1b)	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB							
Listening to Women and their Families: Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.	2a)	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services							
	2b)	In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.							
Staff training and working together: Staff who work together must train together.	3a)	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.							
	3b)	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.							
	3c)	Confirmation that funding allocated for maternity staff training is ringfenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety							
Managing complex pregnancy: There must be robust pathways in place for managing women with complex pregnancies. Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine	4a)	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place							
	4b)	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres							
Risk assessment throughout pregnancy: Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.	5a)	A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance							
Monitoring fetal wellbeing: All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.	6a)	Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.							
Informed consent: All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.	7a)	Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.							

Maternity services assessment and assurance tool

Section 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.
- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.
- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
Safety in Maternity units to be strengthened by increasing partnerships between Trusts and within local networks The National Perinatal Mortality Review Tool	The PMRT Tool is used to standardise review of all cases that are eligible and to feed into other maternity reviews such as Immediate Post Incident Review (IPIR) and/or Concise investigations when	Weekly table top meetings are in place for discussion of incidents that require a PMRT review. These are attended by the MDT with the appropriate clinicians involved.	Quarterly PMRT reports to be submitted to Trust Board. If any specific trends in causes of stillbirths or neonatal deaths, lessons learned	Ongoing / Continual Sarah Howard Bereavement Lead Midwife	Further support is required from the region to implement external reviews by independent clinicians.	Continue with process in place, for majority of PMRT reviews. Where it is deemed there is a requirement for external review this will be sought independently or through the LMS

to review perinatal deaths Themes and trends identified Significant areas where lessons can be learned with individual cases are added to any action plans for individual cases. Action Plans Monitored at the Obstetric and Gynaecology Clinical Cabinet and or Serious Incident Requiring Review Panel(SIRI) if the incident has been reported to StEIS	required. Findings from the PMRT data reports are compiled into a quarterly report that is cascaded throughout the Maternity Service to update all staff. Any improvement actions including actions from the Saving Babies Lives care bundle (V 2.0) are discussed in this review. Mothers/ Families are asked to contribute to all Maternity and Neonatal investigations and feedback is always provided in agreement with the family in a format that is agreed.	**Eligible cases include:** Stillbirth Neonatal Death Maternal Death Reduction in avoidable harms and reduction in numbers of stillbirths Recommendations are implemented	from reviewing the cases or broader concerns identified then these would be raised at the Maternity Service Clinical issues meeting or wider within the network as appropriate. A multi-disciplinary action plan would be developed and monitored through the appropriate forums dependent on the issue identified.	Cathy Stanford Acting Divisional Director of Midwifery. Head of Governance Maternity and Child Health		
Maternity Dashboards	Maternity Dashboards are completed monthly and submitted to Trust Board for the monthly performance report.	Quarterly GM dashboard meetings are held and data is reviewed. Any units that may be an outlier with any of the	There is a National Maternity Dashboard being launched which will pull data from MSDS submissions	Cathy Stanford Acting Divisional Director of Midwifery. Head of Governance Maternity and	Digital Midwife to support the increasing demands for reporting and move towards complete digital maternity	Continue with Head of Governance and facilitator incorporating this into their roles, which is a pressure on the

	Additionally WWL submits data to the GM regional dashboard	metrics are asked to review and provide actions.	which WWL will continue to contribute to through the Euroking Maternity Information System.	Child Health	records.	Governance requirements
Data is submitted to the Maternity Services Dataset monthly	Any discrepancies in the data when the reports are run or the score cards received are investigated and solutions sought with the help of BI and the MIS provider Any data input issues are fed back directly to staff. Any service level issues will be rectified with the appropriate team, either BI, IT or the provider.	The Trust receives a MSDS scorecard monthly outlining compliance with all criteria	Risk assessment has been completed for MSDS submission and support required.	Cathy Stanford Acting Divisional Director of Midwifery. Head of Governance Maternity and Child Health	Digital Midwife to support the increasing demands for reporting and data quality issues and the move towards a complete digital maternity record. Additionally a Digital Midwife will support the Governance agenda with Documentation standards and compliance with data entry and data security.	Continue with Head of Governance and facilitator incorporating this into their roles, which is a pressure on the Governance requirements

WWL has reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution Early Notification Scheme	Independent reviews are received from HSIB and any recommendations for improvement are incorporated into an action plan which is monitored for compliance via the Trust Governance forums.	All cases that meet the criteria are reported to HSIB, Each Baby Counts and MBRRACE and NHS Resolution.	The Maternity Service are aware of the 5 Quality Surveillance principles and have advised the Trust Board of the requirement to have a Quarterly board review of Perinatal Safety.	Cathy Stanford Acting Divisional Director of Midwifery. Head of Governance Maternity and Child Health		System in place for reporting.
Serious Incidents are discussed at: -Maternity Clinical Issues group. -Obstetric and Gynaecology Clinical Cabinet -Surgical Divisional Quality Executive Group -Executive Scrutiny Group -Serious Incidents Requiring Review Panel(SIRI)	All serious incidents will be submitted to Trust Board for oversight and review on a quarterly basis. This will be commenced once WWL are in receipt of guidance from the LMS, a regular report as per the Serious Incident Framework will be submitted to Trust Board.	Serious incidents from all GM trusts will feed into the LMS Serious Incident Group (SIG) going forward. Terms of reference to be defined and agreed. Challenge is received at all Governance forums in terms of any lessons learned and recommendations for improvements	The Trust is committed to implementing the regional proposals for the Quality Surveillance Model that will be circulated in early 2021 and will commit to implementing this. Further Guidance is required in regards to the submission to the LMS as to how and when this will be implemented.	Shatha Attarbashi Clinical Director/ Consultant Obstetrician and Gynaecologist	GAP analysis will be undertaken on the proposed Quality Surveillance model. Dedicated time for Clinicians and Nursing and Midwifery staff to undertake investigations and meet the requirements within the model.	Will continue to report to the Executive Scrutiny Group (ESG) all serious incidents

Immediate and essential action 2: Listening to Women and Families

Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.

(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
Evidence that a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices	Feedback has been obtained on leaflets and visiting. 15 steps walk about undertaken by service users	Service user feedback has been used to make changes and improvements across the maternity floor Consultation was also sought when changes to visiting times was introduced in the past	It is recognised that greater involvement of service users' needs to be implemented and lay representation on Directorate meetings sought.	Anne-Marie Goodall Out-Patient Matron 30 March 2021 Cathy Stanford Acting Divisional	New Chair has been appointed since last meeting. Further 15 steps challenge to be requested, as 2 years since last one	Bi Monthly meetings will continue.

Partnership (MVP) to coproduce local maternity services. Established Maternity Voice Partnership in place with BI-monthly meetings. Patient feedback boards in place across the unit. Trust website and Facebook page	Patient stories have been circulated to staff to communicate the Voice of the Woman. Service users have been involved in the interview process for Bereavement Midwife MVP minutes.	CNST Safety Action 7 compliance. Feedback from MVP members Increased involvement from service users	Meeting to be scheduled in the early new year with the Chair and CCG leads to discuss how we can improve service user involvement and consider how we can increase diversity with the membership.	Director of Midwifery. Head of Governance Maternity and Child Health	undertaken. Review of Maternity website and access to information to be requested from the MVP group to identify any areas for improvement from the woman's perspective. MVP Charter in production from LMS Review maternity agenda items at MVP meetings	
Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues the	Board Level Safety Champions in place in addition to Divisional level Safety Champions. Bi Monthly meetings are scheduled. Non-Executive Director (NED) for	The Maternity and Neonatal Safety Champions are: • Clinical Director for Obstetrics and Gynaecology. • Divisional Medical Director/ Consultant Paediatrician • Divisional Director of Midwifery and Neonates.	Agenda to be formulated for meetings going forward	Ongoing/ Continual All safety Champions 30 March 2021	Quarterly reporting mechanism to board to be formulated and agreed in regards to reports received and feedback / escalation from NED and Safety Champions.	Remains ongoing

identification of an Executive Director with specific responsibility for maternity service	Maternity attends these meetings.	Staff are able to identify the Safety Champions				
Confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard	Role Descriptor for non-exec board safety champion has been received and has been circulated to relevant safety champions. Non-Executive Director (NED) for Maternity attends Safety Champions meetings. Bi Monthly meetings in place to discuss ongoing issues and challenges	Achieve compliance with CNST safety action 9.	Feedback to be requested from NED	Ongoing/ Continual Director of Corporate Affairs	The role will be reviewed in line with new requirements	
Independent Senior Advocate Role to be introduced who will report to the Trust and LMS Boards. Maternity services must ensure that		Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are	External Advocate Role to be defined	This role is not part of NED or MVP role. There will be a national model including framework and principles which will be issued	This role is independent of the trust and therefore to be funded separately and needs to be high level seniority.	Await further information

women and their families are listened to with their voices heard.		discussed, particularly where there has been an adverse outcome.		shortly.		

Immediate and essential action 3: Staff Training and Working Together

Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.

(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 3?	**What are our monitoring mechanisms?**	**Where will compliance with these requirements be reported?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**
Staff who work together must train together Consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week Second round has been implemented with On Call Consultant present	Compliance is not currently reported. Attendance at rounds by the MDT. Documentation of management plans	Consultant meetings Audit meetings. Obstetric and Gynaecology Clinical Cabinet	Ward round book will be completed until actions are embedded. Standardised audit forms to be created by the LMS which will be circulated.	Ongoing/ Continual Clinical Director and Consultant body. Delivery suite lead Midwife and Obstetrician	Additional support may be required if time of second round	Continue with twice daily ward rounds as planned. Escalation policy/ process in place.

and leading. This will be undertaken at 7pm prior to on call Consultant leaving the unit.	and ongoing monitoring arrangements. 7 day rotas are in place with Consultant on call cover	Compliance with CNST Safety Action 8.	TW19-048 SOP 15 Maternity Communication and Hand Over of Care have been updated to reflect this.		is not deemed to be at the appropriate time. Job plans and remuneration for on-call may need to be amended. Additional staffing may be required.	
A MDT training as part of annual Mandatory training schedule is in place which includes: Monthly MDT PROMPT training Monthly CTG training and competency assessment. Human Factors Sepsis Recognition of	Full MDT programme of training in place and compliant with CNST current recommendations. Data Base of attendance and compliance for all staff groups in place. Quarterly updates from Leads presented at Governance forums	Data base of attendance in place to monitor the 90% compliance of all staff groups	Training and competency passports currently being rolled out to all midwifery staff. Regional CTG Training and competency package to be fully introduced fop all staff grades .	Ongoing/ Continual Keeley Jones Practice Development Midwife. Joanne Birch CTG Champion Midwife. Farina Kidwai Consultant Obstetrician PROMPT and CTG training is currently delivered virtually via interactive sessions	Continued support of the Multidisciplinary team in allocating staff to attend training Funding for ongoing training requirements. Increase CTG Champion Midwife to 0.4 WTE from 0.2 to deliver addition required training and support. Appropriate % staffing	Continue with comprehensive training package in place

deteriorating patient. Covid updates/ training Ad hoc/ monthly skills simulations for Obstetric emergencies	Attendance logs and feedback/ debrief sheets				uplift to incorporate all Maternity and Obstetric training needs. Consultant SPA sessions to be reviewed for training and Governance requirements.	
Evidence of submission to LMS of MDT and working.			Awaiting feedback from LMS regarding reporting mechanisms for this			Will continue with Data Base of attendance and compliance for all staff groups in place.
Confirmation that funding allocated for maternity staff training is ring-fenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety	Maternity incentive scheme refund is not currently ring fenced, although Funding has been received from year 1 to implement transitional care and employ Neonatal Nurses. In year 2 the Maternity Service also received money to install a centralised CTG monitoring system to improve patient safety.	Trust Board Executive team meeting	Agreement to be sought from Trust Board in regards to ring fencing CNST refunds	Director of Finance. Chief executive.	Statement of commitment that year 3 CNST incentive scheme refunds will be ring-fenced for maternity.	Business case development for additional funding for either staffing or resource requirement.

Immediate and essential action 4: Managing Complex Pregnancy

There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.

b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	**What are our monitoring mechanisms?**	**Where is this reported?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. Consultant Leads in place for high risk women with designated medical antenatal clinics for complex medical conditions such as: Hypertension	Will be audited as part of all clinical incident reviews. Spot check audits to be undertaken.	Will be reported to Obstetric and Gynaecology Audit meeting and audit department as a registered audit	Audits of compliance to be undertaken. Named Consultants to be clearly identified on women's case notes. (Stickers ordered for all Consultants). Work ongoing to improve continuity within Consultant led Clinics. Incorporate into monthly documentation audits	30 March 2021 Quality and Safety Midwife to Audit compliance. Fatima Abu Amna Obstetric Consultant and Gynaecologist Antenatal Clinic Consultant Lead	GM LMS are considering the use of a standardised audit tool for all units to use.	Spot check audit completed and findings fed back to Consultant and clinic leads. To be further discussed at clinical cabinet and improvement measures identified. Which are:

Cardiac problems, Diabetes and Endocrine Mental Health. Multiple pregnancy Previous pre term birth						
Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team. Pathways in place for referrals to Tertiary units for highly complex conditions such as : HIV Hepatic conditions Renal conditions. Cardiac Conditions	No monitoring processes in place at present		Development of regional Maternal Medicine Centre within the GM network. Review all current pathways in place for referral to tertiary centres for consistency and appropriateness.	Dates TBC. Greater Manchester and Eastern Cheshire, Strategic Clinical Network. 30 March 2012 To be identified.	When regional Maternal Medicine Centre via a hub and spoke model is in place this will likely be a regional referral pathway developed within the GM LMS. Support for audit requirements	Continue with local pathways until GM agreed pathway is in place
Understand what further steps are required by your organisation to support the development of maternal medicine	For Greater Manchester and Eastern Cheshire, it has been agreed that St Marys Hospital, Oxford Rd Campus will be the Maternal Medicine Centre via a				Following a meeting held with the national policy team on 7th December, a proposal to agree funding through a system led commissioner model is to be taken through	

specialist centres.	hub and spoke model. Two physicians with special interest in Obstetrics have commenced Maternal Medicine training.				GM commissioning governance and to the joint commissioning board. Also a request has been made for pump prime funding in Q4, to initiate project support and clinical leadership	
Regional integration of maternal mental health services. Red Flag Perinatal Mental Health Clinic led by Consultant Psychiatrist in place. Antenatal Consultant lead supports all women who have been assessed as Amber Flag for perinatal mental health. Community Midwives support all other with underlying mental Health needs within the teams	Currently no outcome measurements in place. Newly developed Vulnerable team in place who will support the Red Flag clinics to provide Midwifery input.	Risk assessments are completed for referral to relevant level of service.	Audits to be identified to monitor effectiveness of service		Perinatal Mental Health Midwife funding to be identified and post implemented.	Continue working in conjunction with GM to support the perinatal mental health service.

Immediate and essential action 5: Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway. • All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional • Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.						
Link to Maternity Safety actions: **Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?**						
Link to urgent clinical priorities: a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.						
What do we have in place currently to meet all requirements of IEA 5?	**What are our monitoring mechanisms and where are they reported?**	**Where is this reported?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. Comprehensive Risk assessment completed at booking and updated during pregnancy	This is a news action and therefore communications have been sent to all staff. The Personalised Care and Support Plan (PCSP) is updated regular by named Midwives and this is monitored through the Maternity Information System (Euroking) for completion not content.	Once audit programme in place this will be monitored via Obstetric and Gynaecology Audit meetings. Action plans will be monitored through Clinical Cabinet	Monitoring of compliance will be undertaken and review of the documentation to support this. Clarification sought from MIS provider(Euroking) if this can be added to core work flows , Perinatal Institute contacted as case note provider for updates in regards to	Audrey Livesey Inpatient matron Anne-Marie Goodall. Outpatient matron Sam Whelan Quality and Safety Midwife Fatima Abu Amna Antenatal Clinic Lead Consultant	Risk assessment tool needs to be amended to incorporate compliance documentation. MIS provider has been contacted to enquire if there are plans to incorporate this within the system as it is a National recommendation.	All staff have been informed of the need to complete a risk assessment at each contact and prior to labour and delivery. Monitoring of compliance will be ongoing until the action is embedded in practice.

	Documentation within maternal case notes and hand held notes should identify that a risk assessment has taken place detailing all physical assessments as well any other issues and discussion with the women around her continued plan of care and appropriate place of birth.		plans to amend risk assessment templates within notes.			

Immediate and essential action 6: Monitoring Fetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies' lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	How will we evidence that our leads are undertaking the role in full?	What outcomes will we use to demonstrate that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Monitoring fetal wellbeing. Implement the saving babies' lives bundle.	Regular audit and review in place for all elements of saving babies lives.	Reduction in Stillbirths. Recognition of the small for gestational	Carbon Monoxide (CO) monitoring has been suspended throughout the pandemic and is being	Sam Whelan Quality and Safety Midwife. Saving babies lives Midwife Lead	Funding to be received for 6 months 0.6 WTE to support saving babies lives care bundle	Continue working on all elements of the SBL Care Bundle to ensure ongoing compliance.

The leads must ensure that their maternity service is compliant with the recommendations of SBL care bundle 2 and subsequent national guidelines. Comprehensive action plan in place which is monitored via Clinical Cabinet and submitted to the LMS as requested. Saving Babies Lives lead Midwife in place CTG Champions in place Centralised CTG monitoring system in place to provide oversight and assurance for Delivery suite Coordinators and Medical staff.	Feedback from Perinatal institute for compliance and detection levels of small for gestational age infants. Ongoing monitoring and review of clinical incidents.	age infant. Reduction in pre term birth. Optimisation of pre term infants	re-introduced under risk assessment where appropriate and safe to do so. Smoking cessation Midwife still in training. Service is due to start in Mid-January. Baby Clear Smoking intervention programme will be rolled out mid-January once all Midwives have completed training. Pre term birth guidelines awaiting ratification following review of Regional Guideline. Extreme pre term birth Regional guideline out for comments and review.	Amit Verma Saving Babies lives Consultant Obstetrician Lead Julie Bancroft Smoking Cessation Lead Midwife. Anne-Marie Goodall Outpatient matron.	implementation. Funding will be utilised to support the smoking cessation service establish and provide training support for recognition of the growth restricted baby. Case review to be undertaken to determine and act upon all themes related to pre-term birth (prediction, prevention and preparation) that are identified from investigation of incidents, perinatal reviews and examples of excellence	
A second lead is identified so that every unit has a lead midwife and a lead		Reduced incidence of CTG mis-	Increase in Midwife CTG Champions hours dedicated to CTG training	Joanne Birch CTG Champion Midwife	Additional hours increased from 0.2 to at least 0.4 WTE FOR CTG Champion	Continue with in-house training and competency packages.

obstetrician in place to lead best practice, learning and support. Midwife CTG Champion in place who leads on all aspects of CTG training, teaching and compliance in conjunction with Consultant Obstetrician.	Both actively participate in training and development of staff and in the development of guidance, pathways and competencies.	interpretation. Case note reviews evidencing good practice and appropriate management of the Abnormal CTG		Amit Verma Obstetric Consultant lead.	Midwife. Funding for Baby Life line CTG masterclasses for all core Maternity and Medical staff	
Regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines	Weekly table top meetings in place where incidents are discussed , Monthly clinical issues group reviews in places which focus on serious incidents and CTG issues.	Reduced incidence of CTG mis-interpretation. Case note reviews evidencing good practice and appropriate management of the Abnormal CTG	Introduce regular CTG review sessions on the delivery suite facilitated by CTG Champions.	Joanne Birch CTG Champion Midwife Amit Verma Obstetric Consultant lead.	Dedicated time	Continue with in-house training and competency packages.

Immediate and essential action 7: Informed Consent All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery. All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care Women's choices following a shared and informed decision-making process must be respected						
Link to Maternity Safety actions: **Action 7:** Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?						
Link to urgent clinical priorities: a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.						
What do we have in place currently to meet all requirements of IEA 7?	**Where and how often do we report this?**	**How do we know that our processes are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
Pathways of care are clearly described in written information in formats consistent with NHS policy and posted on the Trust website. All leaflets to support informed choice and consent are published to the Trust Internet site. Links to NHS and	Leaflets and guidelines are monitored the Obstetric and Gynaecology Guidelines group and Clinical Cabinet. Additional oversight is monitored through Corporate governance for compliance	Monitored through Corporate Quality Executive Group	The Maternity website needs further development and updating and this is progressing to provide more up to date information in an easily accessible format. Pathways, SOP's and Guidelines are not published on the internet. Further guidance is	Clinical Guidelines Lead Consultant Patient & Public Involvement Team. Communications team	Digital Midwife who will support the implementation of digital maternity records and access to patient portals. Will also support guideline and leaflet development and oversight of compliance. Review of Maternity website and access to information to be	Women who cannot access the website are provided with paper copies for information. Links to additional relevant websites are shared with women

RCOG patient information available. Signposting to relevant APP's. My Birth Choices website and leaflets available			required as to whether this is a requirement.		requested from the MVP group to identify any areas for improvement from the woman's perspective.	

Section 2						
MATERNITY WORKFORCE PLANNING						
Link to Maternity safety standards: **Action 4:** Can you demonstrate an effective system of clinical workforce planning to the required standard **Action 5:** Can you demonstrate an effective system of midwifery workforce planning to the required standard?						
We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.						
What process have we undertaken?	**How have we assured that our plans are robust and realistic?**	**How will ensure oversight of progress against our plans going forwards?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
Birth rate + Analysis undertaken in January 2021 to understand staffing requirements needed to implement Continuity of Carer milestones and achieve compliance of 51% by March 2022	This will be used in conjunction with the National staffing tool to identify staffing for each area and team according to case load and acuity.	Red Flag incidents such as: Lack of supernumerary shift coordinators. Unable to provide 1-2-1 care in labour Staffing Escalation policy in place	Bi Annual staffing papers to be produced and presented to Board.	Ongoing/ Continual Cathy Stanford Acting Divisional Director of Midwifery. Head of Governance Maternity and Child Health Fiona Bryant Acting Assistant Chief Nurse	Any additional funding requirements as identified through Birth rate+	Midwife to Birth ratio Daily weekly staffing reviews undertaken by matrons for each area.
MIDWIFERY LEADERSHIP **Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in** Strengthening midwifery leadership: a manifesto for better maternity care						
The Divisional Director of Maternity and Neonates is responsible and accountable to the Chief Nurse who is an executive Director on the Board. 1) Every trust or health board delivering maternity care should have a Director of Midwifery, with a Head of Midwifery in every maternity unit within the organisation. **There is a Divisional Director of Midwifery in Place, but not a Head of Midwifery. Directors of Midwifery are leaders and advocates for safe, high quality maternity care, managing the strategic and operational delivery of maternity services locally.** **Heads of Midwifery focus on the operational delivery of maternity care locally. They will often not have direct input into or responsibility for strategic, board-level decision-making** 2) A Lead Midwife at senior level in all parts of the NHS, both nationally and regionally						

N/A - Applicable to region / national team

3) More consultant midwives –

WWL does not currently have a Consultant Midwife

4) Specialist Midwives in every Trust.

WWL currently has a Specialist midwife in post for Smoking cessation, Bereavement, Infant feeding and Safeguarding(from Corporate Team). There is a further requirement for a lead Perinatal Mental Health Midwife and a Diabetes Specialist Midwife.

5) Strengthening and supporting sustainable midwifery leadership in education and research

N/A - applicable to HEIs

6) A commitment to fund ongoing midwifery leadership development.

WWL is currently reviewing core training requirements and offers some leadership training. Bespoke leadership programmes would be beneficial. Funding has been identified Nationally to support Maternity Leadership training for senior neonatal and maternity leaders across England. Further details are awaited.

7) Professional input into the appointment of midwife leaders.

The recruitment process at WWL is inclusive of Midwives and Clinicians on interview panels and focus groups for senior posts within the organisation.

NICE GUIDANCE RELATED TO MATERNITY

We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.

What process do we have in place currently?	Where and how often do we report this?	What assurance do we have that all of our guidelines are clinically appropriate?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
MDT Guideline meeting in place which reviews and updates all Clinical Guidelines and SOP's	Monthly. Corporate Governance oversight in place for monitoring compliance with updating			Lead Consultant for guideline development and monitoring. Head of Governance for maternity and Child Health	Admin support	Continue with current embedded processes
NICE Guidelines are	As received.	Discussed and agreed	Continue to maintain	Lead Consultant for	Admin support	Continue with current

reviewed and implemented with baseline assessments completed	Corporate Governance oversight in place for monitoring compliance with updating	at clinical Guidelines group. Bench marking is undertaken and baseline assessment completed. % compliance is then recorded	the MDT guideline and SOP/ policy reviews	guideline development and monitoring Head of Governance for maternity and Child Health		embedded processes
Regional Guidelines are reviewed and implemented. Regional steering groups develop guidelines specific guidelines. Such as: -Stillbirth pathways -Hypertension -Pre term Birth -Fetal Growth Restriction -Intrapartum Fetal Monitoring -Reduced fetal Movements.	These are reviewed within the regional steering groups within the LMS	MDT regional review		Head of Governance for maternity and Child Health All Consultants and members of the Guidelines group.		Continue with current embedded processes

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:	27 January 2021
Presented by:	Director of Corporate Affairs
Prepared by:	Paul Howard, Director of Corporate Affairs
Contact details:	T: 01942 822027 | E: paul.howard@wwl.nhs.uk

Executive summary

In March 2020, the Board approved a COVID-19 risk appetite statement and directed that it should be presented to each subsequent meeting to ensure its continuing appropriateness and relevance. The risk appetite statement was subsequently amended by the Board at its meeting in September 2020. No amendments were made following review at the meeting in November 2020.

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

Link to strategy

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

Risks associated with this report and proposed mitigations

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

Financial implications

There are no financial implications arising out of this report.

Legal implications

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

People implications

There are no people implications in this report.

Wider implications

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

Recommendation(s)

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

COVID-19
Risk appetite statement

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Introduction

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

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

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

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

Underlying principles

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

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

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

Our risk appetite

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

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

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

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

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

Appendix: Risk appetite matrix

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

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Monthly Trust Financial Report – Month 9 (December 2020)
Presented to:	Finance and Performance Committee
On:	20th January 2021
Presented by:	Ian Boyle [Chief Finance Officer]
Prepared by:	Heather Shelton [Head of Financial Management]
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Executive summary

	In Month			Year to Date		
	Actual £000's	Revised Plan £000's	Var £000's	Actual £000's	Revised Plan £000's	Var £000's
Income	34,002	33,635	366	316,631	315,179	1,453
Expenditure	(35,471)	(35,710)	239	(315,990)	(315,201)	(788)
Financial Performance	(2,432)	(3,118)	686	(8,836)	(9,508)	672
Cash Balance	67,986	49,065	18,921	67,986	49,065	18,921
Capital Spend	2,128	1,688	(440)	18,442	16,240	(2,202)

Key Messages:

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

- The Trust submitted a revised forecast to NHSI/E in November for the second half of the financial year. NHSI/E are using this forecast as a plan to monitor the Trust financial performance and this is shown in the table above.

The WWL Way

- National funding arrangements changed from month 7. The Trust has a fixed funding allocation instead of operating under a reimbursement model.

- The Trust is reporting a deficit of £2,4m in month and a deficit of £8.8m year to date.

- Cash is £68.0m at the end of Month 9.

- Capital spend is £18.4m year to date. This includes £5.7m on COVID-19 associated projects which will be fully reimbursed via non-interest bearing PDC.