Board of Directors held in public

Wed 28 July 2021, 13:15 - 15:00

By videoconference

Agenda

13:15 - 13:15

1. Declarations of interest

Information *Robert Armstrong*

13:15 - 13:17

2. Minutes of previous meeting

Decision *Robert Armstrong*

Minutes - Public Board - May 2021.pdf (7 pages)

13:17 - 13:27

3. Patient story

Discussion *Rabina Tindale*

13:27 - 13:32

4. Chief Executive's report

Information *Mary Fleming*

Chief Executive's report.pdf (3 pages)

13:32 - 13:52

5. Assurance and governance

5.1. Committee chairs' reports

Information *Committee chairs*

Verbal item

5.2. Board assurance framework

Discussion *Paul Howard*

BAF - Jul 2021.pdf (31 pages)

13:52 - 14:12

6. Patients

6.1. Q4 2020/21 mortality report

Discussion *Sanjay Arya*

Mortality Report Q4 2020 - 2021.pdf (8 pages)

6.2. IPC board assurance framework

Discussion *Rabina Tindale*

IPC BAF for Board July 2021.pdf (34 pages)

14:12 - 14:32

7. People

7.1. Freedom to Speak Up Guardian's report

Discussion *Alison Balson*

7.1 FTSU report.pdf (6 pages)

7.2. Safe staffing report

Discussion *Rabina Tindale*

Safe Staffing Report for May 2021 TB version.pdf (13 pages)

14:32 - 14:47

8. Performance

8.1. Performance report

Discussion *Sanjay Arya/Alison Balson/Mary Fleming/Rabina Tindale*

Performance report.pdf (5 pages)

14:47 - 14:47

9. Consent agenda

9.1. Finance report

Information

Board Report 21-22 June month 3 Public.pdf (2 pages)

9.2. Your Voice survey

Information

7.1 Your voice report June 2021 Final.pdf (73 pages)

9.3. Guardian of Safe Working report

Guardian of safe working quarterly report.pdf (4 pages)

9.4. Register of Clinical Ethics Group referrals

Information

CEG referrals.pdf (3 pages)

9.5. Approval of terms of reference for Charitable Trust Committee

Decision

For approval - ToR - CTC - 2021 NG.pdf (3 pages)

9.6. Statutory, mandatory and recommended posts

Information

9.6 Statutory, mandatory and recommended posts.pdf (10 pages)

14:47 - 14:47

10. Date, time and venue of next meeting

Information *Robert Armstrong*

29 September 2021, 12.00 noon, by videoconference

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

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

HELD ON 26 MAY 2021, 1.15PM

BY VIDEOCONFERENCE

Present:	Mr I Haythornthwaite	Non-Executive Director (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	Deputy Chief Executive
	Mr M Guymer	Non-Executive Director
	Mrs L Lobley	Non-Executive Director
	Mr S Nicholls	Chief Executive
	Ms R Tindale	Chief Nurse
	Mrs F Thorpe	Non-Executive Director
In attendance:	Mrs K Forrest	Director of Strategic Transformation
	Mr P Howard	Director of Corporate Affairs (minutes)
	Mrs A-M Miller	Director of Communications and Stakeholder Eng.
	Mrs L Sykes	Public Governor (observer)
	Mrs L Hadley	Chief AHP (to minute ref. 62/21 only)

60/21 Declarations of interest

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

61/21 Minutes of the previous meeting

The minutes of the previous meeting held on 31 March 2021 were **APPROVED** as a true and accurate record.

62/21 Staff story: Allied Health Professionals

The Chief Allied Health Professional (AHP) delivered a presentation to summarise the journey of AHPs and Healthcare Scientists at WWL. Note was made of the fact that AHPs are the third-largest workforce in the NHS after nurses and doctors, comprising 14 different professions. She further noted that Healthcare Scientists are made up of a further 40 professions across the NHS. Particular note was made of the fact that AHPs had recently taken on leadership roles, such as Ward Managers and as part of divisional leadership teams, which previously would have been undertaken solely by nurses and the added value to the organisation was acknowledged.

The Board received and noted the verbal update.

63/21 Chief Executive's report

The Chief Executive presented a report which had been circulated with the agenda to update the Board on matters of interest since the previous meeting. Particular note was made of the recent appointment by the Council of Governors of Mark Jones as Chair Designate who will become Chair when Robert Armstrong retires from the role at the end of October 2021 after seven years in post.

The Chief Executive also highlighted the work that was underway around internal communications and outlined some of the improvements that had been made.

The Board received and noted the verbal update.

64/21 Committee chairs' reports

The Director of Corporate Affairs opened this item by relaying an update from the recent meeting of the Quality and Safety Committee, given that the chair of the last meeting had recently left the foundation trust after having served seven years on the board. He confirmed that the committee had met on 14 April 2021 and had been the first to use the new-style board assurance framework. He also noted that the committee had considered a risk around discharge letters which had been escalated to it under the organisation's risk management arrangements and the committee had been pleased to note that the risk had been mitigated and therefore de-escalated. The committee had also received updates around safeguarding and the national patient safety strategy and further work was being undertaken around timeliness of complaint responses which would be the subject of further discussions at a future meeting of the committee.

Lady Bradley noted the significant level of discussion around safeguarding and the risk escalation and took the opportunity to thank Prof Tony Warne, the outgoing committee chair, for his dedicated work throughout his tenure and to welcome Mrs Thorpe as the incoming chair.

Mr Guymer advised that the Finance and Performance Committee had met in both April and May, as required by the changing financial landscape across the NHS. He commented that under normal circumstances a budget would be developed in advance of the new financial year but that this had not been possible as a result of national uncertainties and was therefore undertaken in April 2021 on the basis of new funding models that were being introduced. He confirmed that there was clarity of the funding arrangements for H1 2021/22 only at the current time and particular note was made of the importance of ensuring oversight of COVID-related expenditure and bank and agency expenditure over the coming months.

In terms of performance, Mr Guymer noted the usefulness of the reports received by the committee in providing information and assurance and to ensure the challenges of recovering from the pandemic are well understood.

Confirmation was provided that the Audit Committee had met on 18 May 2021 to consider year-end related matters and that an internal audit progress update had also been received.

The Board received and noted the committee chairs' updates.

65/21 Board assurance framework

The Director of Corporate Affairs presented the new-style board assurance framework which had been introduced for FY2021/22 and explained how it operates. In response to a question from Dr Elliot, the Director of Corporate Affairs confirmed that the document was based on national guidance for NHS board assurance frameworks. Mr Guymer commented on the usefulness of the new layout and noted that there had been a good level of discussion at the Finance and Performance Committee as a result.

The Board received the report and noted the content.

66/21 Performance report

The Deputy Chief Executive opened this item by highlighting the excellent performance against the Emergency Department 4-hour standard in April 2021, notwithstanding the significant increases in activity both at WWL and across the whole of Greater Manchester. She noted the development of initiatives across the region designed to help patients to 'wait well' given the increase in elective waiting times as a result of COVID-19. She noted that, as COVID levels had decreased in the borough, the foundation trust had been able to step up its elective programme but cautioned that this had not been possible in time to facilitate achievement of the targets set by NHS England and NHS Improvement across all points of delivery. That said, the foundation trust had achieved the levels it had forecast in its submission to Greater Manchester and had focused on ensuring that redeployed staff were rested and reorientated before being returned to their substantive areas of employment.

The Deputy Chief Executive highlighted the strong cancer performance and also noted that diagnostic waiting times were amongst the lowest in Greater Manchester but acknowledged the potential impact of any increase in COVID-19 cases on this. On this latter point, the Deputy Chief Executive summarised the proactive work being undertaken by the Health Protection Board.

In response to a question from Mrs Thorpe around the potential correlation between non-elective demand and delays in elective activity, the Deputy Chief Executive noted that there had been an increase in patients attending the Emergency Department for reassurance purposes, many of whom are discharged without the need for diagnostic tests.

Dr Elliot asked how the foundation trust was performing against the 62-day cancer target, to which the Deputy Chief Executive responded that activity was on track and was subject to fortnightly monitoring as part of a recovery plan through to August 2021. She noted that the 85% target was not currently being measured and that the focus was on long waiting patients.

The Medical Director commented that there is a process of clinical prioritisation of patients awaiting surgery and other procedures to ensure that this is undertaken on the basis of clinical need. He also noted that, for the second month in the row, the

foundation trust's Summary Hospital-level Mortality Indicator (SHMI) performance had improved and was within the expected range.

The Director of Workforce highlighted the improving position around recruitment and vacancies, which was also reflected in the safe staffing report, but noted that there had been some impact as a result of international travel restrictions in place. A successful virtual recruitment event had taken place and this was likely to be a model that is taken forward.

With regard to staff survey information, the Director of Workforce advised that the *Your Voice* survey was due to close imminently and noted that this would be shared with the People Committee for further discussion. The role of the *Our Future, Our Family, Our Focus* programme would be instrumental in taking issues forward and confirmation was provided that shared objectives for the collective executive team in this area had been agreed.

The Director of Workforce advised that demand for the wellbeing service continued to increase and briefed the board on the additional areas of focus that had been included, such as supporting redeployed members of staff to reintegrate into their original areas of work. Mrs Lobley commented that the metrics on the balanced scorecard which had been included with the report appeared to present the organisation in a less than positive light, without recognising the significant impact that had been had, and questioned whether parameters or some wider context should be incorporated into the reporting of metrics.

The Board received the report and noted the content.

67/21 Safe staffing report

The Chief Nurse presented a report which had been circulated with the agenda to summarise staffing levels and to provide assurance on the monitoring of nurse staffing levels across inpatient areas in line with national requirements. Particular note was made of the significant reduction in band 5 and band 2 vacancies as a result of recent recruitment activities. The Chief Executive acknowledged the significant work on reducing vacancies and noted that the next important step will be to improve retention levels as well.

In response to a question from Prof Austin about whether there is a capacity to increase the number of placements for undergraduate nursing students, the Chief Nurse commented that this is an area that will be reviewed.

The Board received the report and noted the content.

68/21 Maternity (Ockenden) reports

The Chief Nurse presented a suite of reports which had been circulated with the agenda around maternity, in response to the recommendations arising from the recent Ockenden Review. Confirmation was provided that the foundation trust was compliant with 8 of the 10 CNST requirements, with the intention of full compliance by July 2021.

The Board considered the dashboards and the supporting reports and noted the updates provided. Dr Elliot noted the importance of the planned work around human factors and supported the intention to involve staff in discussions. He also suggested that technological developments may now be able to be used to allow consultants to view cardiotocography charts remotely and to provide advice as needed, and the Medical Director noted that there are processes in place for supporting the review of patients by consultants if not on site.

In response to a question from Mrs Thorpe, the Director of Workforce provided an overview of the Freedom to Speak Up arrangements across the organisation and the plans in place to further develop these. A more detailed report would be presented to the next meeting of the People Committee.

Lady Bradley commented that, at appropriate point of time, it would be useful to receive a summary of the strategic approach to maternity leadership.

The Board received the report and noted the content.

69/21 Transformation programme update

The Director of Strategic Transformation presented a report which had been circulated with the agenda to brief the Board on the outputs from the inaugural meeting of the Transformation Board which was held on 7 May 2021, at which the Transformation Plan for 2021/22 had been approved.

In response to a question from Mrs Thorpe around the potential adverse consequences of virtual consultations which need to be balanced against the positive impact, the Director of Strategic Transformation noted the need to ensure that health inequalities are not widened and confirmed that equality impact assessments are undertaken for all developments and reminded the Board that patient choice would mean that face-to-face appointments would also be available if needed. The Director of Workforce noted the importance of linking this work with achievement of the Accessible Information Standard.

In response to a question from Mrs Lobley around the future reporting arrangements, the Director of Strategic Transformation noted the intention to initially report to Board by exception and, in time, for more detailed reports to be provided when more detail is available.

The Board received the report and noted the content.

70/21 Proposal to establish a Research Committee

The Director of Strategic Transformation presented a report which had been circulated with the agenda to seek approval to establish a Research Committee, noting that the development of research activity is an instrumental component of the foundation trust's intention to become a university teaching hospital.

The Board **APPROVED** the establishment of a Research Committee and the terms of reference as presented.

71/21 Consent agenda

The papers having been circulated with the agenda and the directors having consented to them appearing on the consent agenda, the Board RESOLVED as follows:

1. THAT the register of Clinical Ethics Group referrals as at 21 May 2021 be received and noted.

2. THAT the finance report be received and noted.

3. THAT the terms of reference for the Finance and Performance Committee and the People Committee be **APPROVED** following review.

4. THAT the self-certification against provider licence conditions C6, CoS7 and FT4 be **APPROVED**.

72/21 Questions from the public

No questions from the public had been received.

73/21 Date time and venue of the next meeting

The next meeting of the Board of Directors will be held on 28 July 2021, 1.30pm by videoconference.

Action log

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
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NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	28th July 2021
Presented by:	Chief Executive
Prepared by:	Director of Communications and Stakeholder Engagement
Contact details:	T: 01942 822170 E: anne-marie.miller@wwl.nhs.uk

Executive summary

The purpose of this report is to update the board on matters of interest since the previous meeting.

Link to strategy

The links to overall strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

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

Legal implications

There are no legal implications to bring to the Board's attention.

People implications

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

Wider implications

There are no wider implications associated with this report.

Recommendation(s)

The Board of Directors is recommended to receive the report and note the content.

Report

I am extremely proud of the efforts made by the WWL family in meeting the challenges of COVID-19 and the responsibility staff have taken upon themselves to keep patients, colleagues, families, and friends safe. Despite the Government's easing of nationwide restrictions on Monday 19th July, we still expect all staff, patients, and visitors to adhere to the Trust's effective infection prevention and control measures in all areas in order to continue to reduce the spread of infection within our hospitals and community settings.

We will not alter the way in which we are responding to the pandemic and our priority continues to be staff and patient safety. We have recently communicated this with staff and provided information and support to make sure our teams and services can continue to carry out their day-to-day roles in a safe and efficient manner.

That leads me to personally recognising all the services within the WWL family, who have continued to show their passion for their work and unrelenting dedication to our patients. Our Emergency Department has been extremely busy in recent weeks and months following the easing of lockdown restrictions; this has brought about further challenges for our teams, but I want to thank them for the way in which they have reacted to these testing circumstances and continued to deliver the highest quality of care possible.

Since our last meeting I have attended several events on behalf of the Trust, including the unveiling of a permanent tribute to health, social care, and frontline staff across Wigan Borough in the form of stars installed by Wigan Council outside of Believe Square in Wigan and Leigh Town Hall. The visit, alongside our Chair Robert Armstrong, coincided with the 73rd birthday of the NHS on Monday 5th July, the same day on which Her Majesty the Queen awarded the George Cross to the NHS for the collective courageous efforts of healthcare workers across the United Kingdom in the battle against COVID-19, an honour which we can all be immensely proud of.

I was delighted to recently meet with Chris Kerr, the National Director for We Can Talk and players representing Wigan Warriors, as we launched our new We Can Talk training tool, which has been designed to empower staff to have open conversations with young patients around mental health. We Can Talk training is accessible for any member of staff who sees a child or a young person (up to 25) in their job role, whether that is clinical or non-clinical. The training will help us to continue to improve the experience of young people attending our hospital by increasing staff knowledge and confidence.

It has also been very encouraging to see ongoing developments within our community settings. Planning permission was recently granted for our partnership project with Aspull GP Surgery, Wigan Council, One Medical Group and Wigan Borough CCG, with work on the Aspull Health and Wellbeing Centre due to start this summer. This will see our collective services come together under one roof to better provide joined up services for people in the local area.

There has also been a fantastic example of partnership working at Leigh Walk-in Centre, with the launch of a new service, 'Stronger Together', which is aimed at supporting vulnerable adults in the local area to receive advice, information and medical treatment in a one-stop shop approach. 'Stronger Together' is a team made up of WWL, Wigan Council, 'We Are With You' Wigan and Leigh and Community Health Partnerships Ltd.

And finally, this month, we were delighted to receive confirmation that WWL has received the Employer Recognition Scheme Gold Award for its outstanding support towards the Armed Forces community, as announced by Defence Minister Leo Docherty on Friday 16th July. To achieve this award is testament to the hard work and dedication of the whole Veteran Aware Project Team at WWL and our wider WWL family for the care and passion they provide to our Armed Forces community and I am pleased to say that the whole Executive Team have supported in embedding the programme throughout the Trust.

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Board assurance framework

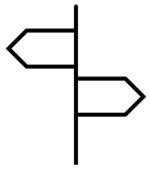
July 2021

The content of this report was last reviewed as follows:

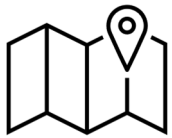
Quality and Safety Committee:	9 Jun 2021
Finance and Performance Committee:	26 Jul 2021
People Committee:	16 Jul 2021
Audit Committee:	7 Jun 2021
Executive Team:	20 Jul 2021

> **assurance** (/əˈʃɔːrəns/) *noun*
>
> *(In relation to board assurance)* Providing confidence, evidence or certainty that what needs to be happening is actually happening in practice
>
> *Definition based on guidance jointly provided by NHS Providers and Baker Tilly*

How the Board Assurance Framework fits in

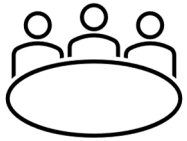


Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how we will deliver against these. The strategy signposts the general direction that we need to travel in to achieve our goals and sets out where we want to go, what we want to do and what we want to be.



Corporate objectives: Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives focus on delivery of the strategy and what the organisation needs to prioritise and focus on during the year to progress the longer-term ambitions within the strategy.

Board Assurance Framework: The board assurance framework provides a mechanism for the Board of Directors to monitor delivery of the agreed objectives by the Executive Team. It sets out the risks to achieving those objectives and provides a clear analysis of progress. It also provides a mechanism for delivering against our longer-term strategic objectives.



Seeking assurance: To have effective oversight of the delivery of our corporate objectives, the Board of Directors uses its committee structure to seek assurance on its behalf. Whilst individual corporate objectives will cross a number of our strategic priorities, each is allocated to one specific strategic priority for the purposes of monitoring. Each strategic priority is allocated to a monitoring body who will seek assurance on behalf of, and report back to, the Board of Directors.

Accountability: Each corporate objective has an allocated director who is responsible for leading on delivery. In practice, many of the corporate objectives will require input from across the Executive Team, but the lead director is responsible for monitoring and updating the Board Assurance Framework and has overall responsibility for delivery of the objective.

Reporting: To make the Board Assurance Framework as easy to read as possible, we use visual scales based on a traffic light system. Red indicates items for immediate attention, such as significant risks or objectives that are significantly off-track, yellow/amber shows items that are of some concern and green shows those which are on target or risks which are at a lower level. In the event that a corporate objective is achieved before the end of the year, blue is used to indicate this.

Understanding the Board Assurance Framework

RISK RATING MATRIX (CONSEQUENCE x LIKELIHOOD)

Consequence ↓	Likelihood →				
	Rare 1	**Unlikely 2**	**Possible 3**	**Likely 4**	**Almost certain 5**
Catastrophic 5	5 Moderate	10 High	15 Significant	20 Significant	25 Significant
Major 4	4 Moderate	8 High	12 High	16 Significant	20 Significant
Moderate 3	3 Low	6 Moderate	9 High	12 High	15 Significant
Minor 2	2 Low	4 Moderate	6 Moderate	8 High	10 High
Negligible 1	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

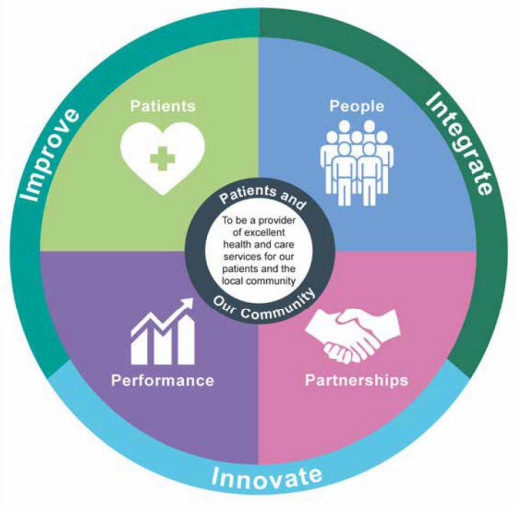
DIRECTOR LEADS

CEO:	Chief Executive	DCA:	Director of Corporate Affairs
DCE:	Deputy Chief Executive	DSP:	Director of Strategy and Planning
CFO:	Chief Finance Officer	DW:	Director of Workforce
CN:	Chief Nurse	MD:	Medical Director
DCSE:	Director of Communications and Stakeholder Engagement		

DEFINITIONS	
Strategic priorities:	The strategic priority that the corporate objective has been aligned to – one of the 4 Ps (patients, people, performance or partnerships)
Strategic risk:	A description of a risk which threatens delivery of the corporate objective
Rationale for assurance level:	This provides a summary of the reasons why the assurance level has been set at the level it has
Operational risk exposure:	The key areas of operational risks scored ≥ 15 that align with the strategic priority and have the potential to impact on objectives
Controls:	The measures in place to reduce either the strategic risk likelihood or consequence and assist to secure delivery of the strategic priority
Assurances:	The measures in place to provide confirmation that the controls are working effectively in supporting mitigation of the strategic risk
Evidence:	This is the platform which reports the assurance
Gaps in controls:	Areas that require attention to ensure that systems and processes are in place to mitigate the strategic risk
Gaps in assurance:	Areas where there is limited or no assurance that processes and procedures are in place to support mitigation of the strategic risk
Actions planned:	Actions required to close the gap(s) in controls or assurance, with timescales and identified owners
Monitoring:	The forum that will monitor completion of the required actions and progress with delivery of the allocated objectives

Our approach at a glance

Our Strategy 2030



Patients:	To be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience
People:	To create an inclusive and people-centred experience at work that enables our WWL family to flourish
Performance:	To consistently deliver efficient, effective and equitable patient care
Partnerships:	To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

FY2021/22: A year of balance

We recognise the need to recover and to allow time to consolidate following COVID-19 and to balance this with starting to make positive steps towards delivering our longer-term ambitions. Our approach for this year therefore has three key areas of focus as set out below.

Recovering from the impact of COVID-19

- Supporting our workforce
- Recovering the elective care programme

Progressing key elements of the strategy that make us unique

- Further developing our leadership role in the Healthier Wigan Partnership
- Continuing to develop Wrightington as a centre of excellence
- Taking positive steps towards our ambition to become a university teaching hospital

Ensuring we have a robust foundation to build on

- Further developing a healthy organisational culture
- Developing our capability and capacity for continuous improvement
- Increasing our substantive workforce, reducing reliance on temporary and agency staff
- Developing our infrastructure plans including digital and estates, reflecting learning and changes from COVID-19
- Improving our financial sustainability through a focus on productivity

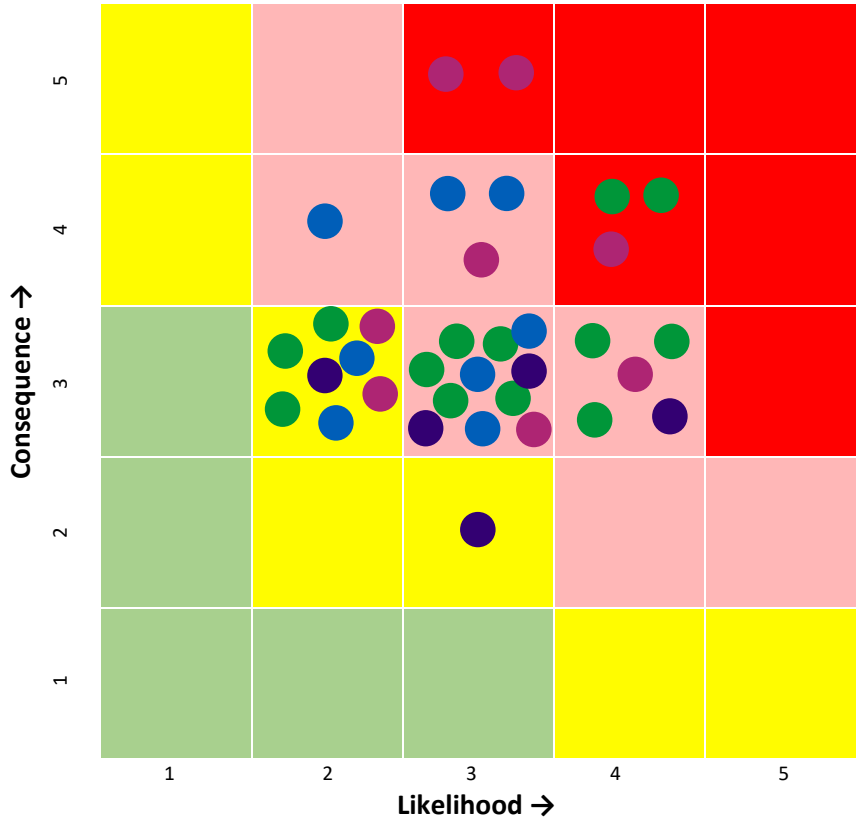
Risk management

We recognise that 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. 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. We also recognise the importance of monitoring strategic risks (those which have the potential to compromise our ability to deliver our corporate objectives) to allow early intervention when needed.

Our risk appetite statement is 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 **LOW** 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	We have a **MODERATE** appetite for financial risk in respect of meeting our statutory duties. We have a **MODERATE** appetite for risk in supporting investments for return and to minimise the possibility of financial lost by managing associated risks to a tolerable level. We have a **MODERATE** appetite for risk in making investments which may grow the size of the organisation.
Compliance/ regulatory	We have a **MODERATE** appetite for risks which may compromise our compliance with statutory duties or regulatory requirements.
Reputation	We have a **MODERATE** appetite for actions and decisions that, whilst taken in the interests of ensuring quality and sustainability of the patient in our care, may affect the reputation of the organisation

The heat map below shows the current distribution of all strategic risk scores:



Green: patients | Blue: people | Pink: performance | Purple: performance

Patients

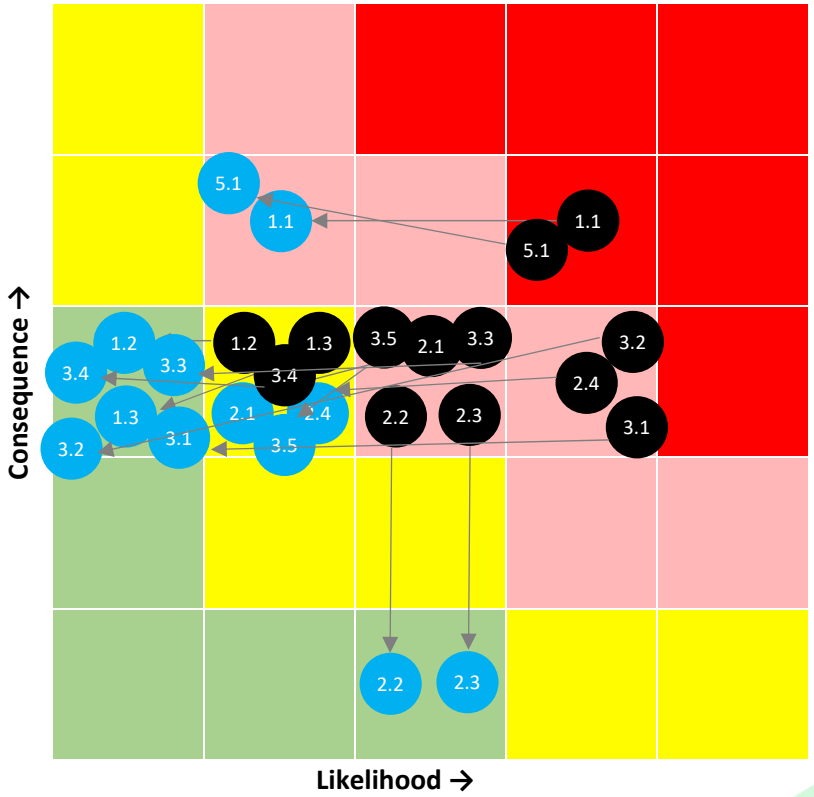
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

Monitoring: Quality and Safety Committee

The following corporate objectives are aligned to the **patients** strategic priority:

Ref.	Headline objective
CO1	We will reduce preventable death, demonstrated by bringing the Summary Hospital-level Mortality Indicator within the expected range by 31 March 2022.
CO2	We will improve the safety and quality of our clinical services by achieving a 25% reduction in mortality related to sepsis and a 25% reduction in mortality related to acute kidney injury by 31 March 2022.
CO3	We will improve the safety and delivery of harm free care by achieving a 50% reduction in hospital-acquired category 3 and 4 pressure ulcers and a 20% reduction in serious incidents related to deteriorating patients by 31 March 2022.
CO4	We will improve the patient experience and the quality of care by ensuring all clinical areas participating in the ward accreditation programme achieve a bronze rating by 31 March 2022.
CO5	We will improve our safety culture by introducing human factors awareness training, ensuring delivery to 50% of our ward managers by 31 March 2022.

The heat map below sets out the current risk profile (black shading) for all strategic risks associated with these corporate objectives and their target risk scores (purple shading):



CO1: To reduce SHMI to within the expected range			
Lead Director: MD	**Risk appetite:** Low (Quality/innovation and outcomes); Moderate (reputation)	**Assurance level:**	
Detailed objective:	We will reduce preventable death, demonstrated by bringing the Summary Hospital-level Mortality Indicator within the expected range by 31 March 2022.		
Rationale for assurance level:	Work has begun on this issue but has not yet had the opportunity to take effect therefore difficult to gauge impact at this stage.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
1.1 Our bed base is the second lowest in GM and lower than the average general and acute beds per 100,000 population. As SHMI calculations are based on percentages derived from bed figures, there is a risk that this artificially inflates our SHMI.	L4 x C4 16 Significant	L4 x C4 16 Significant	L2 x C4 8 High	Additional beds are available on Bryn Ward (51 beds) and Jean Heyes Reablement Unit (20 beds). Community Assessment Unit now open which will increase bed capacity (21 beds) for medically optimised patients.	Jun 2021 Jun 2021	Staffing model for permanent beds on Bryn Ward not funded, therefore the beds cannot be included in our bed base. Retrospective planning permission for Bryn Ward not yet obtained.	A business case to permanently fund the medical and nursing staffing model to be developed and presented to the Business Case Oversight Group.

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
1.2 There is a risk that patients will present late or be readmitted following discharge due to the lack of a joined-up pathway between primary and secondary care.	L2 x C3 6 Moderate	L2 x C3 6 Moderate	L1 x C3 3 Low	Dedicated resource now in post to provide a link between primary and secondary care and working on a joint Mortality Improvement Plan. Monthly meetings with BI/Dr Foster in place to review data Mortality Board in place Mortality mandatory agenda item at Divisional Clinical Cabinet	Jun 2021 Jun 2021 Jun 2021 Jun 2021	A pathway for common conditions with high mortality needs to be developed and monitored through the Mortality Board	Quality Improvement Lead (Mel Hailey) has been tasked to develop this pathway. Focus will initially be on heart failure, lung cancer, renal failure and sepsis patients. Initial scoping and action will be completed by 30 May 2021. Case note review of 25 patients from each pathway to identify themes and trends to be completed by 30 May 2021
1.3 There is a risk that patients will return to hospital following a period of admission as a result of being discharged prematurely.	L2 x C3 6 Moderate	L2 x C3 6 Moderate	L1 x C 3 3 Low	Dedicated resource now in post to provide a link between primary and secondary care and working on a joint Mortality Improvement Plan. Monthly meetings with BI/Dr Foster in place to review data Mortality Board in place Mortality mandatory agenda item at Divisional Clinical Cabinet	Jun 2021 Jun 2021 Jun 2021 Jun 2021	Review of deaths in community to be undertaken to identify those which have adversely impacted on SHMI.	Case note review of sepsis patients within 30 days of discharge to be undertaken by the Quality Lead and Sepsis Nurse by 30 April 2021 to identify where improvements need to be actioned.

CO2: Improve safety and quality of clinical services			
Lead Director: MD	**Risk appetite:** Low (Quality/innovation and outcomes); Moderate (reputation)	**Assurance level:**	
Detailed objective:	We will improve the safety and quality of our clinical services by achieving a 25% reduction in mortality related to sepsis and a 25% reduction in mortality related to acute kidney injury by 31 March 2022.		
Rationale for assurance level:	Whilst measures have been put in place at the start of the year and there is no evidence at this stage to suggest they will not be successful, the absence of any control measures for AKI consultant cover is of concern.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
2.1 There is a lack of recognition, screening and treatment of the deteriorating patient across the foundation trust	L3 x C3 9 High	L3 x C3 9 High	L2 x C3 6 Moderate	This is a dedicated corporate objective for FY2021/22 Rapid Improvement Group Sepsis QI group Sepsis Improvement Plan Visibility of AKI and Sepsis Nurse in clinical areas AKI and sepsis audits undertaken	Jun 2021 Jun 2021 Jun 2021 Jun 2021 Jun 2021 Jun 2021	Workload demands for AKI and Sepsis nurses AKI Improvement Plan needs to be developed	Improvement projects to be identified and progressed by the Deteriorating Patient Improvement Group. Progress will be detailed in the improvement plan and monitored at Patient Safety Quality Improvement Group.
2.2 Limited resources in relation to training and development for staff	L3 x C3 9 High	L3 x C3 9 High	L1 x C3 3 Low	AKI/Sepsis nurse attends all corporate sessions AKI/Sepsis nurse attends clinical audit AKI/Sepsis Bulletins Learning from incidents Monthly AIMS Blood cultures training every 2 weeks	N/A N/A N/A N/A N/A	Workload demands for AKI and sepsis nurses Reduced AIMS faculty members to support the programme Reduced number of blood culture trainers	AIMS training to be increased to monthly for registered staff and alternate months for unregistered staff.
2.3 No consultant cross-cover from Salford Royal for the AKI service	L3 x C3 9 High	L3 x C3 9 High	L1 x C3 3 Low	Nil	N/A	52 week cover needed as not currently in place and on-call and annual leave by Salford Royal not currently covered.	Clinical lead identified at WWL with an interest in AKI who is able to provide support when required.

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
2.4 The AKI and sepsis services are currently single nurse led over a 5-day working week.	L4 x C3 12 High	L4 x C3 12 High	L2 x C3 6 Moderate	Separate clinical leads in place Support is provided by the Critical Care Outreach Team Information is cascaded through attendance at corporate and divisional meetings There is a policy and SOP in place	N/A N/A Jun 2021 Jun 2021	No cover is in place during annual leave, Bank Holidays or other absence. There is no contingency plan in place for patient safety nurses.	AKI and sepsis nurse to work collaboratively to provide cross-cover and ensure that work plans are more aligned.

CO3: To improve safety and delivery of harm-free care			
Lead Director: CN	**Risk appetite:** Low (Quality/innovation and outcomes); Moderate (reputation)	**Assurance level:**	
Detailed objective:	We will improve the safety and delivery of Harm Free Care by achieving a 50% reduction in hospital-acquired category 3 and 4 pressure ulcers and a 20% reduction in serious incidents related to deteriorating patients 31 March 2022.		
Rationale for assurance level:	Measures have been put in place at the start of the year and there is no evidence at this stage to suggest they will not be successful.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
3.1 Unable to accurately document pressure ulcers on arrival in the hospital as policy prevents effective photographs of being taken.	L4 x C3 12 High	L4 x C3 12 High	L1 x C3 3 Low	Efforts are made to take the best possible photograph	N/A	There is a need to revise the photography policy to ensure accurate record keeping is facilitated	Deputy Chief Nurse to progress by the end of Q1 2021/22.
3.2 There is a lack of access to cameras in clinical areas to allow for adequate documentation of pre-existing pressure ulcers	L4 x C3 12 High	L4 x C3 12 High	L1 x C3 3 Low	Nil	N/A	There is a need to provide cameras in relevant clinical areas.	Deputy Chief Nurse to progress by the end of Q1 2021/22.
3.3 There is a risk that Waterlow assessments are not completed or adequately documented	L3 x C3 9 High	L3 x C3 9 High	L1 x C3 3 Low	Mandated field on HIS	N/A	Additional training required to facilitate accurate assessment	Deputy Chief Nurse undertaking a review which will be reviewed by NMALT
3.4 There is a concern that the skill mix in the medicine division may need to be altered to facilitate better recognition of the deteriorating patient	L2 x C3 6 Moderate	L2 x C3 6 Moderate	L1 x C3 3 Low	A diagnostic is in the process of being undertaken and will be concluded by the end of Q1 2021/22.	N/A	To be determined once the diagnostic is complete.	To be determined once the diagnostic is complete.

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
3.5 There is a risk that poor staff retention will result in loss of skills and higher vacancy levels, meaning that staff cannot be released to undertake the training.	L3 x C3 9 High	L3 x C3 9 High	L2 x C3 6 Moderate	A diagnostic is in the process of being undertaken and will be concluded by the end of Q1 2021/22.	N/A	To be determined once the diagnostic is complete.	To be determined once the diagnostic is complete.

CO4: Ward accreditation programme			
Lead Director: CN	**Risk appetite:** Low (Quality/innovation and outcomes)	**Assurance level:**	
Detailed objective:	We will improve the patient experience and the quality of care by ensuring all clinical areas participating in the ward accreditation programme achieve a bronze rating by 31 March 2022.		
Rationale for assurance level:	We will be a better understanding of our current position following the review which is currently being undertaken to determine what is required in order for areas to achieve bronze accreditation and whether those areas require local or organisation-wide action.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
The review which is currently being undertaken will identify the risks to achievement of this objective and this will be reported in future board assurance framework reports							

CO5: Human factors training			
Lead Director: CN	**Risk appetite:** Low (Quality/innovation and outcomes)	**Assurance level:**	
Detailed objective:	We will improve our safety culture by introducing human factors awareness training, ensuring delivery to 50% of our ward managers by 31 March 2022.		
Rationale for assurance level:	Measures have been put in place at the start of the year and there is no evidence at this stage to suggest they will not be successful.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
5.1 The fact that many ward managers are not able to act in a supernumerary capacity impacts on their ability to be released to undertake the training.	L4 x C4 16 Significant	L4 x C4 16 Significant	L2 x C4 8 High	Paper presented to ETM and supported in principle, business case now being drafted for submission to BCOG.	May 2021	No arrangements confirmed as yet	CN developing business case for review at BCOG

People

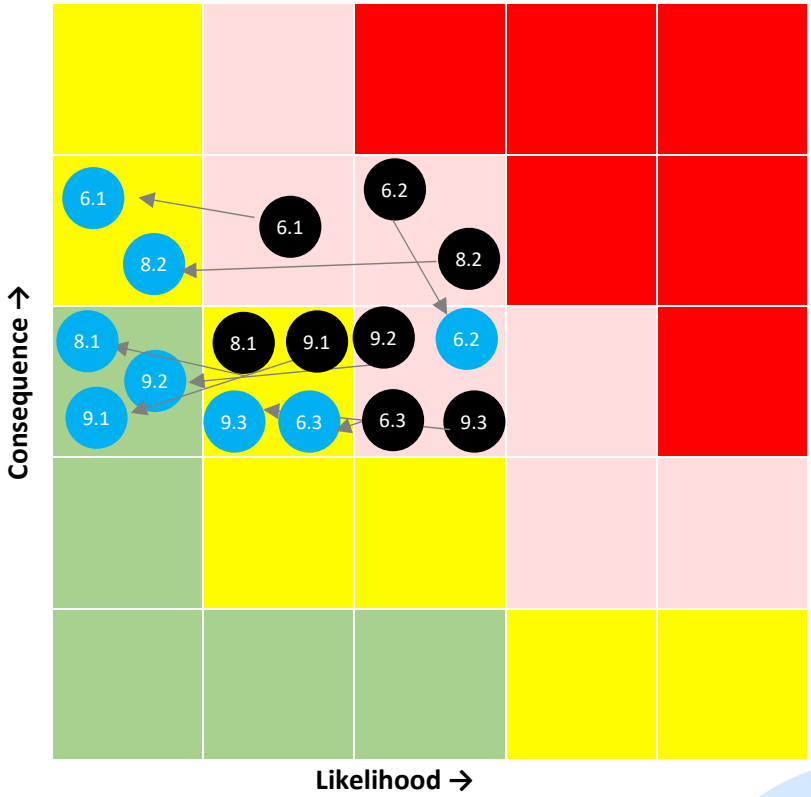
To create an inclusive and people-centred experience at work that enables our WWL family to flourish

Monitoring: People Committee

The following corporate objectives are aligned to the **people** strategic priority:

Ref.	Headline objective
CO6	We will support the physical health and mental wellbeing of our WWL family by ensuring we have a range of wellbeing activities and services that are accessible to our colleagues. By 31 March 2022, we will have achieved a wellbeing score of 3.75 in Your Voice survey and positive evaluation of Steps4Wellness service.
CO7	We will improve nursing, AHP and midwifery recruitment and retention so that by 31 March 2021 we will have achieved a reduction in the clinical vacancy rate to under 5%; 95% of our people having a prioritised personal development plan that is supported by the trust; talent mapping and succession plans for nursing, AHP and midwifery leadership roles; a personal development score of 3.75 in Your Voice survey; and a 5% reduction in leaders with less than 12 months' service
CO8	We will make the WWL experience at work positive and fulfilling by creating an environment where our people feel safe to be themselves, to make suggestions and to call out concerns, knowing that we always look for learning and ways to improve. By 31 March 2022 we will have achieved implementation of the civility and just culture programmes of work; engagement and psychological safety score of 3.75 in Your Voice survey, 30% of people leaders will have undertaken or completed an accredited leadership development programme
CO9	We will place fairness and compassion at the centre of our people policies, always respecting the needs and diversity of our colleagues. By 31 March 2022 we will have reduced our gender pay gap by at least 5% and improved our WRES and WDES outcomes; a compassionate leadership score of 3.75 in Your Voice survey and redesigned key employment policies.

The heat map below sets out the current risk profile (black shading) for all strategic risks associated with these corporate objectives and their target risk scores (purple shading):



CO6: Health and wellbeing			
Lead Director: DW	**Risk appetite:** Moderate (reputation)	**Assurance level:**	
Detailed objective:	We will support the physical health and mental well-being of our WWL family by ensuring we have a comprehensive range of wellbeing activities and services that are accessible to our colleagues. By the 31st March 2022, we will have achieved: • Well-being score of 3.75 in Your Voice Survey • Positive evaluation of Steps 4 Wellness services		
Rationale for assurance level:	Building blocks are in place but delivery of this objective is contingent on approval of the business case as there is no capacity to undertake the additional work without the dedicated teams.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
6.1 There is a risk that the necessary funding to deliver the stepped care model for physical and mental may not be prioritised, meaning that the service cannot be provided.	L2 x C4 8 High	L2 x C4 8 High	L1 x C4 4 Moderate	Business case drafted and subject to review prior to submission to BCOG Working with GM Resilience Hub where appropriate Transferred OHD MSK and counselling services into Steps 4 Wellness function for better resource efficiency	Apr 2021	Key roles to provide full stepped care model (included in business caes)	Steps 4 Wellness to prioritise and recruit to required structures, following business case decsion

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
6.2 There is a risk that, because of workload pressures, sufficient time is not available for staff to participate in preventative and restorative wellbeing activities within working hours, meaning that engagement levels will be lower and evidence suggests this will reduce the success of the programme.	L3 x C4 12 High	L3 x C4 12 High	L3 x C3 9 High	Targeted in-reach activities in high-risk areas. Current focus on returning redeployees and critical care. Feedback from wellbeing walkabouts	Jun 2021 Jun 2021 Jul 2021	Commitment to roster time for people to be released as needed. Monitoring through People Committee, metrics to be developed Inclusion of additional questions around accessibility in the Your Voice surveys	Divisional leadership teams
6.3 There is a risk that organisational commitment to wellbeing reduces as operational pressures and expectations increase.	L3 x C3 9 High	L3 x C3 9 High	L2 x C3 6 Moderate	Executive team focused on this issue at the moment	Jun 2021	Maintaining focus at board level and seeing decision-making through wellbeing lens Well-being lens on all decision making	Wellbeing Guardian Executive Team and divisional leadership teams

CO7: Recruitment and retention			
Lead Director: CN	**Risk appetite:** Moderate (reputation)	**Assurance level:**	
Detailed objective:	We will improve nursing, AHP and midwifery recruitment and retention so that by 31 March 2021 we will have: • achieved a reduction in the clinical vacancy rate to under 5%; • 95% of our people having a prioritised personal development plan that is supported by the trust; • talent mapping and succession plans for nursing, AHP and midwifery leadership roles; • a personal development score of 3.75 in Your Voice survey; and • a 5% reduction in leaders with less than 12 months' service		
Rationale for assurance level:	Further scoping work to identify all related risks currently underway.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
Further scoping work is currently being undertaken which will identify the risks to achievement of this objective. This will be reported in future board assurance framework reports							

CO8: Culture			
Lead Director: DW	**Risk appetite:** Moderate (reputation)	**Assurance level:**	
Detailed objective:	We will make the WWL experience at work positive and fulfilling by creating an environment where our people feel safe to be themselves, to make suggestions and to call out concerns, knowing that we always look for learning and ways to improve. By 31 March 2022, we will have achieved: • Implementation of the civility and just culture programmes of work • Engagement and psychological safety score of 3.75 in Your Voice Survey • 30% of people leaders will have undertaken or have completed (with modular top up requirement) an accredited leadership development programme		
Rationale for assurance level:	All members of the executive team have a shared personal objective linked to this corporate objective, ensuring visibility and ownership of delivery.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
8.1 There is a risk that participation in the programmes will not be prioritised as a result of other service pressures.	L2 x C3 6 Moderate	L2 x C3 6 Moderate	L1 x C3 3 Low	"Our family – Our future – Our focus" engagement reset programme under DCE leadership Board visibility of programme	Jul 2021	Metrics to be reported via People Committee	Workforce team
8.2 There is a risk that the funding for the leadership development programmes and behaviour based 360 feedback will not be prioritised.	L3 x C4 12 High	L3 x C4 12 High	L1 x C4 4 Moderate	Strategic learning needs analysis developed and will be presented to ETM in Q1 and then to BCOG		Once business case approved, progress can be monitored via individual learning dashboards	Workforce team

CO9: Fairness and compassion			
Lead Director: DW	**Risk appetite:** Moderate (reputation)	**Assurance level:**	
Detailed objective:	We will place fairness and compassion at the centre of our people policies, always respecting the needs and diversity of our colleagues. By 31 March 2022, we will have achieved: • reduced our gender pay gap by at least 5% and improved our Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) outcomes • Compassionate leadership score of 3.75 from Your Voice Survey • Re-designed key WWL Employment Policies (Disciplinary, Grievance, Dignity at Work, Attendance Management, Performance Management and Raising Concerns)		
Rationale for assurance level:	WWL has agreed its approach which it is committed to delivering, this would be enhanced by wider participation but at the current time this is still subject to discussion.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
9.1 There is a risk that the organisation will not commit to person-centred employment policies which take a different approach from a more robust escalation and trigger framework	L2 x C3 6 Moderate	L2 x C3 6 Moderate	L1 x C3 3 Low	New disciplinary policy approved without amendments. Work ongoing around grievance and dignity at work policies. Coordinated move across the North West regarding attendance management / well-being policy.	Mar 2021	Focused communications around changes, particularly in relation to capability and attendance management policies linked to culture work programme	Communications Team
9.2 There is a risk that the organisation does not have workforce EDI expertise nor any supporting infrastructure	L3 x C3 9 High	L3 x C3 9 High	L1 x C3 3 Low	Currently recruiting an 18-month EDI specialist.		No ongoing funding commitment, however still subject to proof of concept No supporting infrastructure for the role.	Director of Workforce

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
9.3 There is a risk that we will not get buy-in or funding for a locality-wide workforce EDI strategy	L3 x C3 9 High	L3 x C3 9 High	L2 x C3 6 Moderate	Nil		Discussions around locality-wide approach required at HWP	Chief Executive and Deputy Chief Executive

Performance

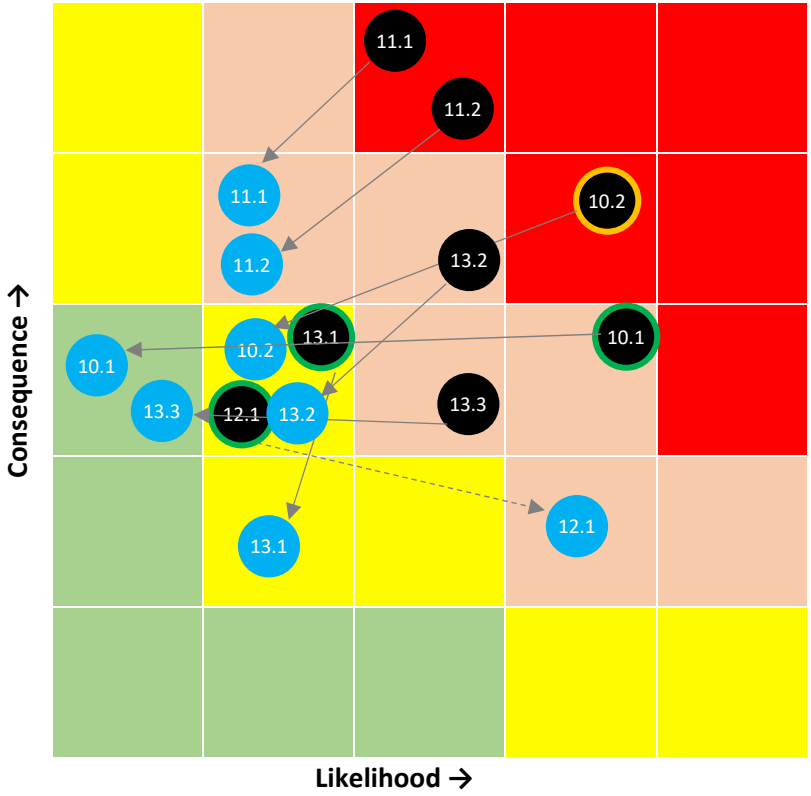
Our ambition is to consistently deliver efficient, effective and equitable patient care

Monitoring: Finance and Performance Committee

The following objectives are aligned to the **performance** strategic priority:

Ref.	Headline objective
CO10	We will minimise harm to patients and staff in recovering and restoring our elective services in line with national recommendations by identifying and treating patients most at risk to reduce the number of patients waiting over 52 weeks; see and treat priority 2 patients within Royal College timescales and improve against national minimum standards for cancer services.
CO11	We will improve the foundation trust's financial sustainability by focusing on productivity in all areas, demonstrated through meeting the expectations of NHSE/I for FY2021/22.
CO12	We will have created and communicated our Digital Strategy by 1 October 2021 and by the end of March 2022 we will have modernised key elements of our IT infrastructure, demonstrated through 100% of staff being provided with the latest versions of MS Office and MS Teams; the deployment of a new, modern telephony solution throughout WWL, implementation of the first clinical pathway in HIS and increased critical system availability.
CO13	We will have refreshed the Estate Strategy by 1 January 2022, exploring and leveraging the benefits of locality working under the One Public Estate initiative whilst support WWL's Service Strategy and incorporating the longer-term implications and benefits of remote working.

The heat map below sets out the current risk profile (black shading) for all strategic risks associated with these corporate objectives and their target risk scores (purple shading):



CO10: To restore elective services in line with national recommendations			
Lead Director: DCE	**Risk appetite:** Low (Quality/innovation and outcomes); Moderate (reputation)	**Assurance level:**	
Detailed objective:	We will minimise harm to patients and staff in recovering and restoring our elective services in line with national recommendations by identifying and treating patients most at risk to: ▪ reduce the number of patients waiting over 52 weeks; ▪ see and treat priority 2 patients within Royal College timescales; and ▪ improve against national minimum standards for cancer services. *(The level of reduction/improvement across the three outcomes will be included once planning guidance is received and the elective recovery modelling is complete in Q1 2021/22)*		
Rationale for assurance level:	Heading in the right direction, number of 52 week waits in April has reduced, every patient on waiting list has clinical priority code allocated and we have maintained 3 of the 4 national cancer standards.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
10.1 There is a risk that because the overall waiting list is growing due to increased numbers of referrals, the waiting list is growing more quickly than we are able to address the backlog which would lead to us not being able to reduce the backlog in a timely way across all three indicators	L5 x C3 15 Significant	L4 x C3 12 Significant	L1 x C3 3 Low	Regular reviews of risk stratification are undertaken according to clinical priority WWL manages patient lists in accordance with risk stratification National communications being issued around how patients will be contacted for review (Ext)	Jul 2021 Jul 2021 ---	Lack of capacity to undertake reviews of allocated risk stratification across all specialties. Patients to be given mechanism for getting in contact with GP or WWL if deteriorating.	Currently being reviewed by senior leadership teams. Joint correspondence from WWL and CCG being sent to every patient to update them and provide contact information.

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
10.2 There is a risk that the value of core (or core +) activity exceeds the funding available because we have to use additional bank/agency or independent sector provision, or we are unable to access ERF funding if we exceed our trajectory, meaning that all work cannot be undertaken.	L5 x C4 20 Significant	L4 x C4 16 Significant	L2 x C3 6 Moderate	Work is ongoing to value the plan that we have submitted and to triangulate that with the activity plan. GM Elective Recovery Reform Group in place with two programmes of work; (1) capacity and demand across GM and (2) reform. Deputy Chief Executive attends for WWL. (Ext.) Reviewing how we can address the issue by activating elective recovery fund at GM level. (Ext) Continue to access independent provider capacity.	Jul 2021 Jul 2021 Jul 2021 Jul 2021	Nil at present; final submission is due in June. The next phase is then to describe the additional capacity available, the costs of doing so and what using that capacity will mean.	---

CO11: Improve financial sustainability			
Lead Director: CFO	**Risk appetite:** Moderate (Financial and VFM)	**Assurance level:**	
Detailed objective:	We will improve the foundation trust's financial sustainability by focusing on productivity in all areas, demonstrated through meeting the expectations of NHSE/I for FY2021/22.		
Rationale for assurance level:	There are lots of uncertainties around delivery of this objective.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
11.1 There is a risk that efficiency targets will not be achieved, resulting in a significant overspend	L3 x C5 15 Significant	L3 x C5 15 Significant	L2 x C4 8 High	Monitored via Executive Team, Finance and Performance Committee and Board of Directors Expenditure is flexed in line with the emerging position Work ongoing across the system on a joint approach to productivity (Ext)	May 2021 May 2021 May 2021	SAVI Programme Board to be reinstated	This is currently subject to discussion and a verbal update will be provided to the meeting
11.2 Allocations and efficiencies for H2 unknown meaning that we cannot plan appropriately	L3 x C5 15 Significant	L3 x C5 15 Significant	L2 x C4 8 High	Lobbying via Greater Manchester (Ext)	May 2021	SAVI Programme Board to be reinstated to identify a range of schemes	This is currently subject to discussion and a verbal update will be provided to the meeting

CO12: To create and implement Digital Strategy			
Lead Director: DCE	**Risk appetite:** Low (quality, innovation and outcomes)	**Assurance level:**	
Detailed objective:	We will have created and communicated our Digital Strategy to drive excellence in digital healthcare for patients by 1 October 2021 and by the end of March 2022 we will have modernised key elements of our IT infrastructure, demonstrated through: ▪ 100% of staff being provided with the latest versions of MS Office and MS Teams; ▪ the deployment of a new, modern telephony solution throughout WWL; ▪ implementation of the first clinical pathway in HIS; and ▪ increased critical system availability from a year-end 2020/21 position of 95% to a 2021/22 year-end position of 98% through conforming to NHS Digital's DSPT resulting in the reduction of unplanned outages		
Rationale for assurance level:	The capital allocation required to support IM&T infrastructure has yet to be agreed.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
12.1 No funding is available to deliver the bullets above as the capital application was rejected on the basis of CDEL being allocated to business critical or existing commitments.	L4 x C3 12 High	L2 x C3 6 Moderate	L4 x C2 8 High	Lobbying via GM (Ext) Preparing business cases to submit in the event of capital slippage MS Teams roll-out undertaken Telephony business case approved Sepsis pathway being input into HIS	Jul 2021 Jul 2021 Jul 2021 Jul 2021 Jul 2021	Alternative funding for digital developments to be explored sought	Chief Information Officer to monitor availability

CO13: To refresh the Estate Strategy			
Lead Director: CFO	**Risk appetite:** Moderate (Financial and VFM)	**Assurance level:**	
Detailed objective:	We will have refreshed the Estate Strategy by 1 January 2022, exploring and leveraging the benefit of locality working under the One Public Estate initiative with Wigan CCG and Wigan Council, whilst supporting WWL's Service Strategy and incorporating the longer-term implications and benefits of remote working		
Rationale for assurance level:	This objective is on track for delivery by the end of December 2021.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
13.1 There is a risk that because the clinical strategies are still under development the estates strategy may not address all elements of intended future delivery	L3 x C3 9 High	L2 x C3 6 Moderate	L2 x C2 4 Moderate	Capital prioritisation exercise undertaken which will inform the estate strategy and therefore link to the future development of clinical strategies.	Jul 2021	Group to discuss the development of the estates strategy alongside clinical strategy development	Director of Strategy and Planning and Director of Estates and Facilities to coordinate
13.2 There is a risk that because of uncertainties around capital funding arrangements the strategy may assume that more investment can be made than is available	L3 x C4 12 High	L3 x C4 12 High	L2 x C3 6 Moderate	Lobbying via Greater Manchester (Ext)	May 2021	---	---
13.3 There is a risk that the estates strategy will not fully address the net carbon zero requirements	L3 x C3 9 High	L3 x C3 9 High	L1 x C3 3 Low	Sustainability Officer in place who can provide expert input Net Zero Champion appointed	Jul 2021 Jul 2021	Need to develop Green Strategy for WWL	Director of Estates and Facilities working with external company to undertake this work

Partnerships

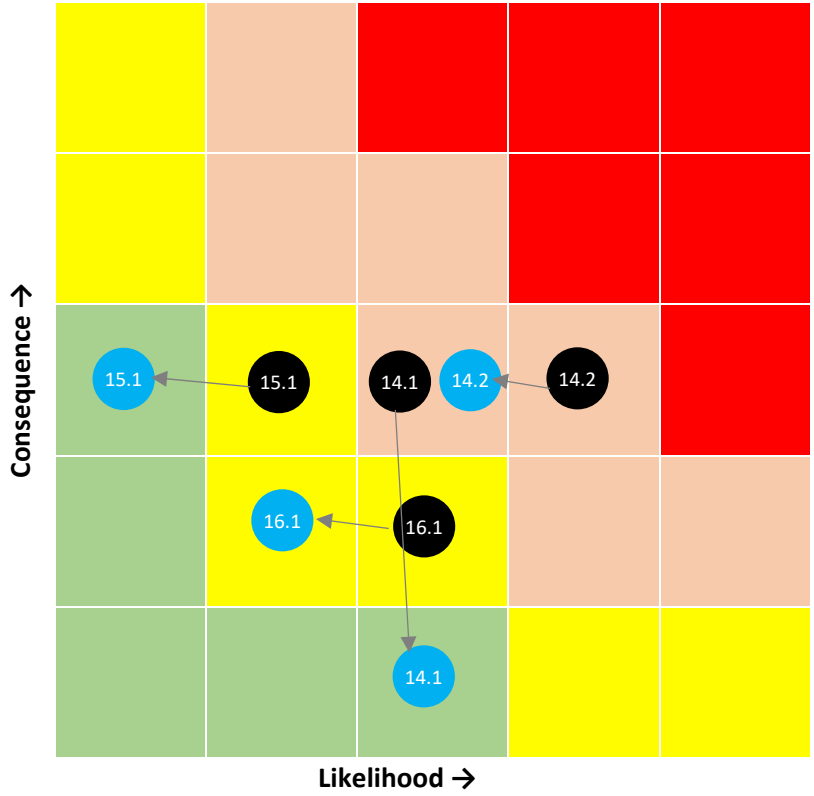
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

Monitoring: Board of Directors

The following objectives are aligned to the **partnerships** strategic priority:

Ref.	Headline objective
CO14	We will become an elective recovery hub at Wrightington to contribute to reducing inequality of access across Greater Manchester and beyond for patients waiting for elective orthopaedic procedures. By the end of March 2022 we will have seen an increase in our out-of-area referrals to 10,000 and restored and recovered to pre-COVID capacity of 20 orthopaedic sessions per working day
CO15	By the end of Q1 2021/22, we will create and agree our development and delivery plan for achieving the criteria required to become a University Teaching Hospital organisation in a maximum of five years' time and we will deliver the 2021/22 elements of the plan by the end of March 2022.
CO16	We will continue to work side by side with our Healthier Wigan Partnership partners in the development and provision of integrated and place-based services and pathways to improve the health and wellbeing of Wigan residents, whilst also actively shaping the emerging new locality construct during 2021/22 and ensuring that we contribute to community wealth building in Wigan, in keeping with our anchor institution role.

The heat map below sets out the current risk profile (black shading) for all strategic risks associated with these corporate objectives and their target risk scores (purple shading):



CO14: Elective hub			
Lead Director: DSP	**Risk appetite:** Moderate (Financial and VFM)	**Assurance level:**	
Detailed objective:	We will become an elective recovery hub at Wrightington to contribute to reducing inequality of access across Greater Manchester and beyond for patients waiting for elective orthopaedic procedures. By the end of March 2022 we will have: • seen an increase in our out-of-area referrals to 10,000; and • restored and recovered to pre-COVID capacity of 20 orthopaedic sessions per working day		
Rationale for assurance level:	Operational teams at advances stages of discussion with Lancashire and South Cumbria ICS and also Jersey and Guernsey.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
14.1 There is a risk that there will be insufficient staff available to undertake the levels of additional activity	L4 x C4 16 Significant	L3 x C3 9 High	L3 x C1 3 Low	Discussions relating to the use of a third party sub contractor at advanced stages	Jul 2021	Contract yet to be finalised	CFO appointed as WWL's point of contact
14.2 There is a risk that WWL may be restricted in the amount of capital it is able to spend	L4 x C3 12 High	L4 x C3 12 High	L3 x C3 9 High	Submission made to Greater Manchester	May 2021	---	---

CO15: University Teaching Hospital			
Lead Director: MD	**Risk appetite:** Significant (Quality, innovation and outcomes)	**Assurance level:**	
Detailed objective:	By the end of Q1 2021/22, we will create and agree our development and delivery plan for achieving the criteria required to become a University Teaching Hospital organisation in a maximum of five years' time and we will deliver the 2021/22 elements of the plan by the end of March 2022.		
Rationale for assurance level:	No difficulties in achieving this objective anticipated.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
15.1 There is a risk that the organisation will not generate sufficient research funding in 2021/22 to qualify for University Hospital Association membership	L2 x C3 6 Moderate	L2 x C3 6 Moderate	L1 x C3 3 Low	Monitoring of research funding	May 2021	Research Committee	Proposal to establish on May board agenda.

CO16: Partnership working			
Lead Director: DSP	**Risk appetite:** Moderate (Financial and VFM)	**Assurance level:**	
Detailed objective:	We will continue to work side by side with our Healthier Wigan Partnership partners in the development and provision of integrated and place-based services and pathways to improve the health and wellbeing of Wigan residents, whilst also actively shaping the emerging new locality construct during 2021/22 and ensuring that we contribute to community wealth building in Wigan, in keeping with our anchor institution role.		
Rationale for assurance level:	Priorities for the locality plan have been agreed and details are being worked up.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
16.1 There is a risk that staff with local knowledge and understanding may be lost given the changes anticipated with CCGs	L3 x C2 6 Moderate	L3 x C2 6 Moderate	L2 x C2 4 Moderate	Locality meeting structures in place to support lasting corporate knowledge	May 2021	---	---

Title of report:	Q4 Mortality Report 2020/2021
Presented to:	Board of Directors
On:	28 July 2021
Presented by:	Medical Director
Prepared by:	Alison Unsworth, Clinical Audit and Effectiveness Manager Contributors: Dr M Farrier, Associate Medical Director Carrie McManus, Head of Patient Safety and Improvement Cathy Stanford, Head of Governance, Maternity and Childrens Lesley Timperley, Professional lead/Community Nurse Andrew Barlow, Head of Governance, Community Division
Contact details:	Sanjay.arya@wwl.nhs.uk

Executive summary

The purpose of this report is to provide the Board of Directors with information regarding Mortality Reviews required by the Learning from Deaths Guidance published by the National Quality Board. The information contained within this report relates to data from Q4 for 2020/21.
The report has been approved at the Q&S Committee on 9th June 2021.

Link to strategy

- Patients
- Performance

Risks associated with this report and proposed mitigations

The Trust's high SHMI position.

Financial implications

None known

Legal implications

None known

People implications

None known

Wider implications

None known

Recommendation(s)

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

Mortality Review

2020 - 2021 Quarter 4

1.0 Introduction

In December 2016 a report from the Care Quality Commission (CQC) *'Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England'* found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements may be missed. In March 2017 the National Quality Board published National Guidance on Learning from Deaths, a framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and learning from deaths in care.

The guidance advised that Trusts were required to publish their policy and approach to Learning from Deaths.

The guidance also advised that Trusts are required to collect specified information on deaths and publish on a quarterly basis. The quarterly reports should be scheduled on the agenda of public Board meetings. The report should include:

- The total number of the Trust's inpatient deaths (including Emergency Department deaths for acute Trusts);
- Deaths subjected to review: Trusts are required to provide estimates of how many deaths were judged more likely than not to have been due to problems in care.

The purpose of this report is to provide Quality and Safety Committee with information regarding Mortality Reviews required by the Learning from Deaths Guidance, outlined above.

2.0 Total Number of Deaths (By Quarter)

Quarter	2020 - 21		2019 - 20	2018 - 19
	Inpatient	A&E Deaths	Total	Total
Quarter 1	443	41	312	293
Quarter 2	261	23	270	271
Quarter 3	549	47	330	286
Quarter 4	387	39	310	343

During quarter 1 2020/2021, the corporate mortality review team began to review deaths of patients in A&E during the weekly audit. These are therefore noted in the above table and will be included in subsequent figures.

There were no patients with COVID positive laboratory result who died in Q2.

Q3 showed the re-emergence of COVID with subsequent rise in deaths from COVID as is evident in the above table.

3.0 Deaths Subjected to Review

The Corporate Mortality Review Team, led by Dr Martin Farrier, Associate Medical Director, review the deaths of all patients who are not on the IPOC (Individualised Plan of Care) and those that have died in the Intensive Care Unit. Review of any patients identified for further analysis by others is also carried out. Some patients on the IPOC are also reviewed. An in-depth review does not take place if there are no clinicians present, however, a preliminary review is conducted by the Clinical Audit and Effectiveness Manager and any concerns are escalated.

From Q1 2020/2021, A&E deaths will also be included in overall figures.

It should be noted that throughout the COVID pandemic deaths were not subject to the same depth of review.

In Q4, 421/426 (99%) of all deaths were reviewed.

Due to the high number of deaths, the usual scoring was not completed.

3.1 Potentially Preventable Deaths

Patient under 70. Known neurofibromatosis. Attends with severe acute onset abdominal pain. Hypotensive at admission and treated for shock. CT abdo shows Coeliac axis bleed. There is potentially a tumour (neurofibromatosis leads to benign tumours) which has caused bleeding from the vessel. There is retroperitoneal blood collection. This patient needs a procedure to stop this bleeding. Unfortunately that doesn't happen. What does happen is a large number of phone calls with various teams to seek support in stopping the bleeding. These included the vascular team at Preston and at MRI. We continue to support the patient with transfusion. ICU are involved to provide support in maintaining BP. When the patient has a final hypotensive unconscious event, it becomes clear that we cannot keep the patient alive and there is no prospect that the patient will be transferred. The patient dies 12 hours after arrival and 8 hours after the CT is reported. Problems with vascular transfers have happened previously and this looks to be another example.

3.2 Themes/Learning

Themes identified during the corporate morality review process were:

- Patients with hospital acquired COVID-19
- Potential COVID-19 vaccine failure
- Potential re-infection with COVID
- Low proportion of non-COVID deaths
- DNACPR and unrealistic expectations from families with conflict over decisions
- Patients positive with COVID for many months
- Patient who dies with bradycardia having been started on drugs which cause bradycardia
- Aortic Stenosis patient with possible delay in referral for TAVI.
- Thrombosis related death following vaccine
- Aminophylline in a patient already on theophylline
- Omitted drugs (issues with NG tubes/Nil by mouth
- Patient with radiotherapy and possible failure of follow up post treatment
- Patient with vascular bleed from coeliac artery and problems with transfers of care
- Patients who were brought in to die

4.0 External Reporting

4.1 Unexpected Deaths Reported to STEIS in Q4 2020-2021

There were 2 incidents that required StEIS reporting:

- Lack of recognition and escalation of a deteriorating patient
- Delay in diagnosis of a patient with stomach cancer

4.2 Deaths of patients with a learning disability (reported to Learning Disabilities Mortality Review Programme - LeDeR)

The deaths of patients who are formally diagnosed with a learning disability and on the learning disability register should be referred to LeDeR. To date the Trust has not received any recommendations from LeDeR.

In Q4 2020 – 2021 the Trust reported **2** hospital death and **2** community death to be reported via LeDeR. There were no concerns identified.

The LeDeR programme was been commissioned by NHS England to support local areas in England to review the deaths of people with a learning disability to:

- Identify common themes and learning points, and
- Provide support to local areas in their development of action plans to take forward the lessons learned.

4.3 Maternal Deaths, Still Births and Child Deaths (reported to MBRACE-UK)

The Trust has had 0 maternal deaths in Q4 2020-21, 2 still births and 1 neonatal death.

- The first stillbirth in Q4 2020-21, was a Mother who had been mildly unwell with Covid 19 in the days leading to her attending with a history of no fetal movements sadly fetal death was diagnosed on admission and the stillbirth occurred at 25 weeks and 5 days gestation.
- The second stillbirth was an expected loss. The Parents had been provided with an antenatal diagnosis of congenital abnormalities incompatible with life following the fetal anatomy scan and referral to a tertiary centre where the diagnosis was confirmed, and all options discussed. The parents had made the decision to continue the pregnancy with the knowledge that the baby would die either before birth or shortly afterwards. The Mother attended with no fetal movements at 27 weeks and 6 days and fetal death was diagnosed.
- The Neonatal death was a baby born with signs of life at a gestation before the threshold of viability, 21 weeks and 6 days gestation. National guidance was followed in not actively treating the baby when it was born with signs of life at this gestation.

All cases have been reported and reviewed appropriately and the cases are currently being processed using the Perinatal Mortality Reporting Tool.

5.0 Community Deaths

There have been 4 community deaths reported via Datix in Q4 2020/2021.

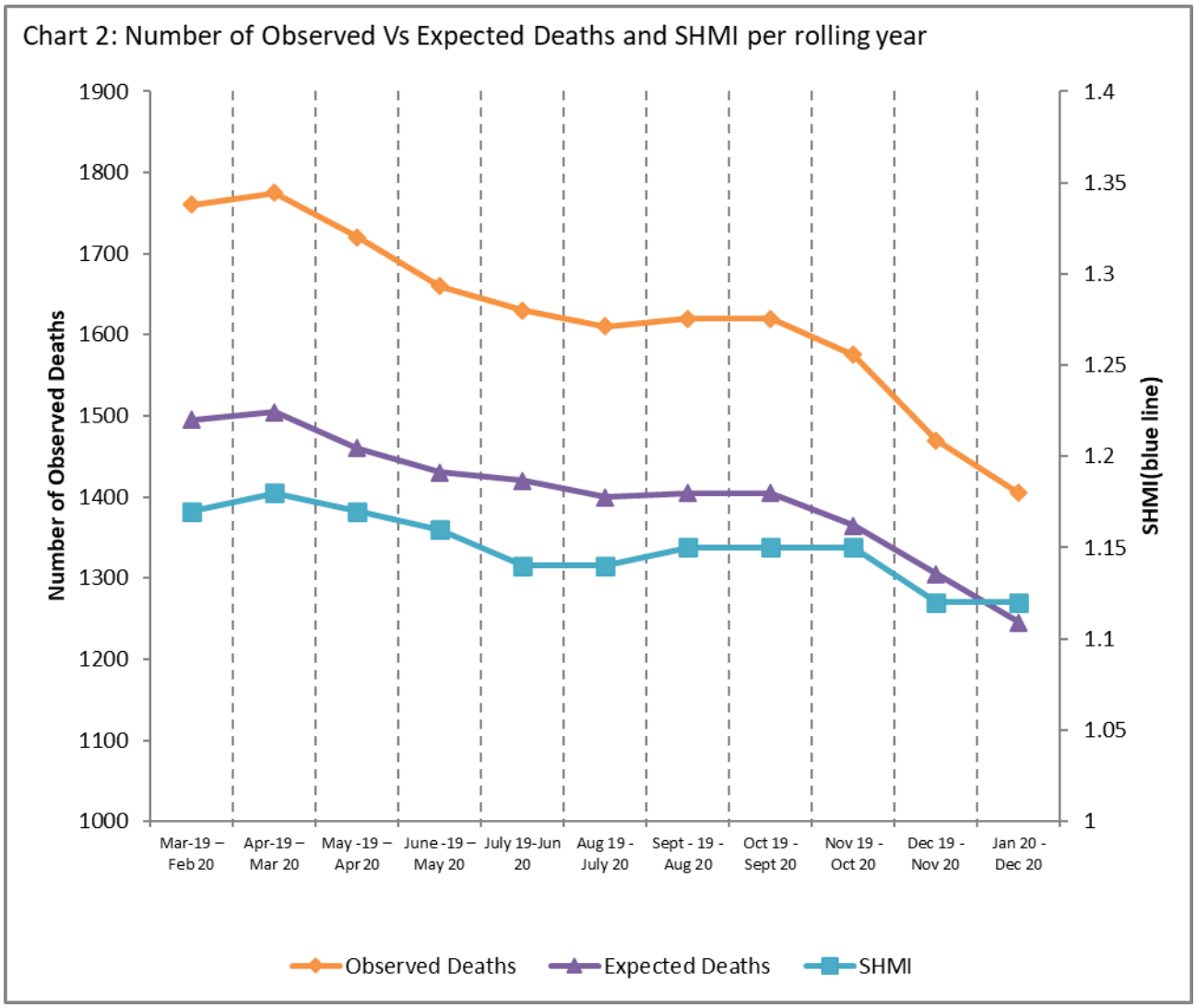
6.0 Prevention of Future Deaths Notices

There have been no Prevention of Future Deaths Notices (Regulation 28) issued by HM Coroner.

7.0 SHMI (Summary Hospital Level Mortality Indicator) (Deaths in hospital and deaths 30 days post discharge) and HSMR (Hospital Standardised Mortality Rate) (Deaths in hospital only)

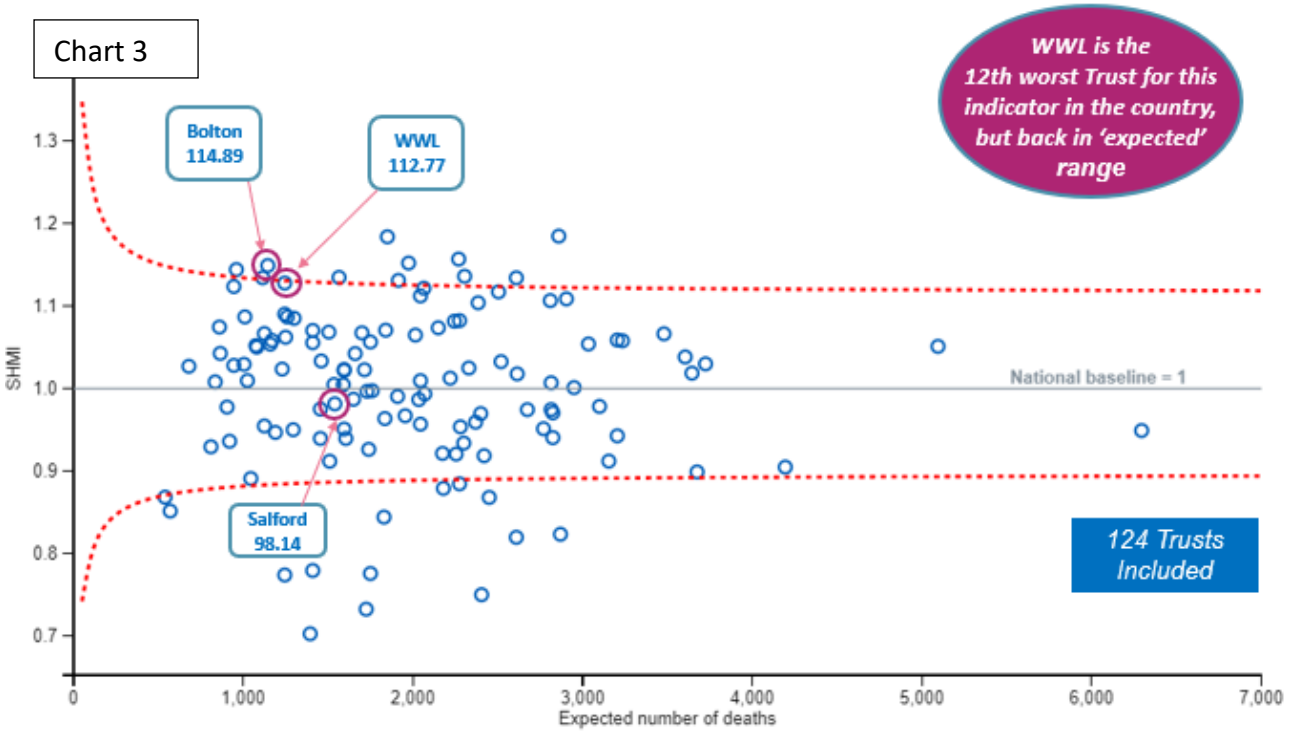
SHMI is now published monthly and the figure given for a rolling 12 months.
The current SHMI value is 1.12 for the period January 2020 to December 2020, which is lower than the previous reported figure of 1.15 for the period November 2019 to October 2020. It should be noted that COVID data is excluded from the figures.

Chart 1	Mar-19 – Feb 20	Apr-19 – Mar 20	May -19 – Apr 20	June -19 – May 20	July 19-Jun 20	Aug 19 - July 20	Sept - 19 - Aug 20	Oct 19 - Sept 20	Nov 19 - Oct 20	Dec 19 - Nov 20	Jan 20 - Dec 20
SHMI	1.17	1.18	1.17	1.16	1.14	1.14	1.15	1.15	1.15	1.12	1.12
Observed Deaths	1760	1775	1720	1660	1630	1610	1620	1620	1575	1470	1405
Expected Deaths	1495	1505	1460	1430	1420	1400	1405	1405	1365	1305	1245
Discharged	46245	45385	43905	42915	42430	41785	38190	41025	39565	38205	37280



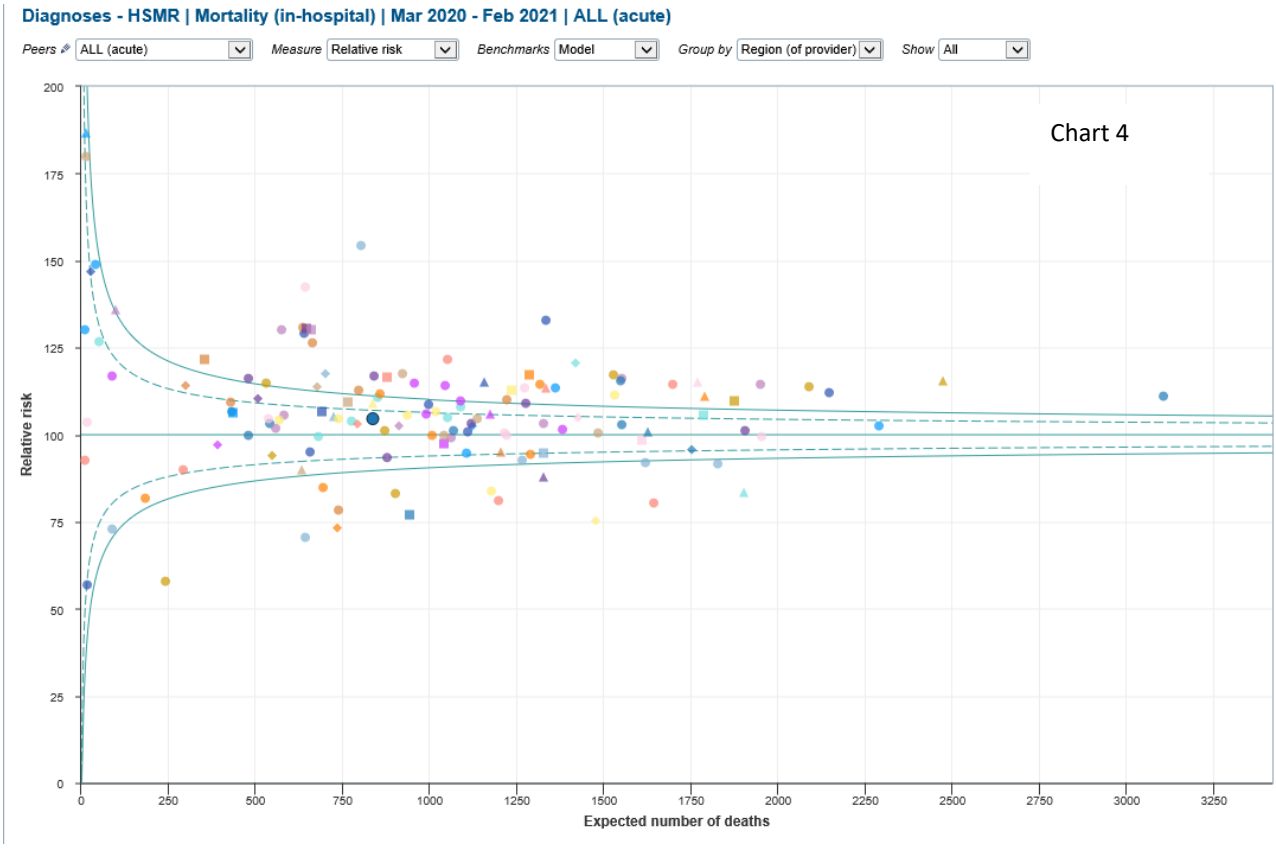
There are currently three diagnostic groups on SHMI with more deaths than expected. These are Septicaemia (except in labour), shock, Urinary tract Infections and Fracture of neck of femur. The Care of the Elderly team are undertaking an audit on UTIs. The orthopaedic team are already aware of the increase in percentage of deaths from fracture neck of femur from the National Hip Data Base Audit and work is currently underway.

The chart below (chart 3) shows the position of WWL when compared nationally. There are 11 Trusts in a worse position than WWL. WWL are within the expected limits.



HSMR

The Trust's HSMR rolling 12 months data. The current data for March 2020 to February 2021 is 104.6. This is a decrease in the previously reported figure (February 2020 to January 2021) of 105.2 This is within the expected confidence intervals. Chart 4 below shows the position of WWL (denoted by large blue circle) when compared with national acute Trusts


Diagnoses - HSMR | Mortality (in-hospital) | Mar 2020 - Feb 2021 | ALL (acute)
Peers ALL (acute)
Measure Relative risk
Benchmarks Model
Group by Region (of provider)
Show All
Chart 4
Relative risk
200
175
150
125
100
75
50
25
0
0
250
500
750
1000
1250
1500
1750
2000
2250
2500
2750
3000
3250
Expected number of deaths

Title of report:	IPC Board Assurance Framework
Presented to:	WWL Board
On:	July 2021
Presented by:	[Rabina Tindale, Chief Nurse, Director IPC]
Prepared by:	[Rebecca Gerrard, Deputy Director IPC]
Contact details:	T: [07798741695] E: [3115]

Executive summary

Summary

A new version of the IPC Board Assurance Framework was released by NHE England/Improvement on 30th June 2021 to support implementation and delivery against the 'COVID-19: Guidance for maintaining services within health and care settings Infection prevention and control recommendations Version 1.2' published June 2021.

Criteria that are new are listed below and highlighted in yellow in the table but the wording in several other criteria has been clarified and/or strengthened.

IPC measures for Trusts are not going to change / be lifted as they are on 19/07/21 outside the Trust. In fact, in many cases throughout this document, additional assurance is being sought that all staff, patients and visitors are being fully compliant re hands, face, space principles as a minimum. For example, there is now a requirement to ensure resources are in place to enable compliance and monitoring of IPC of staff adherence to wearing fluid resistant surgical facemasks in *non-clinical areas* as well as clinical areas.

Gaps in assurance are also listed below before the main table.

New criteria:

Systems and processes are in place to ensure:

- local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff the documented risk assessment includes:
    - a review of the effectiveness of the ventilation in the area;
    - operational capacity;
    - prevalence of infection/variants of concern in the local area.
- triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways.
- when an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment RPE for patient care in specific situations should be given;
- resources are in place to enable compliance and monitoring of IPC practice including:
    - patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE;
- that twice weekly lateral flow antigen testing for NHS patient facing staff has been implemented and that organisational systems are in place to monitor results and staff test and trace.
- additional targeted testing of all NHS staff, if your location/site has a high nosocomial rate, as recommended by your local and regional Infection Prevention and Control/Public Health team.
- there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas.
- assurance processes are in place for the monitoring and sign off following terminal cleans as part of outbreak management and actions are in place to mitigate any identified risk;
- reusable non-invasive care equipment is decontaminated:
    - between each use
    - after blood and/or body fluid contamination
    - at regular predefined intervals as part of an equipment cleaning protocol
    - before inspection, servicing or repair equipment
- implementation of the 'Supporting excellence in infection prevention and control behaviors Implementation Toolkit' has been considered.
- individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation;
- monitoring of Inpatients compliance with wearing face masks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs;

- there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document;
- hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as:
    - staff are maintaining physical and social distancing of 2 metres when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace;
- that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise
- that emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission;
- that sites with high nosocomial rates should consider testing COVID negative patients daily
- that those being discharged to a care home are tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge;
- that patients being discharged to a care facility within their 14 day isolation period are discharged to a designated care setting, where they should complete their remaining isolation;
- that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.

Gaps in Assurance: Gaps in assurance are listed below; the mitigating actions are in the table.

- There is a band 6 vacancy in the IPC nurse team (whose main role is audit).
- The use of FRSMs by staff in non-clinical areas is not currently audited.
- Compliance with staff completing lateral flow tests appears to have reduced. There is no validated system in place to monitor reporting of results.
- WWL are not meeting the new National Cleaning Standards, additional resource is required.
- Decontamination Groups have not met since before the COVID pandemic.
- Compliance of inpatients wearing masks has improved but remains low.
- Due to constrictions on the estate and the number of patients with COVID 19, WWL are not able to separate patient pathways at all times in all places.
- There is a lack of side rooms to isolate every patient who should be isolated.
- There are still issues with compliance in relation to patient swabbing at day 3 and 5 but it has improved.
- A temporary solution for mask fit testing is in place.
- Mask 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.
- Mask fit testing results are not reviewed regularly by the Board.
- It is not possible to prevent all non-clinical staff moving between different patient pathways e.g. porters.
- Workforce data flows and the lack of accurate real time workforce data is on the corporate risk register and is being addressed.

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

Risks associated with this report and proposed mitigations
IPC risks are managed via the IPC Committee.
Some IPC actions required may have adverse reactions in other areas of patient care e.g. not continually moving patient cohorts may lead to increased number of closed beds.

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

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 fully comply with national guidance.
The current challenges associated with COVID-19 on top of the standard IPC workload continues 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)
Please acknowledge the key points in this paper and continue to support the implementation of actions required to enable compliance with national guidance and reduce hospital onset COVID infection.

IPC BAF Framework (last updated 15/7/21):

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: • local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff;	• A new COVID risk assessment has been drafted using this process titled 'There is a risk that non-compliance with best practice guidance associated with sessional use of protective gowns by staff on Winstanley ward for the care of CPAP, BiPAP, NIV patients, could lead to lack of patient confidence and increased risk of infection' to go to IPCC meeting in July.	None	NA
• the documented risk assessment includes: o a review of the effectiveness of the ventilation in the area; o operational capacity; o prevalence of infection/variants of concern in the local area.	See above	See above	See above
• triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways;	• All patients attending AED are screened for COVID on registration with a risk assessment completed. Symptomatic and asymptomatic patients are segregated at this point. • All patients requiring admission undergo a LAMP test as well as a PCR. • Flow chart is in place for ward allocation of symptomatic, asymptomatic, positive and negative patients. • All patients within the community	None	NA

	are contacted to ensure a face to face visit is clinically required ensuring that staff do not mix visits for both symptomatic and asymptomatic patients. • Telephone advice lines are in place where visits are not required. • Patients who are admitted straight to wards e.g. ASU are tested on admission.		
• when an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment RPE for patient care in specific situations should be given;	• Wording from the latest national guidance has been added to the SOP. Introduction of this would be in collaboration with the IPC Team.	None	NA
• there are pathways in place which support minimal or avoid patient bed/ward transfers for the duration of admission unless clinically imperative;	• Microbiology results are obtained and documented in HIS before patients are moved to designated COVID negative or positive wards. • If symptomatic but negative, patients are reassessed by medics. If COVID 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 SOP. • There is an agreed process flow chart to limit the number of times patients who have been a contact of a positive case can be moved and recohorted. • IPC attend bed meetings each morning to support appropriate	None	NA

	patient placement.		
• that on occasions when it is necessary to cohort COVID-19 or non-COVID-19 patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per national guidance;	• Part of the COVID SOP. • Assurance obtained via regular audits including cleaning, hand hygiene and PPE in clinical areas.	None	NA
• resources are in place to enable compliance and monitoring of IPC practice including: o staff adherence to hand hygiene; o patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE; o staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: ▪ a) clinical; ▪ b) non-clinical setting; o monitoring of staff compliance with wearing appropriate PPE, within the clinical setting	• Monitoring of IPC practices against key policies (including COVID-19) is included within IPC audit programme and includes environmental checklists, hand hygiene (monthly) and PPE (RAEI wards audited at least every other month). • Monitoring of IPC practice is also included within matron's mini audits. • Beds/trolleys are at least 2m apart. • Configuration 'bed/chair/locker' used on ward when patients are sat out. • COVID safety Champions audit non-clinical settings.	There is a band 6 vacancy in the IPC nurse team (main role is audit). The use of FRSMs in non-clinical areas is not currently audited.	Vacancy is being actively recruited to – Rebecca Gerrard. Audit of FRSMs is required in non-clinical areas – Rebecca Gerrard
• that the role of PPE guardians/safety champions to embed and encourage best practice has been considered;	• COVID Safety Champions in place; complete audits of own areas. Results collated by IPC and reported via IPCC.	None	NA
• that twice weekly lateral flow antigen testing for NHS patient facing staff has been implemented and that organisational systems are in place to monitor results and staff test and trace	• Implemented as requested in 2020. • Staff encouraged to complete tests twice weekly and report all results on line – regular items in newsletter. • COVID positive staff are followed up by dedicated team and risk	Compliance with staff completing lateral flow tests appears to have reduced. There is no validated system in place to	Moving to national ordering and reporting system in Q2 once all the Trusts Lateral flow boxes have been used – James Baker.

	assessments completed and shared with IPC.	monitor reporting of results.	
• additional targeted testing of all NHS staff, if your location/site has a high nosocomial rate, as recommended by your local and regional Infection Prevention and Control/Public Health team;	• Part of outbreak SOP. • Introduction of this would be in collaboration with the IPC Team.	None	NA
• training in IPC standard infection control and transmission-based precautions is provided to all staff;	• Mandatory training via e-learning is provided for all staff.	None	NA
• IPC measures in relation to COVID-19 are 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. • Jan 21: IPC level 1 and 2 and COVID-19 module reviewed and updated	None	NA
• all staff (clinical and non-clinical) are trained in: o putting on and removing PPE; o what PPE they should wear for each setting and context;	• A PowerPoint Presentation on PPE (along with a quiz to test learning) is on e-learning for all staff and is mandatory • PPE modules reviewed and updated in Feb 21	None	NA
• all staff (clinical and non-clinical) have access to the PPE that protects them for the appropriate setting and context as per national guidance;	• PHE national guidance is 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.	None	NA
• there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace;	• Multi-modal communications strategy in place which includes poster, roller banner and newsletter campaign and regular reminders. • IPC COVID SOP. • Items from National PHE Toolkit	None	NA

	being used in newsletters, websites and social media.		
• IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way;	• DDIPC is on circulation list for updates from PHE and attends GM and NW IPC meetings. • All new guidance is acted upon in a timely manner. Where necessary SOP's are updated. • Changes are communicated through the IPC team, newsletters and Divisional leads.	None	NA
• changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted;	• DIPC presents to the Board through the performance report or specific agenda items. • Quality and Safety committee review quarterly IPC reports.	None	NA
• risks are reflected in risk registers and the board assurance framework where appropriate;	• Trust Risk register • IPC BAF reviews by IPCC, Exec and Board	None	NA
• 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	NA
• the Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep	• IPC check and validate data on HOCI that is downloaded from HIS before submission. CEO and DIPC are copied in so can check data.	None	NA
• the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board;	• New IPC BAF presented to the Exec on 13/7/21 and to be on the agenda for next 4 weeks to monitor progress. • IPC BAF document being presented to the Board again in July.	None	NA

• the 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 Q&S and monthly Performance report to Board	None	NA
• there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas.	• Senior Leadership Walkabouts take place each month • Senior Nurses are establishing a rota and proforma for visiting all areas	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 nursing/medical teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• All redeployed staff undertake additional training to meet their needs • PPE training is mandatory	None	NA
• 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.	None	NA
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	• Domestic provision for the cleaning of isolation rooms and cohort areas follow PHE and National Guidance. • SOP in place agreed in conjunction with IPC. • Rapid Response Domestic team cover terminal cleans and work out of hours.	None	NA
• assurance processes are in place for the monitoring and sign off following terminal cleans as part of outbreak management and	• Document in supervisors office to show what terminal cleans have been undertaken.	None	NA

actions are in place to mitigate any identified risk;	• New sign off form for ward manager to complete has been introduced in July 21.		
• cleaning and decontamination is carried out with neutral detergent followed by 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 IPCT should be consulted on this to ensure that this is effective against enveloped viruses;	• SoChlor is used for the routine cleaning of the environment across all risk pathways and will continue. • SoChlor used at 1,000ppm is used for cleaning in all clinical areas. • Green disinfectant wipes are available in non-clinical areas.	None	NA
• manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products as per national guidance;	• Manufacturers guidance followed and available on the intranet and included in decontamination SOPs	None	NA
• a minimum of twice daily cleaning of: ○ areas that have higher environmental contamination rates as set out in the PHE and other national guidance; ○ 'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails; ○ electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards; ○ rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff;	• All clinical areas undergo decontamination of the environment at least twice daily. • IPC liaise with Facilities to highlight and agree high risk areas. • The wards have Housekeeping schedules outlining frequency of cleaning. • Compliance is audited via Matron and IPC Spot audits and reported to IPC Committee. • Disinfectant wipes are used in non-clinical area PCs and phones. • SOP's in place for all Facilities staff. • Limited designated PPE doffing areas.	Not meeting new National Cleaning Standards	New risk assessment drafted on cleaning – Nick Bastow. Business case being reviewed and revised and will be resubmitted – David Evans
• reusable non-invasive care equipment is decontaminated: ○ between each use	• Decontamination SOP in place. • SOP on Medical Equipment Management Procedure for Decontamination Cleaning of	None	NA

○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol • before inspection, servicing or repair equipment	Devices – reminder sent out in June 21 newsletter.		
• 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 National guidance. • SOP available on the Intranet. • External contractor performance is monitored against the contractual requirements.	None	NA
• 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	NA
• reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance and that actions in place to mitigate any identified risk;	• Strategic and Operational Decontamination Groups. • Decontamination SOP both WWL wide and at department levels in place. • All reusable equipment is decontaminated in line with national guidance. • Audit programme in place. • Risk assessment process in place to minimise risk. • IPC have to sign off new business cases.	Strategic and Operational Decontamination Groups have not met since before COVID.	Strategic and Operational Decontamination Groups to plan to resume – Mary Fleming
• cleaning standards and frequencies are monitored in non-clinical areas with actions in	• Kitchens & toilets are cleaned in non-clinical areas. • With current resources the focus	Additional resource required to meet new cleaning standards	New risk assessment drafted on cleaning – Nick Bastow.

place to resolve issues in maintaining a clean environment;	remains on clinical areas • Monitoring only occurs annually in non-clinical areas.		Business case being reviewed and revised and will be resubmitted – David Evans.
• where possible ventilation is maximised by opening windows where possible 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. • Estates are completing a review of ventilation on all sites for discussion at the IPC Committee in July.	None	NA
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 for antimicrobial stewardship are 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 prescribing and new guidance as appropriate. • Antimicrobial audit programme.	None	N/A
• mandatory reporting requirements is 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	None	N/A

	Safety Committee. • Monthly reporting through Divisional Quality Assurance Groups.		
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: • national guidance on visiting patients in a care setting is implemented	• National guidance in place - policy and SOP. • Changes communicated through Divisional Teams and via COVID Newsletter. • Visitor disclaimer in use. • Visiting is still subject to restrictions but Exec have agreed visitors can attend in exceptional circumstances. Decision tree drawn up and agreed by Exec for special circumstances which includes IPC requirements.	None	NA
• areas where suspected or confirmed COVID-19 patients are being treated have 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 • Clear signage in AED indicating symptomatic and asymptomatic patient areas.	None	NA
• 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	None	NA

	information and advice on https://www.wwl.nhs.uk/		
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved;	• Infection status is communicated verbally before the patient is transferred and then in writing via a transfer form when the patient is moved. • Discharge to assess process works to rapidly discharge patients to the most appropriate setting with a philosophy of home wherever possible reducing contact with others. • Patients swabbed 48hours before discharge to nursing or care home.	None	NA
• there is clearly displayed, 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 entrances. • Patient leaflets includes information on masks, hand hygiene and social distancing.	None	NA
• Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been considered C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	• Review of all resources by IPC and Comms. • Several items have been used in internal and external comms. • Toolkit also shared with HR staff.	None	NA
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:	• Patients are assessed on admission and admitted to the most	None	NA

• screening and triaging of all patients as per IPC and NICE guidance within all health and other care facilities is undertaken to enable early recognition of COVID-19 cases;	appropriate area. • All patients attending A/E are screened for COVID-19 symptoms on registration. • Patients are swabbed on day of admission (day 1; PCR and LAMP tests), day 4, day 6 and then weekly thereafter. Reminders on HIS tracking board to alert staff when swabs are due. • Telephone screening is in place for all elective patients; they are swabbed 3 days prior to admission and asked to self-isolate prior to coming in. • SOPs are in place to support guidance. • App in place to show compliance with swabbing.		
• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from non Covid-19 cases to minimise the risk of cross-infection as per national guidance;	• Patients are further assessed at triage and segregated appropriately to different areas/wards.	None	NA
• staff are aware of agreed template for triage questions to ask;	• COVID-19 risk assessment questions included within COVID SOP. • HIS core assessment questions are included in the COVID-19 checklist	None	NA
• triage is 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.	None	NA

	• Triage questions and COVID-19 checklist assessment within HIS further supports staff in clinical care definition and patient allocation		
• face coverings are used by all outpatients and visitors;	• FRSMs are available in all clinical areas and at all entrances and they are asked to wear one at all times. • COVID SOP includes information on mask wearing.	None	NA
• individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation;	• CEV patients are priority for siderooms. • Included in SOP. • IPC attend bed meetings and are available 24/7 to support patient placement decisions.	None	NA
• clear advice on the use of face masks is provided to patients and all inpatients are encouraged and supported to use surgical facemasks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs;	• FRSMs are available in all clinical areas and at all entrances; staff and visitors are requested to wear masks as they enter hospital. • The COVID SOP includes sections on mask wearing. • Patients are asked to wear a mask unless clinically impossible or medically exempt. • There is an information leaflet for patients on masks approved at IPC Committee.	None	NA
• monitoring of Inpatients compliance with wearing face masks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs;	• Compliance audited in April and June and reported through SIRI and IPCC. Action plan in progress.	Compliance of inpatients wearing masks has improved but remains low	Action plan in place – Rabina Tindale
• patients, visitors and staff are able to maintain 2 metre social & physical distancing in all	• Seating rearranged or areas blocked off to ensure segregation.	None	NA

patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.	• 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 in place at receptions.		
• isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, until proven negative;	• COVID SOP in place. • Symptomatic patients moved to symptomatic ward while awaiting swab result and then moved to either negative or positive wards depending on results (and a medical review if still positive). • 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.	None	NA
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly;	• See above	None	NA
• there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document;	• App available to report on compliance with swabbing and data reported to IPCC and in quarterly IPC report.	None	NA
• 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	None	NA

	undertaken. • All COVID departmental SOPs are signed off by IPC.		
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: • patient pathways and staff flow are separated 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. • One way system in place in Leigh hospital.	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 PHE and other national guidance to ensure their personal safety and working environment is safe;	• Mandatory e-learning for all staff. • Environmental risk assessments have been completed at ward and department level. • Where concerns are raised additional bespoke training is undertaken by the relevant individual to ensure staff comply. • A detailed IPC Checklist was used to assess areas for the safe return of CEV staff.	None	N/A
• all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;	• 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 support IPC to carry out classroom training on donning & doffing. • Don and doff guidance is included in	None	N/A

	the PPE e-learning module.		
• 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 held centrally.	None	NA
• adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk;	• IPC visit wards regularly. • All key wards PPE compliance is audited at least every 2 months. Results fed back to clinicians, reported to IPCC and to Q&S via the quarterly report.	None	NA
• hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: ○ hand hygiene facilities including instructional posters; ○ good respiratory hygiene measures; ○ staff maintaining physical and social distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care; ○ staff are maintaining physical and social distancing of 2 metres when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace; ○ frequent decontamination of equipment and environment in both clinical and non-clinical areas; ○ clear visually displayed advice on use of face coverings and facemasks by	• Instructional posters available at all sinks. • Instructional posters at hand gel stations throughout the hospital and ward/ department entrances. • Guidance is given to all elective patients within the patient information booklet. • Patient information leaflet has information on hands, face and space. • Facemasks are available at all hospital and ward/ department entrances. • Roller banners and posters are used to promote mask use and good respiratory hygiene. • Roller banners and posters used to promote social distancing. • Trust SOPs clearly define the need to maintain 2 metres distance	None	NA

patients/individuals, visitors and by staff in non-patient facing areas.	unless wearing PPE as part of patient care. • There are signs on doors to indicate the maximum number of people who should be in the room at any one point. • Floor markings are present in many outpatient areas and 'keep left' signs in corridors. • Staff asked to avoid car sharing via SOP, newsletters etc. • Comms highlight key messages internally and externally through variety of medias.		
• staff regularly undertake hand hygiene 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.	None	NA
• the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance;	• There are no hand dryers in any clinical areas at WWL. Where hand dryers were available for the public these have been deactivated and replaced with paper towels.	None	NA
• 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 the intranet. • Laminated posters are displayed in all areas	None	NA
• staff understand the requirements for uniform laundering where this is not provided for onsite;	• National guidance has been followed with information for staff on laundering their uniforms • Staff have been updated through the COVID Newsletters.	None	NA
• all staff understand the symptoms of COVID-19 and take appropriate action (even if	• National guidance is being followed and available on the intranet.	None	NA

experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms;	• Updates are included in the COVID Newsletters. • There is a drive through facility for staff testing at Leigh and Wrightington. • IPC liaise closely with H&S and Occupational Health as required. • Staff now have lateral flow kits for twice weekly testing.		
• 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 results. • Positive results from elsewhere come via PHE emails to the IPC inbox and are acted upon. • An in-house COVID-19 App has been developed that supports the collation, evaluation and summary of COVID cases. • HOCI are reported via the daily nosocomial sitrep. • Local PHE information on population transmission is circulated to IPC.	None	NA
• 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 8 or more days after admission. • If the criteria for outbreak is met this is declared and acted upon and reported to DIPC and NHSE/I. • SOP in place that is updated and monitored through IPCC.	None	NA
• robust policies and procedures are in place for the identification of and management of	• SOP for the identification and management of COVID-19 outbreaks	None	NA

outbreaks of infection. This includes the documented recording of outbreak meetings.	that incorporates national guidance. This has been approved by the IPCC. • Daily outbreak meetings are held when necessary and minutes recorded.		
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. • Visiting policy and SOP based on national guidance.	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.	None	NA
• 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.	There is a lack of siderooms to isolate every patient who should be.	There is a risk assessment on lack of siderooms. IPC attend bed meetings and support bed managers with decision making and are available 24/7 if required. A Datix is completed if unable to isolate a patient who should be –

			this includes those who have infections, those suspected to have an infection and CEV patients.
• areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance;	• All bed spaces have been reviewed • Ward staff are requested to use privacy curtains between beds to minimise close contact where safe to do so; reminder in Newsletters and in COVID SOP. • IPC guidance on blue, green and yellow wards has been implemented and circulated to all wards; reinforced through Newsletter and meetings. • SOP covering all actions required. • IPC environmental checklists are reviewed every time an outbreak is declared.	None	N/A
• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement.	• All previous IPC policies, 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. • COVID positive CPAP ward has separate SOP. • Mandatory surveillance data is reported to IPCC and Trust Board.	None	NA
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: • 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. It is provided by Northern Care Alliance, monitoring of compliance is through contractual discussions. • Trust guidance is in line with national guidance on testing for suspected COVID cases and for other infections. • The HIS tracking board highlights when patients need re-swabbing. • System established for antibody testing. • March 21: System established for carrying out additional testing on vaccinated patients and for identifying patients who may have new variants.	None	N/A
• regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available;	• App shows turnaround times. • HIS alert if takes longer than 24 hours.	None	N/A
• regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data);	• National policy is followed. • Patient incident reviews are carried out on all probable and definite hospital onset COVID patients.	None	N/A
• screening for other potential infections takes place;	• National policy is followed. • Alert organisms are reported as required on national database and at IPCC.	None	N/A

• that all emergency patients are tested for COVID-19 on admission;	• All patients tested on admission via LAMP and PCR	None	NA
• that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise;	• COVID SOP • Patients reswabbed if symptoms occur in line with national guidance and moved to a symptomatic ward	None	NA
• that emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission;	• National policy is followed. • An App is in place to monitor compliance. • There are electronic reminders on the HIS tracking board to highlight when swabs are due.	There are still issues with compliance in relation to patient swabbing at day 3 and 5.	In June 21 IPC worked with IT and made some further changes to HIS to help highlight to staff when swabs are due – Rebecca Gerrard. To reaudit in July.
• that sites with high nosocomial rates should consider testing COVID negative patients daily;	• In COVID SOP for IPC to consider if nosocomial rates high. Usually swab all patients 3 times per week in any outbreak.	None	NA
• that those being discharged to a care home are tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge;	• National policy followed. • In COVID SOP.	None	NA
• that patients being discharged to a care facility within their 14 day isolation period are discharged to a designated care setting, where they should complete their remaining isolation;	• National policy followed. • In COVID SOP.	None	NA
• that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.	• National policy followed. • In COVID SOP.	None	NA
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:	• IPC Policies and SOPs are approved at IPCC and are on the Intranet and	None	N/A

• staff are supported in adhering to all IPC policies, including those for other alert organisms;	kept up to date. • IPC and microbiology advice is available 24/7. • IPC level 1 and 2 e-learning is mandatory in line with national guidance		
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff;	• All new guidance is acted upon in a timely manner • Where necessary SOP's are updated • Changes are communicated through the IPC team, newsletters and Divisional leads	None	N/A
• all clinical waste and 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 stores also at Leigh and Wrightington. • In Community, PPE store well stocked and accessible to all teams.		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported;	• All staff requested to complete a self-declaration form confirming if they fall within the extremely vulnerable or high risk categories as defined by PHE. Where staff have been determined to fall within these groups, personal risk assessments have been completed by line managers with the support of Occupational Health. Records of the outcomes from the self-declarations forms logged and maintained within HR. • A comprehensive programme of support has been developed for all staff, including: Access to rest spaces with trained volunteers to provide a listening ear; in-reach support for teams when requested (e.g. at times of higher stress), training for managers in supporting staff; a 24/7 telephone helpline; staff counselling (including remotely); development of roles as clinical wellbeing leads and wellbeing champions; communications and information about self-care and sources of support. This is accessible by all staff, including those who 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	None	N/A

	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. • March 21: Working areas for vaccinated high risk staff has been extended. • April 21: CEV staff returned to work in lower risk areas.		
• that risk assessments are undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic 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	NA
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally;	• Face fit testing is available across all acute sites and at one location in the community and is run by the H&S team. • All mask fit testers have been trained in line with national legislation. • A SOP has been developed and shared with all Testers. • Mask fit training records are held	None	NA

	centrally. • Some staff cannot wear a close fitting FFP3 mask e.g. due to facial hair. Air powered hoods are available if required.		
• 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	There is a temporary solution for mask fit testing in place	A Business case is being submitted to future proof the mask fit testing service – Lynne Bushell .
• 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.	Fit test sessions continue to be advertised. Divisions have been provided with a list of compliant staff to review – Lynne Bushell.
• 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	NA
• those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods;	• Individuals that fail a fit test are tested on an alternative model until options are exhausted. If a secure fit cannot be achieved staff are advised to use a mechanical respirator and hood. Records are kept by the individual and held centrally by the H&S team	None	NA
• 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	None	NA

	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.		
• 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	NA
• 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	NA
• boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board;	• A centrally held mask fit register is maintained and is available.	Fit testing results are not reviewed regularly by the Board	A member of the Board had weekly oversight of a summary of the register during the first wave.
• 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 which includes Staff risk status. • Medical rotas for medical staff. • 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	Head of E&F has 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.

	volume of temporary staff working across the Trust.		
• all staff to adhere to national guidance and are able to maintain 2 metre social & physical distancing in all patient care areas 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. • Office space has been redesigned to ensure social distancing. • All community premises have been reviewed for social distancing and a number of work areas have been designated as no longer in use. • Wards asked to include minimum numbers at staff handovers.	None	NA
• health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone;	• Space planning exercise undertaken at the start of the pandemic. • Maximum staff allowance per room assessments completed and supportive guidance provided to Departmental managers. • Environmental risk assessments completed. • COVID Safety Champions promote and support compliance in own areas – supported by IPC.	None	NA
• 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	NA

• 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. • Well-being offers are widely available to staff members, with pro-active holistic well-being provision through our Steps 4 Wellness and occupational health services. Psychological support programmes are in place including access to well-being apps, EAP, SOS rooms with trained facilitators, critical incident debriefing and departmental support programmes. There are nursing, AHP and medical well-being leads identified along with over 70 well-being champions within wards and departments. • The Trust continues to actively manage and support staff through attendance management procedures. The Strategic HR lead completes a monthly review of all long-term sickness absence cases with HR Business Partners. Staff have access to COVID swab tests via	Workforce data flows and the lack of accurate real time workforce data is on the corporate risk register	Empactis business case accepted and will be rolled out – Alison Balson

	a Trust drive through facility and home testing. • December 20: All staff have been offered own lateral flow testing kit and asked to complete tests twice per week. • Jan 21: Central Unplanned Absence Team established to contact staff on first day of absence and support managers • Feb 21: new Psychological Support Service established.		
• 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.	None	NA

Title of report:	Freedom to Speak Up
Presented to:	Board of Directors
On:	28 July 2021
Presented by:	Director of Workforce
Prepared by:	Workforce Governance Lead
Contact details:	Lynda.Hancock@wwl.nhs.uk

Executive summary

The Francis Report which followed investigations at Mid Staffordshire Hospital NHS Trust made it a requirement for Trusts to improve their speaking up culture and mandated the role of Freedom to Speak Up Guardian (FTSUG).

The decision of our full time FTSU Guardian to step down from their role has left a gap but also provided an opportunity to consider an alternative way of providing this essential service while ensuring that issues in relation to resilience and perceived lack of independence are addressed. Until recently, the Trust was not aware of the option to appoint independent Guardians external to the Trust and the only known provider of this service is the Guardian Service. This approach has been adopted by a number of organisations in the South of England and discussion with the company has indicated that this has the potential to be an ideal solution for WWL.

Not only will the service provide WWL with its own dedicated Guardian, but it will also provide 24/7 access for our staff, significantly improving the resilience and robustness of Speaking Up support. Additionally, the service will resolve a number of issues that we have been unable to address to date such as: gathering user feedback, effective and consistent promotion, and publicising learning organisationally etc. Perhaps most importantly of all, the service will provide complete independence and impartiality, concerns over which can very often deter staff from raising a concern in the first place.

Procurement and business case processes are underway to secure an independent third-party service provider, following an options appraisal and recommendation by the Executive Team. In the interim, limited cover has been and continues to be provided by the Workforce Governance Lead who has undertaken the necessary training to ensure that the service remains available to staff.

MIAA audit

The audit, which was concluded earlier this calendar year, provided limited assurance in the current service provision. The most significant concerns identified were regarding resilience, given that the Trust's FTSU provision has always been reliant on a single person. The move to the third-party service, as described earlier, would remove this concern.

Further recommendations were identified regarding policy inclusions, user feedback mechanisms, the appointment of Speaking Up Ambassadors, engagement with the Community Services division, and the sharing of learning from cases. These specific recommendations are currently on hold pending the implementation of the third party service and alignment to their service delivery model.

A detailed report will be provided to People Committee bi-annually and a summary case tracker will be shared monthly at ETM and at each Audit Committee identifying themes and outstanding actions. All reports will be anonymised to ensure the confidentiality of the individual raising concerns.

Audit recommendations regarding case tracker security, identifying detriment as a result of speaking up, and reporting into People and Audit Committees have been resolved as part of the interim arrangements.

FTSU NED case review and National Guardian Office involvement

The Trust has a long running FTSU case (3 years) that has been escalated to the National Guardian Office due to issues in the management of the concerns, delays, and victimisation. Some concerns raised by this individual remain unresolved, although processes are in place for independent investigation for the outstanding issues. Investigation has found that this individual has experienced detriment and victimisation as a result of raising concerns. A meeting with the individual and their representative, the Director of Workforce, NED with oversight of FTSU and the workforce Governance Manager is scheduled to provide opportunity for discussion about how the issue of detriment and victimisation can be resolved.

It is essential where resolution is not possible between the individual who raises concerns and / or the FTSUG, that accountability for delivering against the actions required to investigate or resolve the concerns sits with the relevant portfolio manager.

NGO Case Reviews

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

As noted in the last report, the NGO carried out a case review at Whittington Health NHS Trust. The report made 14 recommendations and a gap analysis has been undertaken against these. Key areas for consideration include:

- Provision of supervision / wellbeing support to the FTSU Guardian;
- Regular FTSU meetings with HR colleagues;
- FTSU Policy review in line with National Standard Integrated Policy;
- Use of local staff survey to gain feedback in relation to FTSU;
- Production of a Comms Strategy for FTSU;
- Annual review of FTSU Board self-assessment;
- Meaningfully thanking staff for speaking up;
- Incorporation of FTSU / speaking up question in exit interviews / surveys.

Given current capacity and cover arrangements, it is proposed that these items are reviewed with the Guardian Service aligned to their contract with WWL, subject to business case approval.

Case data

FTSU Guardian

Below is a summary of contacts made to the FTSU Guardian between October 2020 and May 2021 (5 in total) and one long standing open case:

Ref. number	Theme	Date opened	Date closed	Comments
FTSU120	Clinical practice Clinical governance Subsequently raised – Bullying, victimisation & detriment	28.11.20	Ongoing	External review completed (April 2021) Peer review (expected to be concluded July 2021) Investigation completed and report shared. Meeting to discuss proposed remedy (June 2021) This case included significant delays / lacked timely ownership of required actions and has involved escalation to the National Guardian Office.
FTSU132	Quality and Safety	02.10.20	20.10.20	Concerns raised around PPE. Concerns were directed to Infection Control Team and response provided by them. Feedback provided to the individual.
FTSU133	Quality and Safety	20.10.20	31.10.20	Concerns raised around PPE. Concerns came in at the time FTSUG was going on sick leave. Contact details were given to the individual for Workforce Governance Lead but no further contact has been made by the individual.
FTSU134	Bullying and Harassment	6.11.20	23.11.20	Referred into HR team. Temporary redeployment was given to individual to facilitate return to work. Individual confirmed that they did not wish to pursue further HR process. Individual was happy with the support that had been provided at the time and feedback was given that the matter would be closed from a FTSU perspective whilst HR support continued.
FTSU135	Bullying and Harassment	16.12.20	14.1.21	Concerns raised were in relation to observed behaviour within their team rather than behaviours experienced by them personally. The individual was referred into the HR team as an external review was already being undertaken with regard to the department and the individual was invited to feed into that. Referral made to the Psychological Support Team. No further action required from FTSU. Feedback provided and case closed.
FTSU136	Job role and unfair treatment	24.02.21	11.03.21	Individual raised concerns in relation to their job role and unfair treatment

				compared to colleagues. Initial meeting was held with individual but on reflection they decided not to pursue their concerns further as they felt their situation had improved. Case was closed.

The number of new contacts made during this period is significantly lower than seen in previous years. The full year contacts for 2019/20 amounted to 44 in total. The reasons for this are not clear, but could be linked to the lack of resilient FTSUG service during the period, COVID escalation or other factors.

All new cases were resolved within a month which is in line with the policy timescale of 4 weeks.

In addition to this, there were five longstanding cases which had remained open during this period (not including the case referred to the NGO and referenced earlier in the report). All of these cases required no further FTSU intervention as they were being managed to the satisfaction of the individual via HR processes or external reviews but had remained open should the individual wish to draw further on FTSU support. These cases have now been closed.

Fraud Specialist Manager

During this period, 7 contacts were received by the Fraud Specialist Manager which developed as incidences/investigation and 10 referrals were managed informally as 'advice and guidance given' and not via the formal fraud route.

Out of the 7 that have been reported via the Fraud Specialist Manager there was:

- 1 individual (member of public) who was allegedly in possession of articles for use in frauds Fraud Act 2006 (section 6);
- 4 individuals that allegedly committed fraud by false representation (section 2);
- 1 individual that was allegedly in possession of articles for use in frauds Fraud Act 2006 (section 6);
- 1 individual that was allegedly failing to declare Contrary to section 3 Fraud Act 2006.

Of these, all matters were either raised via the line manager of the department or anonymously.

From these allegations:

- 3 cases were determined as not meeting the criminal standard to warrant further action from a fraud perspective – one individual resigned prior to the HR disciplinary proceeding, but paid the full redress figure;
- 1 case is currently being investigated with the Fraud Specialist Manager assisting the Police and GMC;
- 3 cases remain ongoing with the Fraud Specialist Manager.

The Fraud Specialist Manager has recovered **£16,030.00** in redress monies for 2020/21. The Fraud Specialist Manager provides an annual report on matters to the Audit Committee; a bi-monthly update report to Audit Committee and monthly updates to the Chief Finance Officer. Included within the updates and reports are outcomes from investigations; ongoing investigations; breaches of the Trust's Standing Financial Instructions; and financial redress from matters.

The Fraud Specialist Manager also provides the fraud service to Bolton NHS FT, which enables the Trust to share best practice including emerging fraud risks/alerts and benchmarking. The Fraud Specialist Manager is also a member of the Board of the North West Fraud Forum (NWFF) and has developed a key relationship in 2020-21 with Greater Manchester Police (GMP) enabling fraud alerts/threats in real-time to be sent to staff and key officers of the Trust.

Matters raised in accordance with Public Interest Disclosure Act (PIDA)
The Trust's Freedom to Speak Up policy is not limited to those concerns or disclosures raised in accordance with the PIDA. Qualifying disclosures are disclosures of information where the worker reasonably believes (and it is in the public interest) that one or more of the following matters is either happening, has taken place, or is likely to happen in the future:

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

In this regard the Trust would report that during the period 7 concerns have been reported which could qualify under the Act.

Out of all concerns reported in the period there have been no conclusions that any reports or concerns raised have been made maliciously.

Link to strategy
A culture of psychological safety is a core component of the 2030 strategy, as it underpins patient and staff safety. It also provides the bedrock of a learning organisation that supports innovation. The FTSUG is a core role in helping us to create this organisational culture, providing a route for colleagues to raise concerns and to provide assurance that these critical issues are reviewed and addressed.

Risks associated with this report and proposed mitigations
There is a risk that because WWL does not currently have an appropriately resourced FTSU service which provides resilience and accountability, staff will not feel able or willing to raise concerns meaning that the organisation does not have the ability to address matters at an early stage, learn lessons or take necessary action.

Financial implications
A business case has been submitted in order to procure our FTSU service via a third party provider.

Employment Tribunal claims where the protection of the Public Interest Disclosure Act (1998) apply can result in compensation under the provisions of the Act that are uncapped and potentially unlimited.

Legal implications
There is a requirement following the Francis report that every Trust has a FTSU service in place and this enables colleagues to safely raise concerns, in the knowledge that they will be listened to and actions agreed and taken to resolve / address the issue.

Failing to handle FTSU cases appropriately, including the victimisation and detriment of colleagues who raise concerns. can result in claims at Employment Tribunal under the Public Interest Disclosure Act (1998).

People implications
A resilient and robust FTSU service, where actions are owned and delivered against, is essential for an organisational culture underpinned by psychological safety.

Wider implications
The Trust has two cases that have been escalated to the National Guardian Office. One of these cases (FTSU 120) remains active.

Recommendation(s)

The Committee is asked to receive and note the report, including the current process to procure and commission an independent external third-party provider and potential risks associated with any legal claims made under the Public Interest Disclosure Act.

Title of report:	Safe Staffing Report
Presented to:	Trust Board
On:	July 2021
Presented by:	Rabina Tindale, Chief Nurse
Prepared by:	Allison Luxon, Deputy Chief Nurse, and Divisional Directors of Nursing and Allied Health Professionals
Contact details:	T: 01942 82 2176 E: allison.luxon@wwl.nhs.uk

Executive summary

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

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

The Board are asked to note:

- The overall vacancies across nursing and midwifery have not been provided as this data was not available.
- The is a risk associated with the number of registered staff vacancies across theatres within the Trust and targeted recruitment is being planned to mitigate any risk to the delivery of care and to mitigate the risk of patient cancellations. Consideration of targeting ODP's with the skills/knowledge to work across all areas of the theatre complex is essential.
- There has been a reduction in the reporting of red flags within nursing aligned with the proactive use of SafeCare to monitor patient acuity.
- There has been good utilisation of the redeployment function within SafeCare which assists in the triangulation of risk and in monitoring the impact on individual teams.
- The increased fill rates across inpatient areas of the Trust. This can be triangulated with a reduction in vacancies, deployed staff returning to their substantive areas, and improved fill rates of temporary staff across the Trust, and the over-establishment in some areas associated with the placement of International Nurses.
- There is a risk associated with the delivery of Maternity Services as a consequence of vacancies within the area. Whilst there have been no reported harms, there has been a requirement to

close the unit for a short period due to staffing shortfalls. The outcome of the bid for funding to address the recommendations within the Ockenden Report is not known at the time of writing.

- A review of NHSP Booking reasons is being undertaken by the Head of Nursing for Surgery and is due to be presented to NMALT in June 2021. In addition, a review of the E-Rostering Policy and associated KPI's is planned by the senior nursing team

- There has been an overall reduction in agency expenditure from April to May of £63k

- 3 red flags have been raised with respect to Maternity Services within the reporting period which has not been linked to patient harm, however, there are vacancies within the service which has resulted in the requirement to close the unit to admissions for a couple of hours on 1 occasion.

- 2 StEIS reported hospital acquired pressure ulcers have been reported in Month on Standish Ward. The Division continues to progress its improvement plan which is linked to the Trust Strategic Pressure Ulcer Improvement Plan.

- 0 Falls with harm have been reported.

- 3 medication incidents with harm have been reported in month. These have not been linked to shortfalls in staffing.

Link to strategy

Delivery of safe care

Risks associated with this report and proposed mitigations

- Registered and unregistered nurse recruitment is being proactively managed, and the Trust is seeing an overall reduction of vacancies at both B5 levels. Further work is required to understand turnover by grade of staff and to evaluate the Trust offer to improve retention.
- Registered staff vacancies within theatres present to risk to patient safety and experience and the overall Trust Covid recovery plan
- The report highlights a continued lack of adherence to the Pressure Ulcer Policy.

Financial implications

Temporary staffing costs related to sickness/absence and vacancy levels, and backfill requirements for staff still redeployed

Legal implications

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

People implications

- Potential shortfalls in midwifery establishments in response to vacancies, and the requirements to deliver different models of care.
- Ongoing potential impact on staff wellbeing associated with the pandemic, vacancies and sickness/absence.

Wider implications

- Increased scrutiny from Commissioners and Regulators

Recommendation(s)

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

Safe Staffing Report – May 2021.

1.0 INTRODUCTION

The purpose of this report is to provide the Board to provide assurance of the ongoing monitoring of nurse staffing levels across inpatient areas in line with national requirements.
For completeness this report also includes adult and children's community services.
It includes exception reports related to nurse staffing levels, related incidents and red flags which are then triangulated with a range of quality indicators.

2.0 SAFER STAFFING EXCEPTION REPORT

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

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

(*All incidents displayed by those that resulted in moderate and severe harm / resulted in minor or no harm)

- Patient experience data collection had not been recommenced at the time of the report and therefore these areas are incomplete within Appendix 1.

3.0 CURRENT POSITION – May 2021

The current reporting period reflects the staffing position as the Trust continues the recovery phase following wave 2 of the Covid pandemic.

E-roster staffing levels have been unchanged from the pre-Covid agreed levels.

The format of the report has been amended and now incorporates divisional analysis from the Directors of Nursing and AHP's alongside triangulation with the quality metrics.

Community Division

This report is focusing on District Nursing and the Community Assessment Unit (CAU) only. Further reports will be expanded to cover other teams within the Division including Health Visiting, School Nursing and Learning Disability.

Staffing levels within District Nursing teams are currently based on historical settings and there currently is no recognised safer staffing models for District Nursing based on caseload demands which have remained high. Peer discussion suggests that an average caseload should be approximately 12 patients with a combination of complex and active visits. The Board are asked to note that within the month the District Nursing Teams average caseload has been 15-20 per staff member. No harms have been identified during month as a consequence of the increase in caseload, however the quality of the visit and the time for staff to undertake all the required

assessments has reduced. Further benchmarking work is required to determine whether WWL is an outlier in this regard.

E-Roster compliance has been maintained within month and planned leave is within the agreed parameters.

CAU metrics will be included within Appendix 1 from June 2021 and will permit greater transparency of triangulation of data.

In month, e-roster compliance and associated utilisation of staff has been within target KPI's except for annual leave which is slightly below target. There have been no unutilised hours in month.

The unit design does not always facilitate observation of all patients from a central location, and therefore when 1:1 observation is required due to falls risk this has required the use of temporary staff to maintain safety. Despite the addition of staff there were 6 falls reported in month, 5 no harm and 1 low harm which is consistent with the number of reported falls in April. The Board should note that the patient cohort, age 65 and over with enablement/reablement needs) has a potential for a higher prevalence of falls compared to a general inpatient area.

Specialist Services Division

In month Registered day shift fill rates have been exceeded as a consequence of e-roster not being updated in real time and requests for additional staff not being updated, and the requirement for enhanced observation for a small cohort of patients. The Division have increased access to e roster permissions for registered staff who take charge and amended the bleep holder responsibilities to ensure real time management of rosters is achievable.

CSW fill rates have been exceeded across the 24-hour continuum on Aspull ward because of the requirement for enhanced care observations. Therefore, there has been a reduction in the number of falls reported, with 2 occurring in month both with no harm to the patient.

6 Red Flags were raised on Aspull Ward in month, all of which related to a shortfall of 1 registered nurse on duty at night. There were no reported incidents during this time. in addition to the red flags raised, 2 Datix forms were submitted with regards to a delay in analgesia and to a delay in the administration of antibiotics. These incidents were not linked to any shortfalls in staffing.

All WTE vacancies on the wards have now been filled with some over-recruitment in some areas due to a commitment to the International Nurse (IN) Recruitment Programme. Each inpatient area now has 6 IN's. The IN's are being supported to achieve their competencies, however progress is varied dependant on the individual.

There remain vacancies within Theatres within the division and targeted recruitment to this specialist area is being planned.

There were 2 medication incidents reported in Month, Aspull and Ward B. Both incidents have been investigated and there were no links to staffing levels at the time these incidents occurred.

Division of Medicine

Emergency Village

The fill rates within the Emergency Department remain over the budgeted roster requirement for both registered and unregistered staff due to the ongoing escalated staffing numbers required to provide the additional patient streams associated with the COVID-19 response. The Board are already sighted on the increasing numbers of attendances within the department and will recognise the need to provide additional state to maintain patient safety and to provide direct care.

Appendix 1 shows an amber fill rate for in relation to the Nurse Practitioners due to a vacancy within the team that has historically been difficult to fill and is currently out to advert for a second time.

On CDW there is currently an amber underfill rate associated with a CSW vacancy which has been recruited to. This situation should be resolved in June/July dependant on the conclusion of the recruitment process.

The Paediatric Emergency Care Centre (PECC) has also faced considerable pressures within month due to the sustained increase in attendances. It should be noted that sickness within the area in currently 0% which is an achievement considering the increased demand for services.

Medical Wards

ASU, Astley, CCU, Ince and Winstanley are all showing overfill rates for registered staff (Appendix 1). This is predominantly associated with the supernumerary status of team members and the need to backfill with own staff to support and is again linked to the Trust commitment to IN recruitment. In addition, Winstanley Ward has required additional staffing to safely support the delivery of enhanced care to patient requiring CPAP.

ASU has seen a higher acuity of patients from a medical perspective and an increase in those patients requiring enhanced observations.

MAU amber fill rate is due to 1 RN being on long term sick leave which is being managed via Trust processes.

Appendix 1 indicates that Lowton ward has a 10.27% vacancy rate, however this has been fully recruited to.

Bryn Ward North remains open as an escalated area.

Across the medical division the ward management teams have been reviewing their rosters to ensure that they are completed in a timely manner and that staff availability is fully utilised.

There was 1 reported harm associated with medicine administration on Standish Ward; there were no staffing issues reported at the time of the incident which is currently under review.

There were 2 StEIS reportable pressure ulcers on Standish Ward in May 2021. These incidents will be subject to concise investigation and review by the pressure ulcer improvement group. The Division continues to progress it improvement plan in this regard.

Surgical Division

ICU/HDU
Staffing requirements have fallen slightly below requirements for bed occupancy and acuity on both day and night shifts for RN's. Although there are no current vacancies, sickness is above average at

7.18%. It should be noted that staffing ratios are diluted due to the recruitment of IN's and junior staff requiring critical care induction and supernumerary status.

Critical care has had recent business case approved to support the provision of a supernumerary registered nurse in charge and therefore recruitment into 5.38 wte is in progress. There is currently no establishment of CSW's for nights.

There is record of 4 drug admin errors with no harms, none of these are associated with staffing shortfalls.

Langtree
RN Day shift staffing is slightly lower than shift requirements, however on night shifts meets RN requirements with staffing ratios maintained at 1:8 with additional requirements of CSW's to support enhanced care for all shifts (Appendix 1).

4 RN vacancies have recently been backfilled with 2 x2 sets of IN's who are supernumerary and undertaking induction. The establishment for CSW's was agreed for 2 for days and 2 for nights, however patient acuity requires 3 CSW's both day and night shifts and this is reflected in the fill rates for this cohort of staff.

4 nursing red flags were completed on 4 shifts; there were no associated patient harms reported at this time. However there has been an increase in falls (n5) noted within the clinical area .

Orrell

Orrell was previously reported upon as a medical ward and staffing requirements often did not reflect the bed occupancy and acuity of other medical wards for CSW requirements. However, with the recent confirmation that the ward is to remain within the Surgical division and the bed base to is to be reduced to 17 to house Surgical Assessment and Emergency Care (SAEC), this will require review.

Currently the ward has a disproportionate amount of Band 4 vacancies. This role has been difficult to recruit to and has been found to be limiting in its scope and therefore review of how this role or alternative role can enhance/complement service provision is being undertaken.

There were no red flags raised within month, however there were 5 falls with no harms and 3 drug admin errors no harm. None of these incidents are related to shortfalls in staffing

Swinley
Fill rates for registered staff have been met within month. The division have undertaken a review of temporary spend to realign to appropriate acuity of patients and bed occupancy, particularly for CSW's. This is reflected in the documented additional shifts for both days and nights.

4 falls and 2 drug administration errors were reported in May with no associated harm and no linkages to shortfalls in staffing.

Rainbow
RN fill rate requirements have been met according to bed occupancy and acuity with additional staffing of CSW's to support 1:1 for Children and Young People, particularly those with mental health needs. Additional shifts for CSW's night have a low fill rate and therefore although not cost effective, it is often necessary to put out requests for RN/CSW to ensure cover.

Maternity Services

Fill rates within Maternity services for registered midwives have been met within month despite the vacancies and sickness rates across the division. There are currently 13 WTE vacancies for

registered midwives across the service, 3 off which have yet to be appointed to. Those appointed are not due to commence in post until September 2021.

The division continues a consultation process with registered midwives with respect to the expansion of the Continuity of Carer provision nationally mandated.

The maternity unit closed for a few hours in month, in accordance with escalation processes due to a shortfall in staffing.

There were 3 reported maternity red flags noted in month associated with the inability to provide a supernumerary labour ward co-ordinator. No patient harms were noted at this time.

Supporting evidence for CNST and Ockenden is due to be submitted to Board in June 2021. As yet there has been no feedback from the bids made for increases in workforce associated with the Ockenden recommendations; this is expected at the end of June 2021.

Vacancies

A Trust wide vacancy report is no longer provided by Finance. Information relating to the overall vacancy situation will be provided in the next report to Board as this information is held divisionally until reports can be obtained from Trac. A timescale for the production of these reports is as yet not available.

International Recruitment

Of the 185 IN's agreed within the business case, 183 have been placed within the divisions. As reported previously, this has resulted in over-establishment within some inpatient areas and the Divisions are currently reviewing options for staff movement to bring clinical areas back within their budgeted establishments.

Bank and Agency Utilisation

Bank and agency utilisation continues to be higher than expected with an increase in overall demand from April to May.

The fill rate for registered staff via NHSP increased to71% in month, whilst agency usage reduced by 2% to 6%. The average lead in time for releasing shifts to NHSP was 24 days, a reduction of 1 day from the previous month, against a target of 42 days which is a slight deterioration from the previous report received. The top 3 reasons for requesting temporary staff are escalation, vacancy and 1:1 care required. Further work has been undertaken within clinical areas to ensure that all unfilled shifts at the point of roster approval are released to NHSP to improve opportunities to fill shifts and to ensure the correct booking reason is provided. Direct booking of agency shifts increased from 8% in April to 17% in May with most direct bookings being initiated across Theatres and the Emergency Department.

The Community Division has continued with work to reduce agency bookings resulting in a reduction in agency usage from 18% in April to 5% in May.

Overall agency expenditure in May 2021 was £133k, a reduction of £69k on the previous month. Bank expenditure in month was £1.5m, an increase of £100k from the previous month.

Review of NHSP request codes is currently being undertaken and is due to report to the NMALT in June2021 led by the Head of Nursing for the Surgical Division.

Roster Utilisation

It has been identified that the E Roster Policy is due for review and amendment where required. The Deputy Chief Nurse is planning to develop an plan for review of systems and processes to enable greater scrutiny and divisional assurance of effective rostering prior to the roster period being worked.

Staff Redeployment

Most staff redeployed as part of the pandemic have now returned to their substantive area of work.

With regards to data on SafeCare there have been 193 staff deployed to other areas in response to patient acuity and short notice absence. The table below provides further divisional detail with regards to redeployment.

Division	Number of staff redeployed	Areas redeployed to
Specialist Services	28	8 to acute medical areas 20 within the division
Surgical Division	3	1 to acute medicine 2 within the surgical division
Medical Division	162	8 to surgical wards 1 to specialist services 2 to CAU 151 across the medical division

Deployment of staff in response to risk within the community division is not included within this report but will be explored in future reports.

CHPPD

CHPPD data from the Model Hospital is provided in Appendix 2 Table 6; this data has not been refreshed since March 2021, and an update will be provided in the next report.

4.0 ACTIONS BEING TAKEN

Expansion of the report to include other services within the Community Division and to develop appropriate quality indicators with benchmarked caseload numbers to support greater triangulation.

Continued focus on the utilisation of temporary staffing with the aim of improving accuracy of reasons for booking and improving lead times for booking to achieve further improvements in fill rates.

Review of e rostering policy and procedures to support effective roster utilisation.

Targeted recruitment events for Theatres across the Trust.

5.0 RECOMMENDATIONS

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

Appendices

Appendix 1 Safe Staffing Exception Reports

May 2021

Division of Medicine – Scheduled Care

	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Vacancies (%) - Registered Nursing Band 5-8	Datix Incidents - related to staffing/Red Flags	CDT	Falls (Harm / No Harm)	PU (Grade 1&2 / Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the hospital staff did everything they could do to control your pain?	Have you been given the care you felt you required when you needed it most?
Acute Stroke Unit	122.4%	169.4%	4.2	171.8%	160.0%	7.2	7.17%	0.00%	0.00%			0/6		0/1		
Astley	136.8%	153.3%	3.9	131.4%	166.0%	6.0	8.18%	0.00%	0.00%			0/3				
Bryn North	100.0%	106.9%	3.1	127.9%	146.1%	5.5	Unable to report as this cost centre is not recorded on FBI or ESR			2		0/3				
Bryn South							Unable to report as this cost centre is not recorded on FBI or ESR									
Coronary Care Unit	193.6%	116.3%	10.1	192.5%	0.0%	3.8	5.52%	1.94%	12.96%	1		0/1				
Highfield							Unable to report as this cost centre is not recorded on FBI or ESR									
Ince	134.2%	103.8%	3.6	138.7%	171.0%	5.1	6.14%	13.80%	23.41%		2	0/4		0/3		
Pemberton	123.4%	100.1%	6.2	165.6%	165.9%	7.2	4.09%	0.00%	0.00%			0/1		0/1		
Shevington	113.6%	102.4%	3.3	158.7%	169.8%	6.4	4.18%	0.00%	10.05%			0/8				
Standish	103.9%	104.7%	3.2	146.0%	190.8%	6.3	3.73%	25.25%	27.13%	1		0/6		1/1		
Winstanley	146.9%	141.5%	9.3	108.3%	143.5%	10.6	8.17%	0.00%	0.00%			0/1				

Division of Surgery

	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Vacancies (%) - Registered Nursing Band 5-8	Datix Incidents - related to staffing/Red Flags	CDT	Falls (Harm / No Harm)	PU (Grade 1&2 / Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the hospital staff did everything they could do to control your pain?	Have you been given the care you felt you required when you needed it most?
ICU/HDU	90.1%	86.9%	41.4	94.4%		4.9	7.18%	0.00%	0.00%					0/4		
Langtree	93.8%	98.9%	2.7	151.8%	193.1%	3.7	7.23%	4.79%	25.67%	4		0/5		0/2		
Orrell	105.1%	99.6%	3.4	121.6%	147.9%	5.7	9.14%	0.00%	4.43%			0/5		0/3		
Swinley	103.2%	111.5%	3.4	129.0%	162.1%	3.4	6.85%	0.00%	6.13%			0/4		0/2		
Maternity Critical Care / Delivery	96.3%	91.9%	2801.2	0.0%	0.0%	0.0	2.27%	4.81%	6.18%					0/1		
Maternity Ward	104.9%	96.3%	2.9	131.0%	150.3%	3.6	7.12%	0.00%	1.08%							
Neonatal Unit	116.9%	130.8%	12.3	114.0%		1.7	2.94%	0.00%	0.00%	1				0/2		
Rainbow	109.7%	105.9%	9.6	162.3%	82.3%	3.9	7.20%	0.00%	0.00%					0/3		

Division of Specialist Services

	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Vacancies (%) - Registered Nursing Band 5-8	Datix Incidents - related to staffing/Red Flags	CDT	Falls (Harm / No Harm)	PU (Grade 1&2 / Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the hospital staff did everything they could do to control your pain?	Have you been given the care you felt you required when you needed it most?
Aspull	109.0%	99.2%	3.4	142.6%	174.3%	6.19	11.46%	14.61%	27.36%	6		0/2		1/3		
Ward A	123.3%	96.5%	4.0	89.8%	104.6%	3.47	2.53%	5.25%	3.57%					0/1		
Ward B	159.6%	113.2%	4.3	102.8%	123.0%	3.76	7.56%	21.80%	19.87%			0/2		1/1		
JCW							12.23%	17.30%	18.01%							

Division of Medicine – Unscheduled Care

	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Vacancies (%) - Registered Nursing Band 5-8	Datix Incidents - related to staffing/Red Flags	CDT	Falls (Harm / No Harm)	PU (Grade 1&2 / Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the hospital staff did everything they could do to control your pain?	Have you been given the care you felt you required when you needed it most?
A&E Emg Care	117.5%	125.7%		160.5%	239.1%		7.67%	11.08%	20.95%	1		0/4				
A&E Paeds	95.4%	101.6%					0.00%	8.48%	8.48%							
A&E NP's	90.1%	0.0%		33.0%	0.0%		12.27%	31.05%	19.28%							
CDW	89.6%	86.8%		92.1%	103.4%		16.22%	9.41%	19.57%							
Lowton	108.2%	102.3%		112.1%	161.5%		12.56%	10.27%	10.21%	1		0/5				
Medical Assessment Unit	87.0%	109.9%		112.2%	145.5%		8.54%	8.78%	25.12%	2	1			0/5		

Division of Community

	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Vacancies (%) - Registered Nursing Band 5-8	Datix Incidents - related to staffing/Red Flags	CDT	Falls (Harm / No Harm)	PU (Grade 1&2 / Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the hospital staff did everything they could do to control your pain?	Have you been given the care you felt you required when you needed it most?
Community Assessment Unit: RAEI							10.2%	0.00%	0.00%			0/6		0/2		

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

Appendix 2

	April 2021		May 2021	
No of areas	Red Metrics Registered Staff Days	Red Metrics Registered Staff Nights	Red Metrics Registered Staff Days	Red Metrics Registered Staff Nights
24	**3**	**3**	**0**	**0**

Table 1. Red Metrics in Inpatient Areas April/May 2021

Month	Registered WTE	B2 Unregistered WTE
March	102	2
April	119.75	0
May	Data not avail	Data not avail

Table 2. Nurse Vacancies Not Appointed to March/May 2021 Trust Wide)

	March 2021	April 2021	May 2021
Specialty	B5 vacancies		
Medicine	17.09	0	
Surgery	14.67	11.88*	
Specialist Services	19.92	20.54	
Community Services	3.96	6.85	
Corporate	0		
Total	**55.64**	**39.27**	

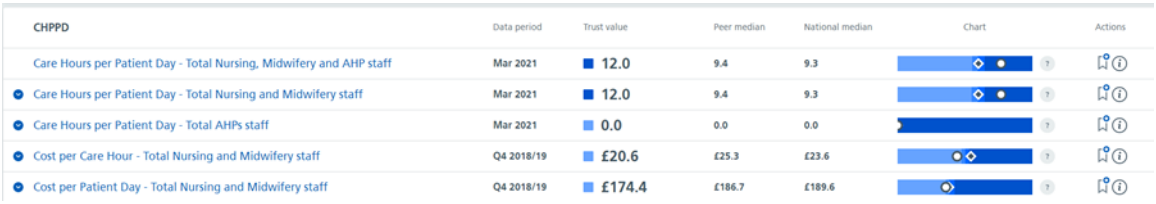
Table 3. B5 Nurse Vacancies March/April 2021 by Division (vacancies have not been reduced to reflect the over-establishment in ICU and Neonatal Unit

Red Flag Category	No. of Incidents March 2021	No. of incidents April 2021	No. of incidents May 2021
Shortfall of more than 8 hours or 25% of registered nurses in a shift	48	48	13
Delay of 30 minutes or more for the administration of pain relief	2	1	5
Delay or omission of intentional rounding	0	2	
Less than 2 registered nurses on shift	13	9	2
Vital signs not assessed or recorded as planned	0	0	
Unplanned omission of medication	0	0	
Total	**63**	**60**	**20**

Table 4. Nursing Red Flags March/May 2021

Red Flag Category	No. of Incidents March 2021	No. of Incidents April 2021	No. of Incidents May 2021
Unit on Divert	0		
Co-Ordinator Unable to Remain Super-numerary	0	1	3
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0		
Delay of 30 or more between presentation and triage	0		
Delay of 2 hours or more between admission for induction and beginning of process	0		
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0		
Total	**0**	**0**	**3**

Table 5. Maternity Red Flags March/May 2021.



CHPPD	Data period	Trust value	Peer median	National median	Chart	Actions
Care Hours per Patient Day - Total Nursing, Midwifery and AHP staff	Mar 2021	12.0	9.4	9.3		
Care Hours per Patient Day - Total Nursing and Midwifery staff	Mar 2021	12.0	9.4	9.3		
Care Hours per Patient Day - Total AHPs staff	Mar 2021	0.0	0.0	0.0		
Cost per Care Hour - Total Nursing and Midwifery staff	Q4 2018/19	£20.6	£25.3	£23.6		
Cost per Patient Day - Total Nursing and Midwifery staff	Q4 2018/19	£174.4	£186.7	£189.6		

Table 6. Use of Resources March 2021 (Source Model Hospital)

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	WWL M3 Balanced Scorecard
Presented to:	Board of Directors
On:	28th July 2021
Presented by:	Medical Director, Chief Nurse, Director of Workforce and Deputy Chief Executive
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.

For this month, a proposed exception page has been included to show example trends for some of the failing metrics within the Activity and Efficiency quadrant with supporting narrative. Should this proposed exception page format be approved, DAA will add the scoping of this work for automation to the DAA Programme schedule and work with each quadrant owner accordingly.

Link to strategy
Patient
Partnership
Workforce

The WWL Way

Site and Service

Risks associated with this report and proposed mitigations

Financial implications
None currently highlighted.

Legal implications
None identified.

People implications
None identified.

Wider implications

Recommendation(s)
The committee is recommended to receive the report, note the content, and advise whether the proposed Exception page is approved, and whether it should be extended for failing metrics in each of the quadrants.

Report: M3 WWL Balanced Scorecard: June 2021

Overall Trust Performance - Balanced Scorecard from 1 April 2021 to 30 June 2021

QUALITY & SAFETY

	Month	ON/OFF Track	Why?
Patient Safety (Safe)			
Never Events	*M01*	*On Track*	*0 in month, 0 YTD*
Number of Serious Incidents	*M01*	*Off Track*	*10 in month, 10 YTD*
Sepsis - Screening and Antibiotic Treatment (Grouped)	*M01*	*Off Track*	***Red Flag:** AE on Track, Ward Off Track* ***Elevated Score:** AE on Track, Ward Off Track*
Serious Pressure Ulcers (Lapses in Care)	*M12*	*Off Track*	*2 Incident in month, 36 YTD (Community & Hospital Acquired)*
Serious Falls	*M01*	*On Track*	*0 in month, 0 YTD*
Infection Prevention and Control (Grouped)	*M01*	*Off Track*	*3 / 6 in month, 3 / 6 YTD; Metrics Off Track*
Clinical Effectiveness (Effective)			
SHMI Rolling 12 months	*M9 2021*	*Off Track*	*Latest position: 112.77*
National Patient Safety Strategy (Grouped)		*Under Development*	
Patient Experience (Caring)			
Complaints Responses	*M01*	*Off Track*	*22.0% M01, 22.0% YTD; Target 90%*
Improved Discharge (Grouped)		*Under Development*	
Patient Experience		*Not Currently Collected*	

ACTIVITY & EFFECTIVENESS

	Month	ON/OFF Track	Why?
A&E Performance (Single)	M03	Off Track	83.13% M02, 86.91% YTD; Target 95%
Cancer Performance (Grouped)	M02	Off Track	2 / 7 in month, 3 / 7 YTD; Metrics Off Track
RTT Performance (18 Weeks)	*M02*	*Off Track*	*61.83% M02, 60.98% YTD; Target 92%*
RTT Performance (52 Weeks)	*M02*	*Off Track*	*2660 patients waiting 52+ weeks*
Diagnostics Patients waiting under 6 weeks	M03	Off Track	88.63% M03, 89.06 YTD; Target 99%
Recovery plan - NHS E/ I	M03	Off Track	3 out of 4 measures achieved
Recovery plan - WWL	M03	On Track	128% of 2019 Activity; Target 90%

PEOPLE

	Month	ON/OFF Track	Why?
Employment Essentials			
Clinical Vacancy Rate	M03	Off Track	6.96% M03, 5.66% M12, 6.96% M11; Target 5.0%
Agency vs NHSI Ceiling	M03	Off Track	£653k M3, £1,304k M12, £643k M11; Target £502K per month
Premium Cost Spend	M03	Off Track	£609k under budget M3, £563k M2; (2.28% over budget)
Go engage			
Your voice scores (engagment enablers, feelings & behaviours)	Q1	Off Track	3.9 Q1, 3.8 Q4, 3.91 Q3; 3.77 Q2; Target 4
Your voice response rate	Q1	Off Track	16% Q1, 18.0% Q4, 12.0% Q3, 19.2% Q2; Target 50%
Route Planner			
Mandatory Training over rolling 12 months	M03	Off Track	91.2% M3, 88.9% M1, 89.9% M11; Target 95%
PDR`s over rolling 12 months	M03	Off Track	75.8% M3, 74.7%M1, 72.7% M11; Target 90% (N.B. Excludes M & D Staff)
Steps for Wellness			
Sickness Abence	M02	Off Track	5.07% M2, 5.38% M12, 7.02% M10, 8.15% M8;
Time Lost due to other unplanned absence	M02	Off Track	1.81% M2, 3.16% M12, 3.21% M10; Target 4%
Covid Risk Assessments	M02	Off Track	91.5% M2, 91.13% M1, 91.11% M11; Target 95%

FINANCE

Financial Position (£000s)

	In Month Actual £000's	In Month Plan £000's	In Month Var £000's	Year to Date Actual £000's	Year to Date Plan £000's	Year to Date Var £000's	H1 Plan £000's	Full Year Plan £000's
Income	39,727	38,349	1,378	113,226	110,660	2,567	221,052	TBC
Expenditure	(39,782)	(38,528)	(1,254)	(110,844)	(108,555)	(2,289)	(213,908)	TBC
Surplus / Deficit	(1,257)	(1,381)	125	(1,283)	(1,503)	220	(70)	TBC
Cash Balance	40,290	35,489	4,801	40,290	35,489	4,801	34,321	TBC
Capital Spend	1,006	770	(236)	2,539	2,504	(35)	6,302	11,022

Reported position : M03

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

Note: Showing June 2021 data where available. *Details in italics where latest month details have not been signed off or been presented to the relevant committee.*

M3 WWL Balanced Scorecard Commentary : June 2021

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)

The Trust had no Never Events since the last Q&S meeting. With regards to Serious incidents, during April 2021 there were 10 incidents escalated to StEIS. These have included 5 hospital acquired pressure ulcers, 1 community acquired pressure ulcer and 4 maternity incidents. It is important to note that 3 of the maternity incidents have been retrospectively reported following review by HSIB. There continues to be a high number of pressure ulcers reported. All reportable pressure ulcers continue to be discussed at the pressure ulcer review panel.

Clinical Effectiveness (Effective)

In relation to the Trust's SHMI figures, this shows that the Trust has improved it's figures, however further work is underway to improve this indicator.

Patient Experience (Caring)

Work continues in relation to addressing the backlog of complaint responses following the pause in the formal complaints process during the pandemic and the knock-on effect. Divisions have worked to reduce the numbers and this continues. Complaint workshops have been held, led by the Deputy Chief Nurse, to better align the divisional processes to ensure consistency in approach. The Head of Compliance has arranged further "A journey through complaints and communication using empathy" for 14 and 28 July provided by an external trainer. These will be the fifth and sixth full day sessions provided in the last 8 months.

In the month of April 2021, there were 50 complaints due a response based on the timeframe agreed with the complainant. Of these, 11 were achieved within the timeframe agreed which equates to 22%. Work is underway corporately and divisionally to reduce the number of overdue complaint responses as well as focussing efforts on those responses which are coming for being due. There were no contacts in the month of April from the PHSO. The main subject for the formal complaints received were clinical treatment , with communication (4) and Discharges (3).

For the month of May 2021, there were 39 complaints which were due a response, of which 12 were responded to within the timescales agreed with the patient or their loved one at the start of the process. This equates to 31% which is an improvement on the previous month but still short of the target. The main subjects of new formal complaints received in May were clinical treatment, with communication (6), Values and Behaviours (6), Patient Care (4). There was no contact from the PHSO during May.

In relation to June's complaints response performance, 9 out of 35 complaints which were due a response were responded to within the timescale agreed with the patient or their loved one; this equates to 26%. There were no contacts from the PHSO in this timeframe. For the month of June 2021, clinical treatment remains the majority of concerns raised; with Values and behaviours (8), patient care (6), Trust Admin/ policies/procedures including patent record management (5), Communications (5) – there was also concerns in respect of waiting times (4).

ACTIVITY & EFFECTIVENESS

COVID:

The number of daily new cases of COVID-19 continues to Increase. Data from early July show that Wigan Borough and parts of Greater Manchester (GM) are all reporting a higher number of daily new cases than during the peak of December-January 2021. The recent confirmation that remaining restrictions will be relaxed on 19th July is likely to fuel a further increase in community infections. Although hospital Covid occupancy rates are gradually increasing across Greater Manchester, the proportion of patients hospitalised is lower than in previous waves. During this fourth wave, the Trust continues to request mutual support through GM Gold Command for the transfer of Critically Care patients when demand exceeds capacity.

Scheduled Care

The Trust continues to follow national guidance to facilitate prioritisation of patients based on clinical risk. Assurance is gained from the reducing number of patients both on the Priority 2 list and those waiting over 52 weeks. However, within some specialties non-urgent demand continues to grow, further compounded by higher volumes of urgent referrals, staffing constraints and reduced capacity due to infection prevention guidance. The Trust continues to work closely with Greater Manchester Clinical Reference Groups (CRG) established within those specialties facing the biggest challenge in relation to waiting times. Discussions have been initiated with each CRG regarding additional waiting list initiatives each Trust could deliver, the expectation being that this will be funded via the Elective Recovery Fund along with the belief that Integrated Care Systems will continue to develop plans to support elective recovery including during times of further urgent care pressures (e.g., over winter). The development of elective hubs that can maximise the use of available capacity and protect delivery of Green pathways remains a priority. Wrightington is it at the forefront of these developments having been named the High-volume Low acuity Elective Hub for orthopaedics, collaboration has already commenced.

Unscheduled Care

During 2020, in response to the pandemic, Greater Manchester (GM) wide Urgent and Emergency Care (UEC) service redesign was expedited. However, despite investment in new services to manage demand e.g., 111 First and GM Clinical Assessment Service, emergency demand has returned to pre-pandemic levels across many localities. A range of causes for the rise in demand is being described by system leaders. In May 2021, the Greater Manchester Utilisation Management (UM) Unit was asked to support the delivery of the Greater Manchester wide Accident and Emergency Department (A&E) patient survey with the aim to understand the reasons why people choose to attend A&E. The final report suggests that in the main the increase is within expected range given the year-on-year increase, 2020 being an exception due to Covid-19. The report findings go on to say that numbers at most Type 1 A&E sites across Greater Manchester have returned to expected trend, however two main variations are called out in the report; One Greater Manchester provider as having below expected levels and Royal Albert Edward Infirmary numbers being 'significantly' higher than forecast. The GM wide survey has been presented to the locality leads and a Wigan borough specific report is expected imminently. In the meantime, we continue to do all we can to support staff in A&E who are working hard to manage unprecedented demand.

PEOPLE

Employment Essentials

Recruitment has continued, including international with the re-opening of India for recruitment. Work is ongoing to identify a new means to record and report vacancies, which means the data included may not be completely accurate. The patchwork business case has been approved and work is ongoing to implement from September. This work should further reduce temporary spend on medical workforce.

Go Engage

Work is progressing on the 4 themes under Our Family, Future, Focus. This will be launched to the organisation at a Town Hall event at the end of July. Analysis of the Your Voice data shows that these programmes of work remain the areas for prioritisation and KPIs to monitor progress are being agreed in each workstream.

Route Planner

Progress continues to be made towards the end of September target date for mandatory training completion. Pay progression aligned to mandatory training completion is to be re-instated from October. Divisions will be reporting their progress against their recovery trajectory through performance reviews.

Steps 4 Wellness

Sickness levels continue to decrease and this is most notable in the areas and staff groups where targeted interventions have been put in place. The outline business case to sustainably deliver the stepped care model for physical and mental health to meet the level of demand (which will be self funding through sickness absence reduction, presenteeism reduction and associated temp spend reduction) will be submitted to BCOG in August. Unplanned absence associated with covid (special leave, self isolation and sickness) are now increasing aligned to increasing levels of the Covid-19 virus in the community. This is most notable for school bubble closures, which should be addressed through the new arrangements post July 19th.

FINANCE

(Relates to: Financial Position (£000s) - Income, Expenditure, Surplus / Deficit, Cash Balance & Capital Spend)

In month 3, the Trust reported a deficit of £1.3m, which was £0.1m favourable to plan.

Cash is £40.3m at the end of month 3 which is £4.8m above the plan.

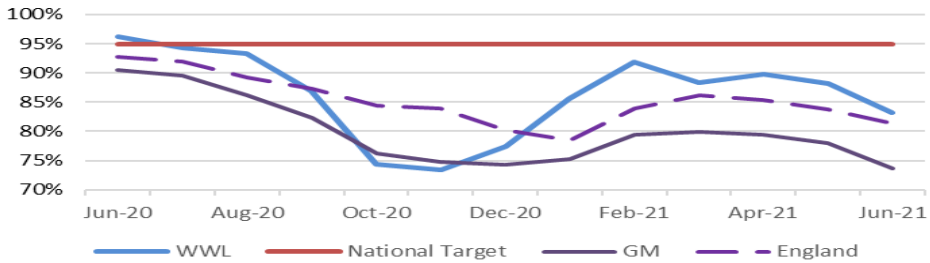
Capital expenditure is £1.0m for month 3 which is £0.2m above plan. Year to date, capital expediture is £2.5m and on plan.

Please see the monthly finance report for further commentary.

Note: Relating to June 2021 where available, or the latest details that have been signed off or presented to the relevant committee.

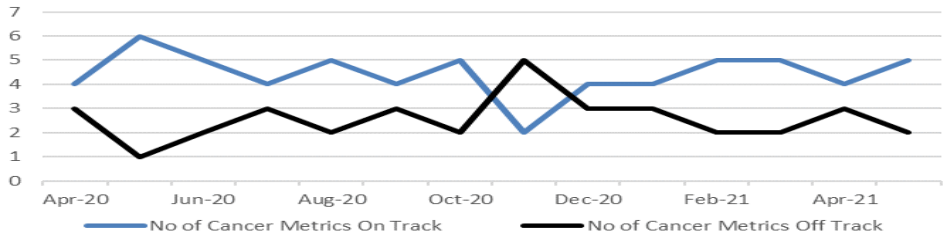
Scorecard Exception Reporting

Metric : A&E Performance (Single)



Narrative and Planned Actions :
Current in month performance is 83.1%; performance remains challenging in part, due to the sustained increased number of A&E attendances - over 14,000 patients attended A&E and Leigh Walk in Centre during both May and June 21.
Nationally in June, WWL ranked 38th out of 111 Acute Trusts with published data, and remain above the national average of 81.3%. WWL retained first place in the GM rankings during the month.

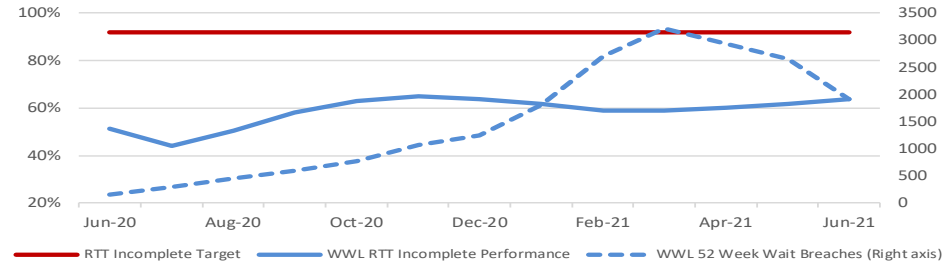
Metric : Cancer Performance : Grouped



Narrative and Planned Actions :
The chart to the left tracks the number of cancer metrics on and off track.
The failed cancer metrics (reported 1 month in arrears) relate to the following targets: 62-day cancers: First treatment from urgent GP referral; performance during May 71.67% compared to a target of 85%.

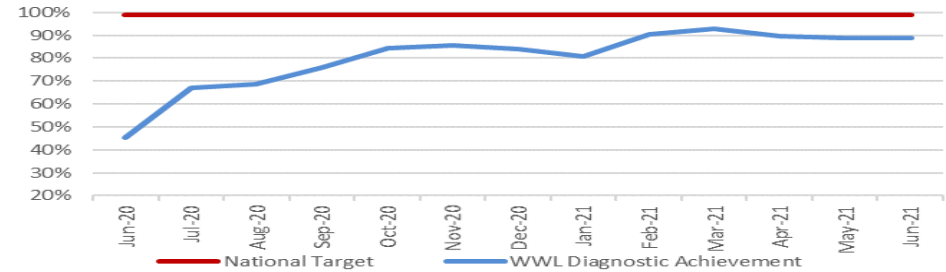
31 Day Standard (Diagnosis to First Definitive Treatment) – Performance 90.65% compared to a target of 96%.

Metric : RTT Performance (18 weeks)



Narrative and Planned Actions :
The Overall 18 Weeks Waiting List continues to grow. Despite this increase, the Trust has seen the number of patients waiting over 52 weeks for treatment drop for the third consecutive month, reducing by 24% since the start of the financial year. This, combined with a 7% financial year-to-date decrease in the amount of Priority 2 patients waiting for treatment, shows that the Trust's current elective strategy is working and that the growth of the waiting list is due to an increase in new RTT referrals.

Metric :Diagnostics Patients waiting under 6 weeks



Narrative and Planned Actions :
Most diagnostic areas experienced a decline in performance during the Covid period but have seen improvements over the last few months. For June 21 our overall performance was 88.6% against a target of 99%.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Monthly Trust Financial Report – Month 3 (June 2021)
Presented to:	Board of Directors
On:	28th July 2021
Presented by:	Chief Finance Officer
Prepared by:	Senior Finance Team
Contact details:	E: ged.murphy@wwl.nhs.uk

Executive summary

	In Month			Year to Date		
	Actual £000's	Plan £000's	Var £000's	Actual £000's	Plan £000's	Var £000's
Income	39,727	38,349	1,378	113,226	110,660	2,567
Expenditure	(39,782)	(38,528)	(1,254)	(110,844)	(108,555)	(2,289)
Financial Performance	(1,295)	(1,370)	75	(1,288)	(1,468)	179
Cash Balance	40,290	35,489	4,801	40,290	35,489	4,801
Capital Spend	1,006	770	(236)	2,539	2,504	(35)

Key Messages:

- The Trust has agreed a balanced budget for the first half (H1) of 2021/22 with the Greater Manchester (GM) system and NHSE/I.
- The block contract and system top up funding arrangements have been extended for H1, as national tariff remains suspended.
- In month 3, the Trust reported a deficit of £1.3m, which was £0.1m favourable to plan. Year to date, the Trust is reporting a deficit of £1.3m which is £0.2m favourable to plan.

The WWL Way

- Cash is £40.3m at the end of Month 3.
- Capital spend is £1.0m in month and £2.5m year to date.

YOUR VOICE SURVEY

Staff Engagement Survey

Quarterly Pulse Check Report

(June 2021)

Contents

Executive Summary

The information contained within this report has been generated from the responses given by staff employed by WWL in May 2021, to the Your Voice staff engagement survey. The survey was launched on 07/05/2021 and was open for 20 days, closing on 26/05/2019. The overall response rate was 16% based on 913 completed out of 5710 invited. This was a -2% decrease on last quarter's response rate of 18%.

Due to the low response rate, results should be interpreted with caution as they may not be representative of the whole staff group. Work is needed to improve response rates which averaged at 17% in 2020.

Overall engagement for this quarter is 3.90 out of 5. This is compared to 3.93 in February 2021. Overall engagement has remained stable between 3.90 and 3.93 over the previous four quarters. This is a good score and positive that engagement has fluctuated very little since June 2020.

Trust (4.02), Work Relationships (3.92) and Resources (3.73) continue to be the highest scoring enablers. Perceived Fairness (3.45), Influence (3.39) and Recognition (3.32) continue to be the lowest scoring enablers, however these are not low scores.

Resources (3.73), Clarity (3.67), Perceived Fairness (3.45) and Advocacy (3.91) have all significantly decreased since last quarter, however these are not low scores. Resources is significantly higher than in Q1 last year (Jan 2020). Whilst we saw positive results in Q4, the decrease in some scores may seem disappointing this quarter, however the journey to improve scores over time will not be linear and the benefits of some the actions from previous surveys will not yet have been realised. The launch of the new strategy and corporate objectives this quarter may help to improve Clarity.

Overall, the scores are still 'good' with several 'strong' areas and many bordering on positive e.g. work relationships almost 4, focus almost 4, adaptability and advocacy above 3.90.

Our family, our focus, our future, will help to drive engagement scores at Trust and divisional level, via from senior managers to shape and implement actions as well as improve response rates.

Friends and Family Scores

- Staff recommending the Trust as a place to work has decreased from 69.66% last quarter to 67.58% this quarter
    - The Corporate division scored highest (74.52%)
    - The Specialist Services division scored lowest (62.89%)

Top reasons to recommend the Trust as a place to work include 'a great place to work'; 'staff are well supported' and 'I enjoy my job'. Top reasons not to recommend the Trust as a place to work include 'staff are not treated fairly'; 'poor working relationships' and 'staff are not valued'.

- Staff recommending the Trust as a place for care or treatment has also decreased from 77.49 % in the previous quarter to 73.27% this quarter
    - The Specialist Services division scored highest (77.78%)
    - The Medicine division scored lowest (67.78%)

Top reasons to recommend the Trust as a place to receive care include previous personal experience of excellent care/treatment; high standards of care and caring and dedicated staff. The top reason not to recommend the Trust as a place to receive care was previous experience of a friend/relatives' poor care.

Group Differences

The **Corporate** division and **Estates and Facilities** division continue to score significantly higher than other divisions across a number of enablers this quarter. The **Surgery** division scored significantly lower than other groups on Influence (3.23), Recognition (3.14) and Work Relationships (3.82). The latter was also a lower scoring area last quarter for Surgery. Whilst this is not a low score, some comments suggest that there may be issues with working relationships that could be addressed.

Nursing and Midwifery continue to score significantly lower compared to other staff groups. Lots of actions have been put in place to support this group of staff since December 2020, including rapid access to mental health support, recruiting non-clinical staff to support nurses on wards via the Government's Kickstart scheme and leadership support circles to listen to and normalise experiences. Comments reflect that some nursing staff feel a lack of support from senior management, staffing issues, workload and staffing skill mix. Influence (3.26), Recognition (3.20) and Energy (3.25) are the lowest enablers for this group, so efforts should focus on listening and acting on feedback from this group of staff, recognising their contribution to the organisation and ensuring that well-being support continues to be a priority for this group of staff.

Scientific and Technical staff and **Admin and Clerical** staff scored significantly higher across several engagement enablers.

Positively this quarter, **Wrightington** is no longer a negative outlier when compared to other sites. Staff based in the **Community** are reporting significantly lower scores for **Resources** (3.58), although this is not a low score.

Recommendations

All key recommendations from the previous survey continue to be relevant to support staff engagement both at Trust level and targeted action where needed.

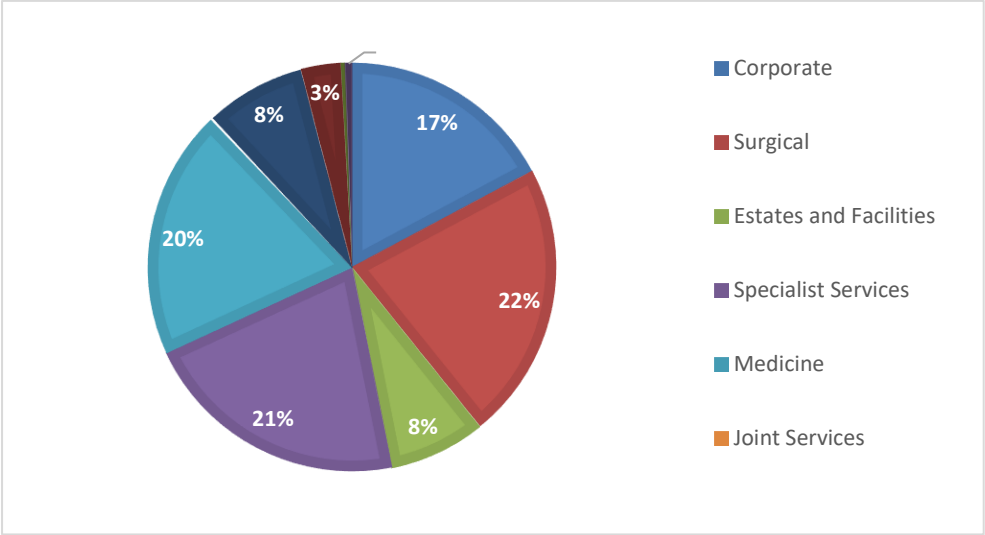
- Response rates - Senior managers and internal communications to support promotion of the survey and dissemination of results.
- Communications - More feedback should be shared with staff about what happens with survey results and 'you said, we did' communications, so that we demonstrate actions that are happening as a result of staff survey feedback and explaining why changes are not possible if this is the case. The Communications priority theme of Our Family, Our Future, Our Focus, led by Director of Communications, will support this.
- Continue work to support Nursing and Midwifery staff and those staff who are returning to their substantive roles from redeployment elsewhere in the Trust.
- Review feedback from staff who were redeployed as part of a learning process to identify where this could be improved should there be a requirement to redeploy staff again, or for staff to support other areas of the Trust
- Engagement with the workforce in relation to reward and recognition – e.g. Long Service Award
- Design and roll-out of Executive Shadowing Scheme

- Re-launch of Go Engage Teams to build Influence and Recognition at local level. Several teams have expressed an interest and the programme will launch this summer
- Actions from staff forums will continue to be addressed
- Psychological Safety and Just Culture pilot programme – this work will support staff engagement, via Influence (feeling safe to speak up, share ideas etc) and promoting positive Working Relationships and tackling negative behaviour

Response Rates

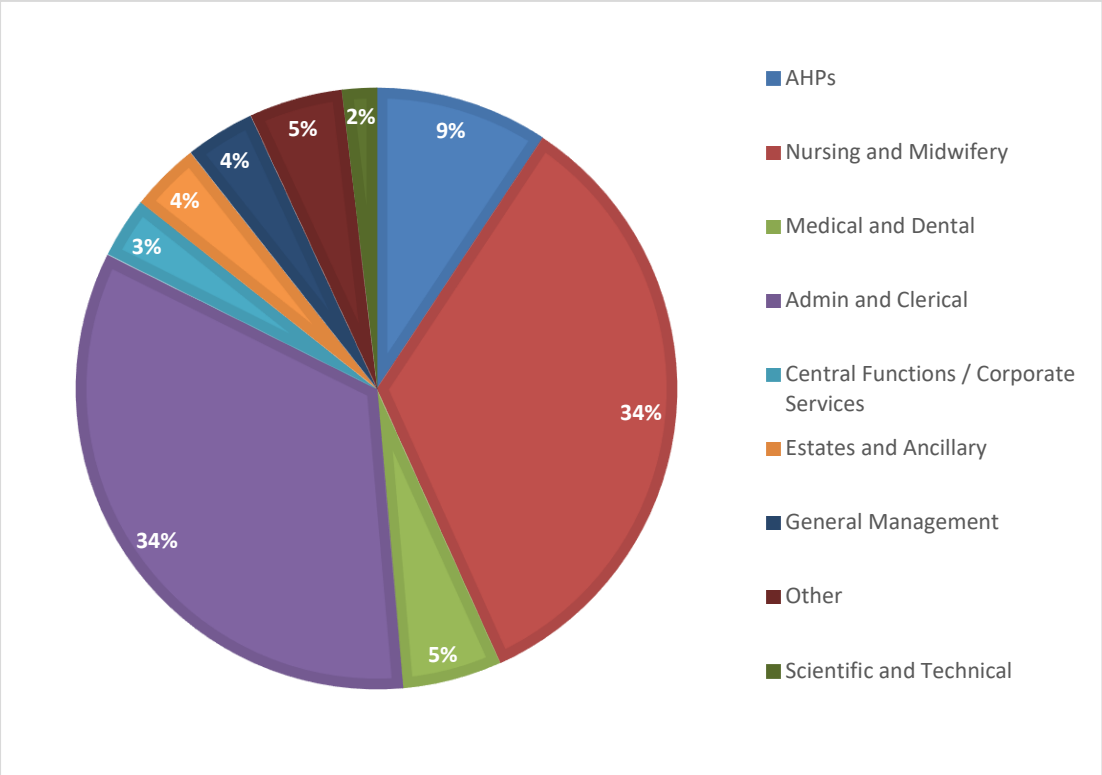
The survey was launched on 07/05/2021 and was open for 20 days, closing on 26/05/2019. The overall response rate was 16% based on 913 completed out of 5710 invited. This was a -2% decrease on last quarter's response rate of 18%. The figures below outline the proportional split of responses across Divisions, Staff Groups, Job Grades, Sites and Length of Service.

Figure 1 and Table 1 : Proportional split of responses across Division.



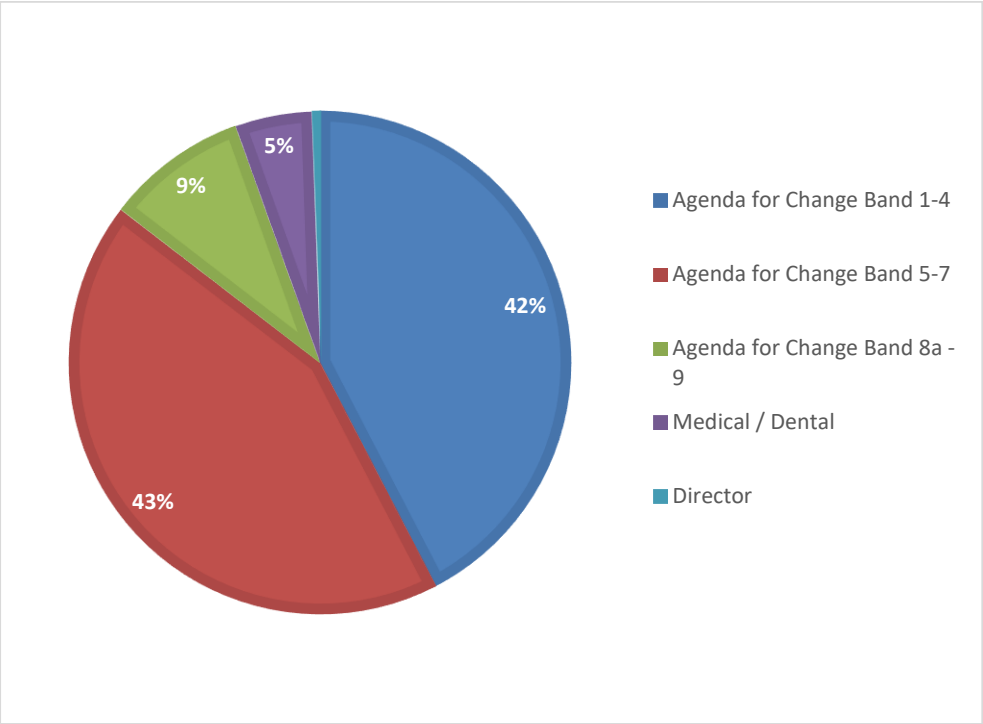
Division	Number Invited	Number of Responses	% Split of Responses	Response Rate
Corporate	572	157	17%	27%
Surgical	1341	201	22%	15%
Estates and Facilities	595	70	8%	12%
Specialist Services	1072	194	21%	18%
Medicine	1322	180	20%	14%
Joint Services	0	2	0%	-
Community - Adults'	513	72	8%	14%
Community - Children's	266	29	3%	11%
Community Learning Disability Team	29	3	0%	10%
Redeployment	0	5	1%	-
Total	5710	913		16%

Figure 2 and Table 2 : Proportional split of responses across Staff Group.



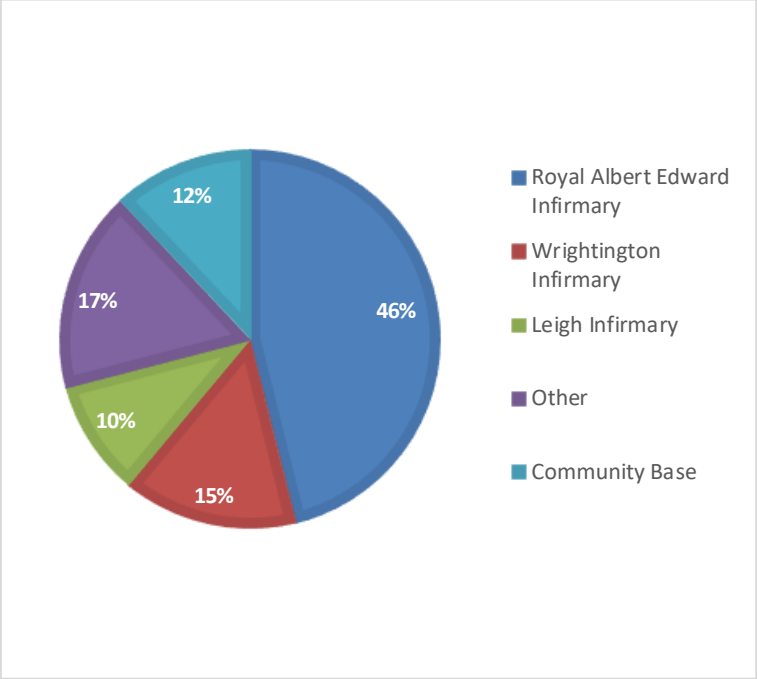
Staff Group	Number of Responses	% Split of Responses
AHPs	85	9%
Nursing and Midwifery	310	34%
Medical and Dental	49	5%
Admin and Clerical	308	34%
Central Functions / Corporate Services	30	3%
Estates and Ancillary	34	4%
General Management	34	4%
Other	46	5%
Scientific and Technical	17	2%
Total	913	

Figure 3 and Table 3: Proportional split of responses across Job Grade.



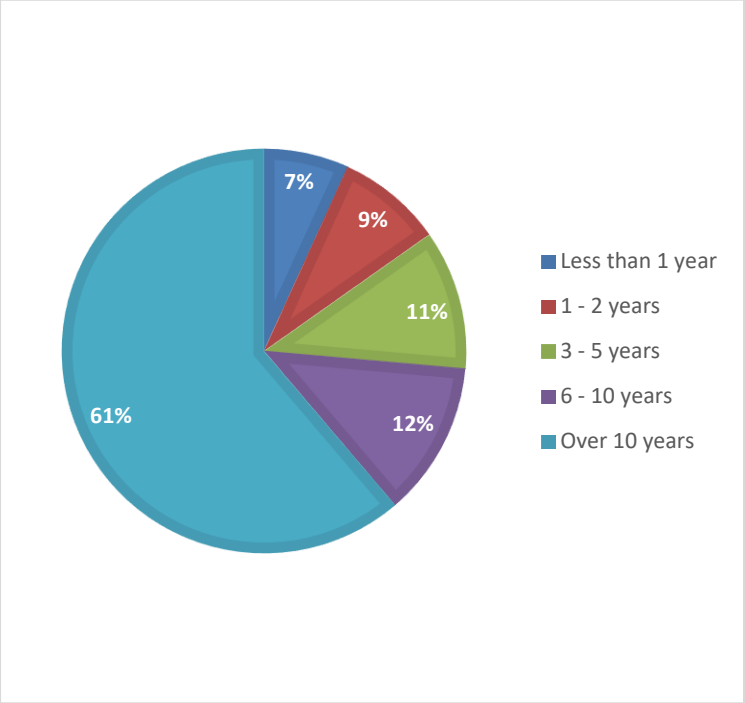
Job Grade	Number of Responses	% Split of Responses
Agenda for Change Band 1-4	387	42%
Agenda for Change Band 5-7	393	43%
Agenda for Change Band 8a - 9	83	9%
Medical / Dental	45	5%
Director	5	1%
Total	913	

Figure 4 and Table 4: Proportional split of responses across Site.



Site	Number of Responses	% Split of Responses
Royal Albert Edward Infirmary	421	46%
Wrightington Infirmary	132	14%
Leigh Infirmary	88	10%
Other	156	17%
Community Base	116	13%
Total	913	

Figure 5 and Table 5: Proportional split of responses across Length of Service.



Length of Service	Number of Responses	% Split of Responses
Less than 1 year	62	7%
1 - 2 years	77	8%
3 - 5 years	102	11%
6 - 10 years	113	12%
Over 10 years	559	61%
Total	913	

Summary Overview

This Quarterly Pulse Check survey used 47 questions to measure several key factors associated with levels of staff engagement, and factors that are perceived by staff to enable or block their engagement. The results from the survey have been analysed and summarised within this report as follows:

Feeling engaged at WWL:

- **Energy** – the extent to which staff feel willing to invest energy into their work.
- **Dedication** – the extent to which staff feel strongly involved in their work, experiencing a sense of purpose, inspiration, pride and commitment.
- **Focus** – the extent to which staff feel fully engrossed in their work.

Engagement related behaviours demonstrated at WWL:

- **Discretionary effort** – the extent to which staff go beyond their role responsibilities to help others and more generally the organisation.
- **Persistence** – the extent to which staff demonstrate effort over time and perseverance through challenges.
- **Adaptability** – the extent to which staff respond to changes quickly and successfully.
- **Advocacy** – the extent to which staff have a positive view of the organisation, and are willing to recommend the organisation to others.

Work Relationships - the extent to which staff perceive support from their line manager and colleagues
Resources - the extent to which staff believe they have the necessary tools, training and equipment required to do their work.
Clarity - the extent to which staff have a clear understanding of what is expected of them, what the organisation's objectives are, and what is going on in their place of work.
Mindset - the extent to which staff are encouraged to believe in themselves, believe in moving forwards, and have a positive state of mind.
Personal Development - the extent to which Staff perceive opportunities for personal growth or experience opportunities to use their strengths.
Influence - the extent to which staff are involved in wider decisions that may impact upon them.
Recognition - the extent to which staff receive recognition and perceive their contributions are valued.
Perceived Fairness - the extent to which staff perceive fair treatment within the organisation
Trust - the extent to which staff are trusted with responsibility and freedom to act.

There is vast research evidence to suggest that increasing staff engagement can lead to outcomes such as reduction in sickness absence, reduction in staff turnover, increase is staff performance, improvement in quality of patient care and improvements in safe practice.

Results Dashboard

Figure 6 shows the overall picture of staff engagement across the organisation, based on a five-point Likert scale. The findings are presented using the 'Staff Engagement Pathway' model as a framework.

Figure 6: Results Dashboard

Scale

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

	Scores on average positively
	Scores on average moderately
	Scores on average negatively

⇧⇩	The average score has significantly increased/decreased since the previous quarter
⬆⬇	The average score has significantly increased/decreased since the previous year

Positive Scores

Figure 7 shows the percentage of positive scores achieved on all measures of staff engagement enablers.

Figure 7: % of positive scores for each measure of staff engagement enabler, comparing Jan 20 Q4 – May 21 Q1.

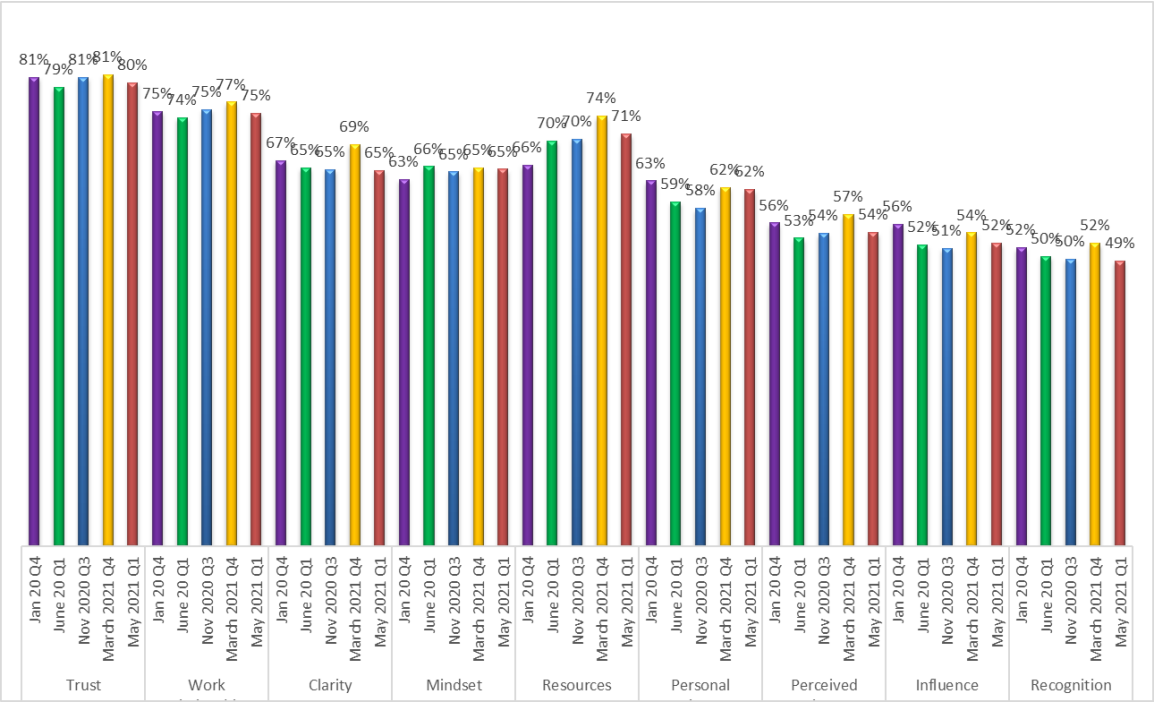
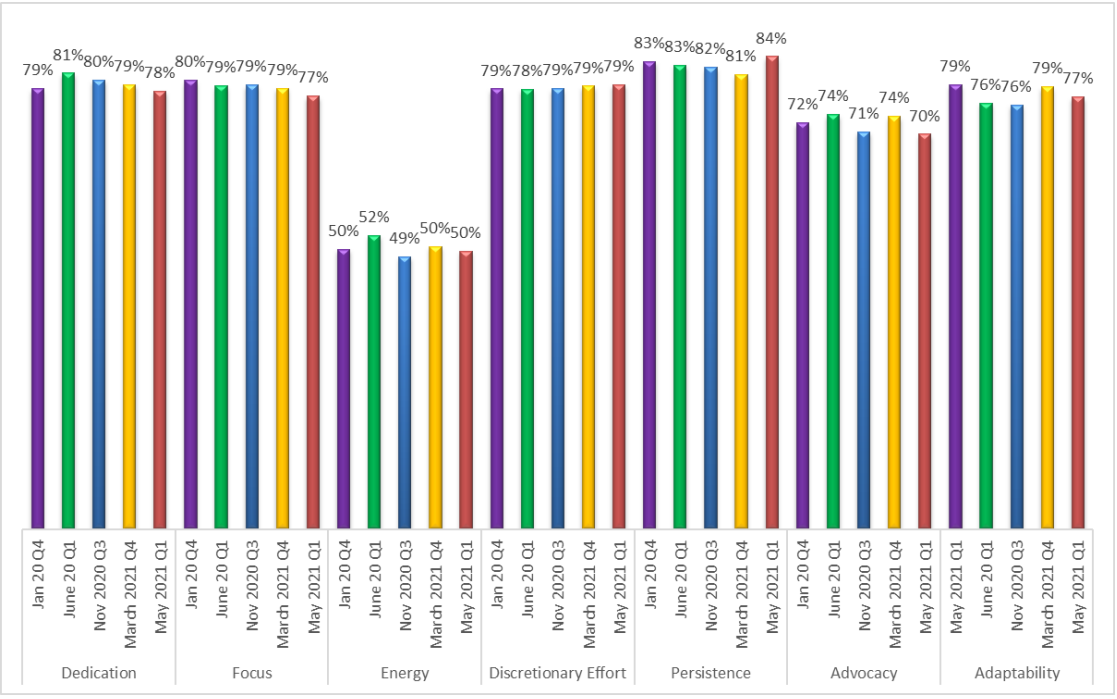


Figure 8 shows the percentage of positive scores achieved on all measures of staff engagement.

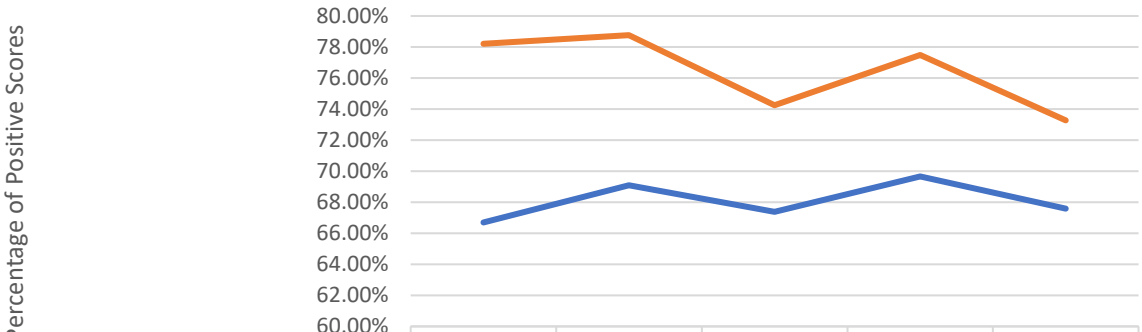
Figure 8: % of positive scores for each measure of staff engagement, comparing Jan 20 Q4 – May 21 Q1.



Staff Friends and Family Test

The following figures show the results for the staff Friends and Family Test questions, for each quarterly survey.

Figure 9: % of positive scores for questions on the staff "Staff Friends and Family Test":



	Jan 20 Q4	June 20 Q1	Nov 2020 Q3	March 2021 Q4	May 2021 Q1
How likely are you to recommend the Trust to friends and family as a place to work?	66.70%	69.10%	67.38%	69.66%	67.58%
How likely are you to recommend the Trust to friends and family if they needed care or treatment?	78.20%	78.76%	74.25%	77.49%	73.27%

A total of 165 staff gave reasons for why they would be likely to recommend to friends and family if they needed care or treatment. Their reasons included:

Previous personal experience of excellent care/treatment x23
Caring and dedicated staff x23
High standards of Care x22
Previous experience of a friends/relative's excellent care/treatment x17
Excellent staff in general x13
Overall an excellent Trust x8
Depends on the department/treatment required x8
I am familiar with the Trust x7
Enjoy my job x6
Strong patient focus x6
Local x4
Forward thinking and improving x4
Experienced, knowledgeable staff x4
I trust my colleagues to provide good care x3
Patient Feedback x3
Better than other Trusts x3
Good services x3
Cleanliness x2
Safe x1
Supported by manager x1
My team provide an excellent service x1
An organised Trust x1
Well managed x1
Caring staff x1

A total of 46 staff gave reasons for why they would not be likely to recommend to friends and family if they needed care or treatment. Their reasons included:

Previous experience of a friends/relative's poor care/treatment x10
Poor leadership x4
Poor staff x4
Pandemic x2
No Choice x2
Not learning from mistakes x2
Work pressures x2
Staffing levels x2
Previous personal experience of poor care/treatment x2
Poor standards of care x2
Not sufficiently informed to recommend x2
Not my local Trust x2
Not feeling listened to x1
Personal choice x1
Poor staff commitment x1
Outcomes x1
Poor Communication x1
Waiting times/ lists are high x1
The environment x1
Targets are prioritised before patients x1
More resources are needed x1
Depends on the department/treatment required x1

A total of 196 staff gave reasons for why they would be likely to recommend to friends and family as a place to work. Their reasons included:

I enjoy my job x24
A great place to work x26
Staff are well supported x25
It's a friendly Trust/WWL family x17
Depends on the department/area x16
Training and development opportunities x14
Excellent Colleagues x9
Job security x7
Familiar with the Trust x5
Personal Choice x5
Well led/good leaders x5
Fair x4
High standards of care x4
Job opportunities x4
Flexible x4
Previously recommended x4
Staff are valued x3
Staff benefits x3
Safety is a priority of the Trust x2
This Trust is better than other Trusts x2
Forward thinking and improving x2
Staff teamwork x2

Good communication x2
The Trust lives by its values x1
Good pay x1
Local x1
Resources x1
Good policies x1
Well organised x1
Good feedback x1

A total of 183 staff gave reasons for why they would not be likely to recommend to friends and family as a place to work. Their reasons included:

Staff are not treated fairly x26
Poor working relationships x18
Staff are not valued x17
Lack of training/development opportunities x15
Poor management/leadership x15
Staff are not supported x13
Staffing levels x10
Not listened to x9
Lack of resources/poor resources/facilities x8
Exhausting job/workload/pressure x7
Low staff morale x7
Trust culture x7
Poor communication x6
Depends on the department/area x5
Poor pay x4
Stressful job x4
I don't enjoy my job x3
Staff are not involved in decision making x3
Poor care x3
Not sufficiently informed to recommend x1
Uncertain future of the Trust x1
Discrimination x1

Trends

Areas of staff engagement that score on average positively and have been sustained over 12 months:

Table 6: Average scores at 4 or above on the five point likert scale are deemed positive:

Measure	Item	Jan 20 Q4	June 20 Q1	Nov 20 Q3	March 21 Q4	May 21 Q1
Feeling	Dedication: I feel proud to work for this area/team/department.	4.08	4.16	4.13	4.13	4.09
Behaviour	Persistence: At my job I always persevere, even when things do not go well.	4.21	4.20	4.21	4.19	4.22
Behaviour	Discretionary Effort: I go beyond my role responsibilities to help my colleagues when required.	4.42	4.42	4.43	4.43	4.40
Behaviour	Discretionary Effort: I always act upon opportunities to show initiative in my role.	4.14	4.15	4.18	4.17	4.14
Behaviour	Advocacy: How likely are you to recommend the Trust to friends and family if they needed care or treatment?	4.12	4.12	4.06	4.14	4.01
Enabler	Trust: I am trusted to do my job.	4.24	4.20	4.27	4.26	4.20
Enabler	Work Relationships: I am satisfied with the level of support I get from my work colleagues.	4.05	4.02	4.07	4.09	4.04
Enabler	Work Relationships: The people I work with cooperate to get the job done.	4.06	4.04	4.07	4.07	4.04
Enabler	Clarity: I always know what my work responsibilities are.	4.18	4.06	4.14	4.18	4.12

Table 7: Areas of staff engagement that have significantly improved over 12 months:

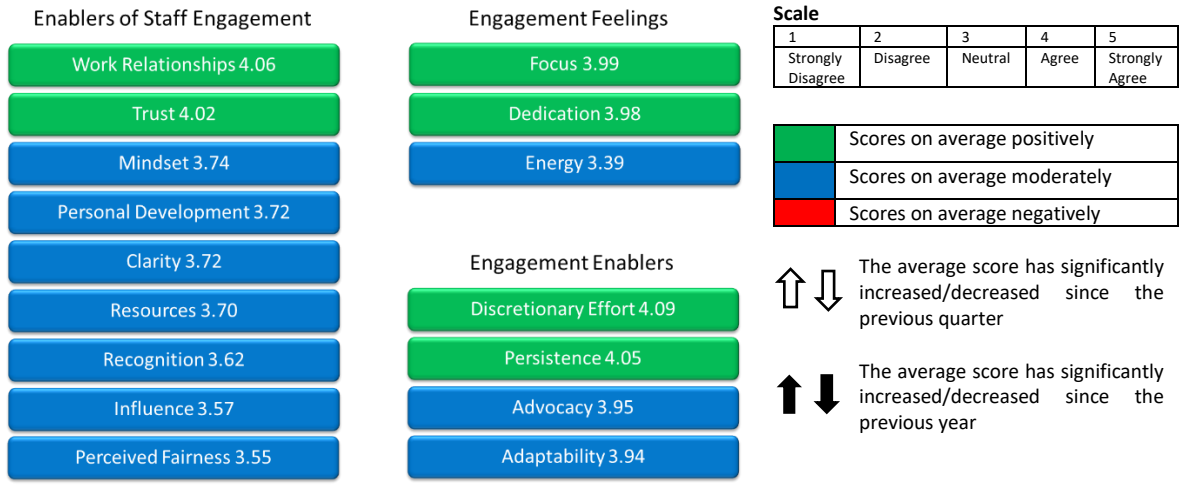
Measure	Item	Jan 20 Q4	June 20 Q1	Nov 20 Q3	March 21 Q4	May 21 Q1
Feeling	Energy: At work I feel full of energy.	3.26	3.39	3.28	3.31	3.26
Enabler	Resources: I have adequate materials, supplies and equipment to do my work.	3.34	3.59	3.57	3.72	3.59
Enabler	Mindset: I feel confident in the future of the Trust.	3.49	3.61	3.61	3.66	3.60

Table 8: Areas of staff engagement that have significantly declined over 12 months:

Measure	Item	Jan 20 Q4	June 20 Q1	Nov 20 Q3	March 21 Q4	May 21 Q1
Behaviour	Advocacy: How likely are you to recommend the Trust to friends and family if they needed care or treatment?	4.12	4.12	4.06	4.14	4.01
Enabler	Trust: I am satisfied with the level of freedom to choose my own method of working.	4.05	3.95	4.06	4.04	4.00
Enabler	Clarity: I always know what my work responsibilities are.	4.18	4.06	4.14	4.18	4.12
Enabler	Clarity: I have clear, planned goals and objectives for my job.	3.99	3.89	3.96	4.01	3.94
Enabler	Clarity: The Trust communicates clearly with staff about what it is trying to achieve.	3.54	3.53	3.53	3.67	3.31
Enabler	Perceived Fairness: Overall the Trust is fair in the way it treats and rewards its staff.	3.28	3.19	3.16	3.32	3.21
Enabler	Perceived Fairness: Decisions about people are made using fair procedures.	3.24	3.15	3.16	3.29	3.19
Enabler	Influence: The Trust encourages staff to suggest new ideas for improving services.	3.63	3.49	3.49	3.57	3.47

Results: Corporate

Number invited to complete the survey:	**572**	**Number completed:**	**157**	**Response Rate:**	27%
Level of engagement: Average percentage of positive scores across all measures of engagement = 75.52%					
Staff Friends and Family Test • 74.52% of staff would be happy with the standard of care provided by the Trust if a friend or relative needed treatment • 74.52% of staff would recommend the Trust as a place to work					



Highest / Lowest Scoring Enablers

Five Highest Scoring Enabler Items		
Item	**This Group**	**All Other Groups**
Trust: I am trusted to do my job.	4.18	4.21
Work Relationships: I am satisfied with the level of support I get from my work colleagues.	4.14	4.02
Work Relationships: The people I work with cooperate to get the job done.	4.11	4.02
Trust: I am satisfied with the level of freedom to choose my own method of working.	4.06	3.99
Perceived Fairness: My immediate manager treats me fairly.	4.05	3.92

Five Lowest Scoring Enabler Items		
Item	**This Group**	**All Other Groups**
Influence: The Trust acts on staff feedback.	3.17	3.07
Clarity: The Trust communicates clearly with staff about what it is trying to achieve.	3.26	3.32
Perceived Fairness: Decisions about people are made using fair procedures.	3.29	3.16
Perceived Fairness: Overall the Trust is fair in the way it treats and rewards its staff.	3.31	3.19
Recognition: I feel satisfied with the extent the organisation values my work.	3.39	3.11

	Positive finding in relation to other groups (group results scored significantly higher than other groups for this survey)		**Finding that is typical of all groups for this survey** (finding that is typical of all other groups for this survey)		**Negative finding in relation to other groups** (group results scored significantly lower than other groups for this survey)

Compared to the last survey (Feb 21 Q4), there has been a significant improvement in:

No significant improvements

Compared to last year (Jan 20 Q4), there has been a significant improvement in:

No significant improvements

Compared to the last survey (Feb 21 Q4) there has been a significant decline in:

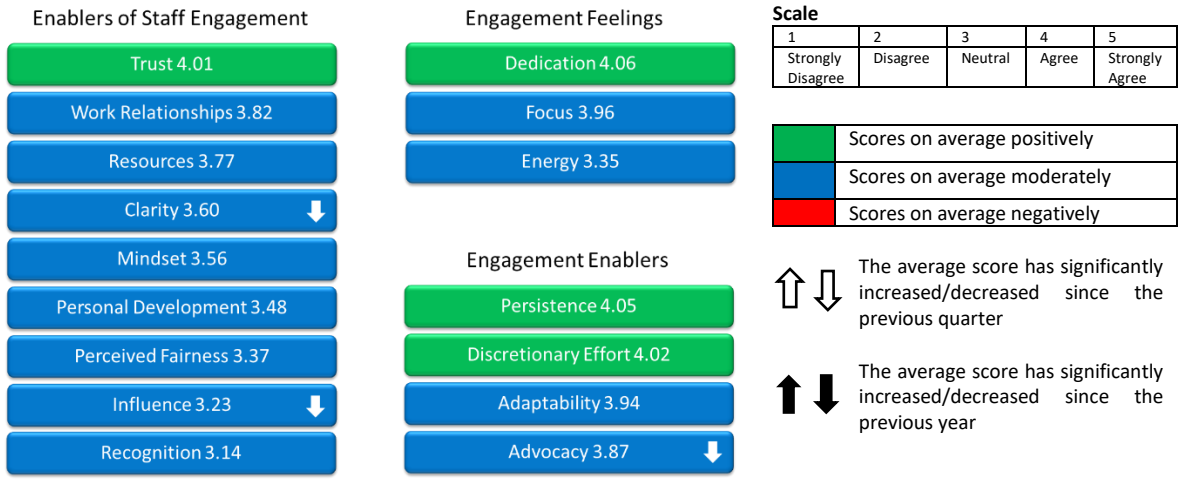
	Last Survey	This Quarter
Item	**March 2021 Q4**	**May 2021 Q1**
Clarity: The Trust communicates clearly with staff about what it is trying to achieve.	3.69	3.26
Resources: I have received the right level of training to do my job effectively.	3.97	3.76
Influence: The Trust acts on staff feedback.	3.41	3.17

Compared to last year (Jan 20 Q4), there has been a significant decline in:

No significant decreases.

Results: Surgery

Number invited to complete the survey:	1341	**Number completed:**	201	**Response Rate:**	15%
Level of engagement: Average percentage of positive scores across all measures of engagement = 72.73%					
Staff Friends and Family Test • 73.13% of staff would be happy with the standard of care provided by the Trust if a friend or relative needed treatment • 63.18% of staff would recommend the Trust as a place to work					



Highest / Lowest Scoring Enablers

Five Highest Scoring Enabler Items		
Item	**This Group**	**All Other Groups**
Trust: I am trusted to do my job.	4.21	4.20
Clarity: I always know what my work responsibilities are.	4.19	4.10
Work Relationships: The people I work with cooperate to get the job done.	4.00	4.05
Trust: I am satisfied with the level of freedom to choose my own method of working.	3.99	4.01
Resources: I have received the right level of training to do my job effectively.	3.97	3.85

Five Lowest Scoring Enabler Items		
Item	**This Group**	**All Other Groups**
Influence: The Trust acts on staff feedback.	2.96	3.12
Recognition: I feel satisfied with the extent the organisation values my work.	3.00	3.21
Perceived Fairness: Decisions about people are made using fair procedures.	3.10	3.21
Perceived Fairness: Overall the Trust is fair in the way it treats and rewards its staff.	3.14	3.23
Clarity: The Trust communicates clearly with staff about what it is trying to achieve.	3.15	3.35

	Positive finding in relation to other groups (group results scored significantly higher than other groups for this survey)		**Finding that is typical of all groups for this survey** (finding that is typical of all other groups for this survey)		**Negative finding in relation to other groups** (group results scored significantly lower than other groups for this survey)

Compared to the last survey (Feb 21 Q4), there has been a significant improvement in:

No significant improvements

Compared to last year (Jan 20 Q4), there has been a significant improvement in:

	Last Quarter	This Quarter
Item	**Jan 20 Q4**	**May 2021 Q1**
Resources: I have adequate materials, supplies and equipment to do my work.	3.29	3.57

Compared to the last survey (Feb 21 Q4), there has been a significant decline in:

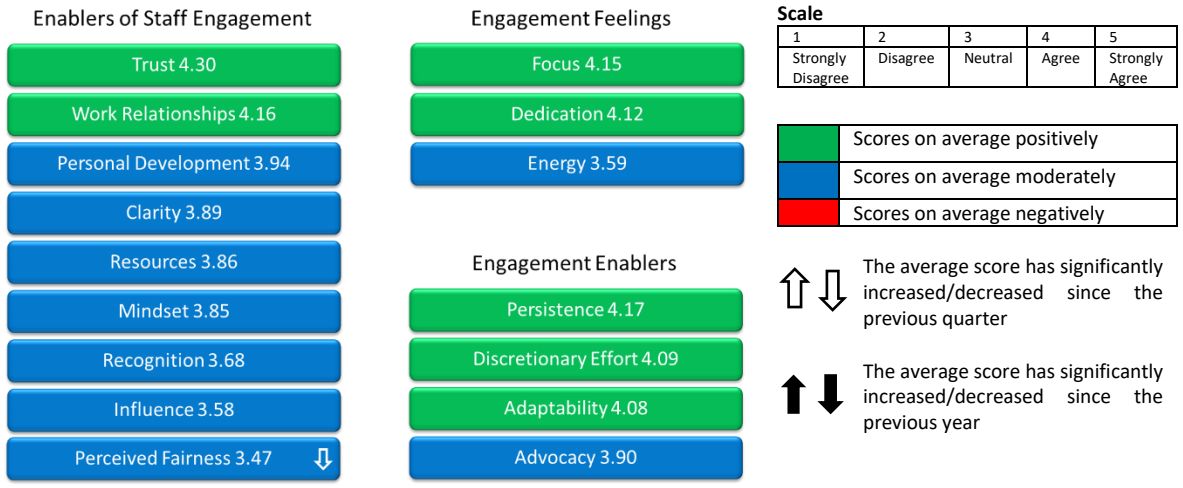
	Last Quarter	This Quarter
Item	**March 2021 Q4**	**May 2021 Q1**
Clarity: The Trust communicates clearly with staff about what it is trying to achieve.	3.55	3.15
Influence: The Trust encourages staff to suggest new ideas for improving services.	3.54	3.30

Compared to last year (Jan 20 Q4), there has been a significant decline in:

	Last Quarter	This Quarter
Item	**Jan 20 Q4**	**May 2021 Q1**
Advocacy: How likely are you to recommend the Trust to friends and family as a place to work?	3.94	3.71
Clarity: I have clear, planned goals and objectives for my job.	4.13	3.94
Clarity: The Trust communicates clearly with staff about what it is trying to achieve.	3.62	3.15
Mindset: I feel positive about working in my work area/team/department.	3.82	3.58
Mindset: I feel able to overcome challenges and set backs at work.	3.82	3.63
Influence: The Trust encourages staff to suggest new ideas for improving services.	3.63	3.30

Results: Estates and Facilities

Number invited to complete the survey:	**595**	**Number completed:**	**70**	**Response Rate:**	**12%**
Level of engagement: Average percentage of positive scores across all measures of engagement = 79.20%					
Staff Friends and Family Test • 71.43% of staff would be happy with the standard of care provided by the Trust if a friend or relative needed treatment • 71.43% of staff would recommend the Trust as a place to work					



Highest / Lowest Scoring Enablers

Five Highest Scoring Enabler Items		
Item	**This Group**	**All Other Groups**
Trust: I am trusted to do my job.	4.50	4.18
Clarity: I always know what my work responsibilities are.	4.29	4.10
Trust: I am satisfied with the level of freedom to choose my own method of working.	4.24	3.98
Work Relationships: I am satisfied with the level of support I get from my work colleagues.	4.21	4.03
Clarity: I have clear, planned goals and objectives for my job.	4.20	3.92

Five Lowest Scoring Enabler Items		
Item	**This Group**	**All Other Groups**
Perceived Fairness: Decisions about people are made using fair procedures.	3.11	3.19
Influence: The Trust acts on staff feedback.	3.19	3.08
Perceived Fairness: Overall the Trust is fair in the way it treats and rewards its staff.	3.19	3.21
Clarity: The Trust communicates clearly with staff about what it is trying to achieve.	3.41	3.30
Recognition: I feel satisfied with the extent the organisation values my work.	3.50	3.13

	Positive finding in relation to other groups (group results scored significantly higher than other groups for this survey)		**Finding that is typical of all groups for this survey** (finding that is typical of all other groups for this survey)		**Negative finding in relation to other groups** (group results scored significantly lower than other groups for this survey)

Compared to the last survey (Feb 21 Q4), there has been a significant improvement in:

No significant improvements

Compared to last year (Jan 20 Q4), there has been a significant improvement in:

	Last Quarter	This Quarter
Item	**Jan 20 Q4**	**May 2021 Q1**
Resources: I have received the right level of training to do my job effectively.	3.79	4.10

Compared to the last survey (Feb 21 Q4), there has been a significant improvement decline in:

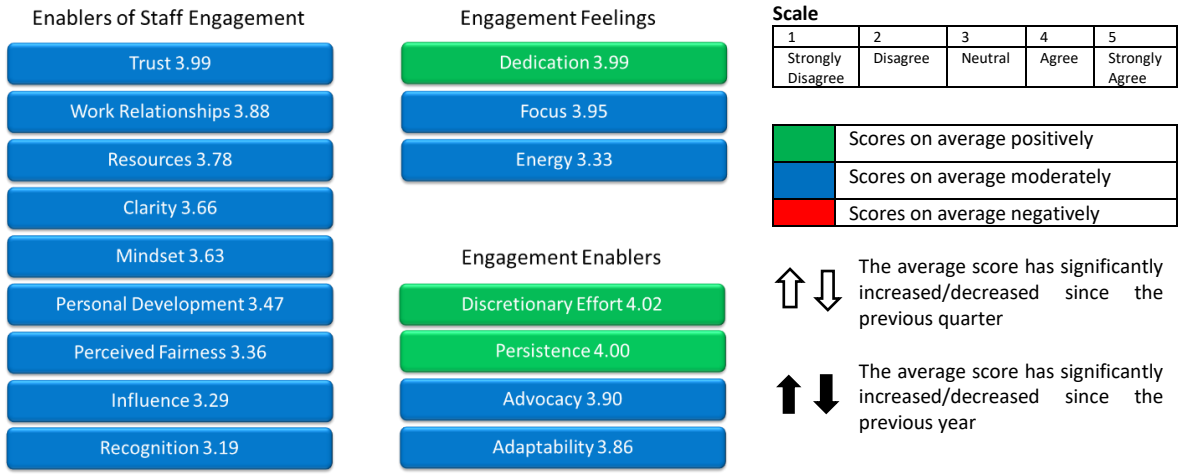
	Last Quarter	This Quarter
Item	**March 2021 Q4**	**May 2021 Q1**
Advocacy: How likely are you to recommend the Trust to friends and family if they needed care or treatment?	4.30	3.91
Resources: I have adequate materials, supplies and equipment to do my work.	3.99	3.63
Perceived Fairness: Overall the Trust is fair in the way it treats and rewards its staff.	3.60	3.19
Perceived Fairness: Decisions about people are made using fair procedures.	3.49	3.11

Compared to last year (Jan 20 Q4), there has been a significant decline in:

No significant decreases

Results: Specialist Services

Number invited to complete the survey:	**1072**	**Number completed:**	**194**	**Response Rate:**	18%
Level of engagement: Average percentage of positive scores across all measures of engagement = 72.94%					
Staff Friends and Family Test • 76.29% of staff would be happy with the standard of care provided by the Trust if a friend or relative needed treatment • 62.89% of staff would recommend the Trust as a place to work					



Highest / Lowest Scoring Enablers

Five Highest Scoring Enabler Items		
Item	**This Group**	**All Other Groups**
Trust: I am trusted to do my job.	4.19	4.21
Clarity: I always know what my work responsibilities are.	4.14	4.11
Work Relationships: I am satisfied with the level of support I get from my work colleagues.	4.03	4.05
Work Relationships: The people I work with cooperate to get the job done.	4.00	4.04
Trust: I am satisfied with the level of freedom to choose my own method of working.	3.96	4.01

Five Lowest Scoring Enabler Items		
Item	**This Group**	**All Other Groups**
Influence: The Trust acts on staff feedback.	3.01	3.10
Recognition: I feel satisfied with the extent the organisation values my work.	3.06	3.19
Perceived Fairness: Decisions about people are made using fair procedures.	3.11	3.21
Perceived Fairness: Overall the Trust is fair in the way it treats and rewards its staff.	3.11	3.24
Influence: My manager involves me in deciding on changes introduced that affect my work area/team/department.	3.27	3.44

	Positive finding in relation to other groups (group results scored significantly higher than other groups for this survey)		**Finding that is typical of all groups for this survey** (finding that is typical of all other groups for this survey)		**Negative finding in relation to other groups** (group results scored significantly lower than other groups for this survey)

Compared to the last survey (Feb 21 Q4), there has been a significant improvement in:

No significant improvements

Compared to last year (Jan 20 Q4), there has been a significant improvement in:

	Last Quarter	This Quarter
Item	**Jan 20 Q4**	**May 2021 Q1**
Resources: I have adequate materials, supplies and equipment to do my work.	3.46	3.65

Compared to the last survey (Feb 21 Q4), there has been a significant improvement decline in:

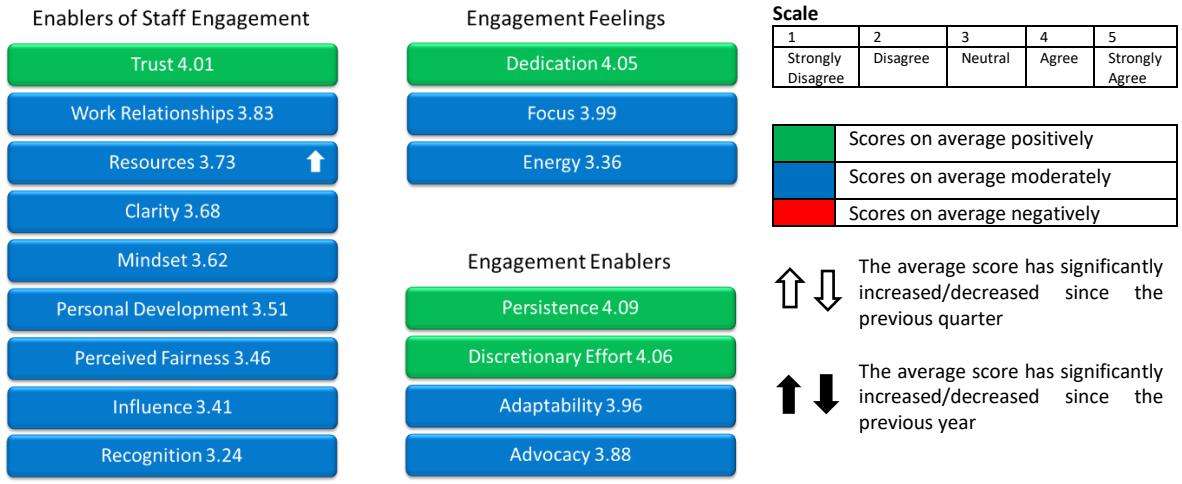
	Last Quarter	This Quarter
Item	**March 2021 Q4**	**May 2021 Q1**
Clarity: The Trust communicates clearly with staff about what it is trying to achieve.	3.67	3.38

Compared to last year (Jan 20 Q4), there has been a significant decline in:

No significant decreases

Results: Medicine

Number invited to complete the survey:	1322	**Number completed:**	**180**	**Response Rate:**	14%
Level of engagement: Average percentage of positive scores across all measures of engagement = 74.51%					
Staff Friends and Family Test • 67.78% of staff would be happy with the standard of care provided by the Trust if a friend or relative needed treatment • 69.44% of staff would recommend the Trust as a place to work					



Highest / Lowest Scoring Enablers

Five Highest Scoring Enabler Items		
Item	**This Group**	**All Other Groups**
Clarity: I always know what my work responsibilities are.	4.18	4.10
Trust: I am trusted to do my job.	4.14	4.22
Trust: I am satisfied with the level of freedom to choose my own method of working.	3.98	4.01
Clarity: I have clear, planned goals and objectives for my job.	3.98	3.93
Work Relationships: I am satisfied with the level of support I get from my work colleagues.	3.96	4.07

Five Lowest Scoring Enabler Items		
Item	**This Group**	**All Other Groups**
Recognition: I feel satisfied with the extent the organisation values my work.	3.10	3.18
Influence: The Trust acts on staff feedback.	3.17	3.06
Perceived Fairness: Overall the Trust is fair in the way it treats and rewards its staff.	3.23	3.21
Perceived Fairness: Decisions about people are made using fair procedures.	3.23	3.17
Clarity: I am well informed by my line manager about what is going on in our Trust.	3.31	3.43

	Positive finding in relation to other groups (group results scored significantly higher than other groups for this survey)		**Finding that is typical of all groups for this survey** (finding that is typical of all other groups for this survey)		**Negative finding in relation to other groups** (group results scored significantly lower than other groups for this survey)

Compared to the last survey (Feb 21 Q4), there has been a significant improvement in:

No significant improvements

Compared to last year (Jan 20 Q4), there has been a significant improvement in:

	Last Quarter	This Quarter
Item	**Jan 20 Q4**	**May 2021 Q1**
Resources: I have adequate materials, supplies and equipment to do my work.	3.21	3.62
Mindset: I feel confident in the future of the Trust.	3.32	3.63

Compared to the last survey (Feb 21 Q4), there has been a significant improvement decline in:

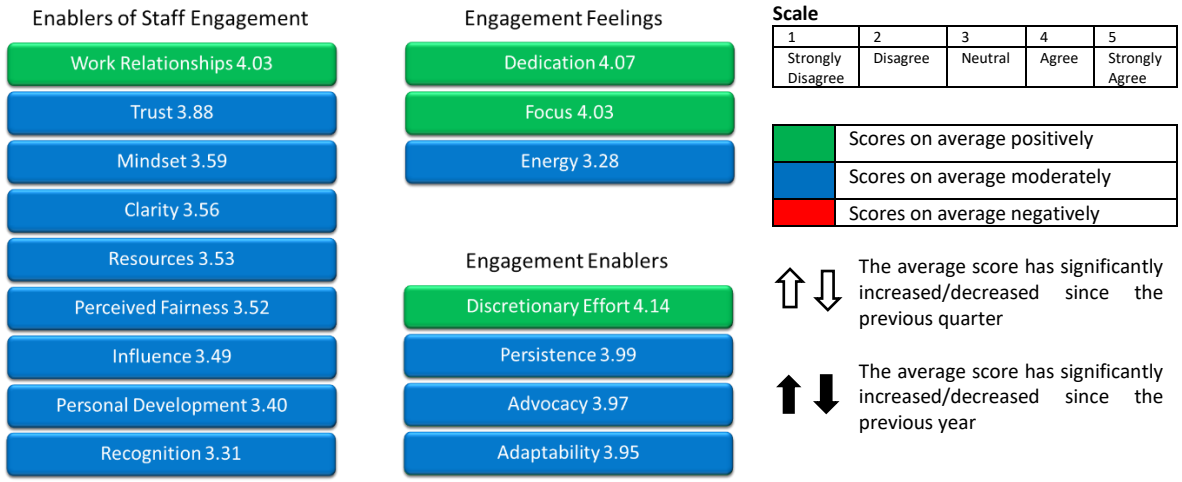
	Last Quarter	This Quarter
Item	**March 2021 Q4**	**May 2021 Q1**
Clarity: The Trust communicates clearly with staff about what it is trying to achieve.	3.78	3.45

Compared to last year (Jan 20 Q4), there has been a significant decline in:

No significant decreases

Results: Community – Adults

Number invited to complete the survey:	**513**		**Number completed:**	**72**	**Response Rate:**	**14%**
Level of engagement: Average percentage of positive scores across all measures of engagement = 75.09%						
Staff Friends and Family Test • 77.78% of staff would be happy with the standard of care provided by the Trust if a friend or relative needed treatment • 66.67% of staff would recommend the Trust as a place to work						



Highest / Lowest Scoring Enablers

Five Highest Scoring Enabler Items		
Item	**This Group**	**All Other Groups**
Work Relationships: I am satisfied with the level of support I get from my work colleagues.	4.31	4.02
Work Relationships: The people I work with cooperate to get the job done.	4.26	4.02
Trust: I am trusted to do my job.	4.08	4.21
Clarity: I always know what my work responsibilities are.	3.96	4.13
Perceived Fairness: My immediate manager treats me fairly.	3.94	3.94

Five Lowest Scoring Enabler Items		
Item	**This Group**	**All Other Groups**
Recognition: I feel satisfied with the extent the organisation values my work.	3.13	3.16
Influence: The Trust acts on staff feedback.	3.15	3.08
Clarity: The Trust communicates clearly with staff about what it is trying to achieve.	3.15	3.32
Personal Development: I am satisfied with the opportunities I have at work to learn and professionally develop.	3.24	3.51
Perceived Fairness: Decisions about people are made using fair procedures.	3.25	3.18

	Positive finding in relation to other groups (group results scored significantly higher than other groups for this survey)		**Finding that is typical of all groups for this survey** (finding that is typical of all other groups for this survey)		**Negative finding in relation to other groups** (group results scored significantly lower than other groups for this survey)

Compared to the last survey (Feb 21 Q4), there has been a significant improvement in:

	Last Quarter	This Quarter
Item	**March 2021 Q4**	**May 2021 Q1**
Discretionary Effort: I go beyond my role responsibilities to help my colleagues when required.	4.43	4.63

Compared to last year (Jan 20 Q4), there has been a significant improvement in:

No significant improvements

Compared to the last survey (Feb 21 Q4), there has been a significant improvement decline in:

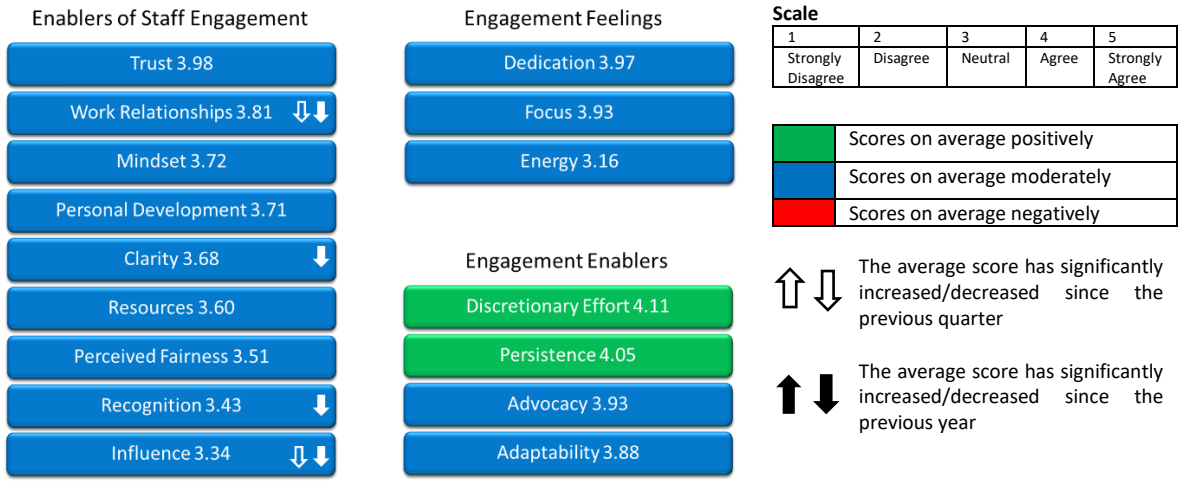
	Last Quarter	This Quarter
Item	**March 2021 Q4**	**May 2021 Q1**
Clarity: The Trust communicates clearly with staff about what it is trying to achieve.	3.71	3.15

Compared to last year (Jan 20 Q4), there has been a significant decline in:

	Last Quarter	This Quarter
Item	**Jan 20 Q4**	**May 2021 Q1**
Trust: I am trusted to do my job.	4.37	4.08
Trust: I am satisfied with the level of freedom to choose my own method of working.	4.12	3.79
Clarity: The Trust communicates clearly with staff about what it is trying to achieve.	3.66	3.15
Perceived Fairness: Decisions about people are made using fair procedures.	3.53	3.25

Results: Community – Childrens

Number invited to complete the survey:	**266**	**Number completed:**	**29**	**Response Rate:**	**11%**
Level of engagement: Average percentage of positive scores across all measures of engagement = 70.91%					
Staff Friends and Family Test • 75.86% of staff would be happy with the standard of care provided by the Trust if a friend or relative needed treatment • 72.41% of staff would recommend the Trust as a place to work					



Highest / Lowest Scoring Enablers

Five Highest Scoring Enabler Items		
Item	**This Group**	**All Other Groups**
Trust: I am trusted to do my job.	4.17	4.20
Clarity: I have clear, planned goals and objectives for my job.	4.03	3.94
Trust: I am satisfied with the level of freedom to choose my own method of working.	4.03	4.00
Perceived Fairness: My immediate manager treats me fairly.	3.97	3.94
Mindset: My manager helps me to develop confidence in my ability to do my job well.	3.97	3.59

Five Lowest Scoring Enabler Items		
Item	**This Group**	**All Other Groups**
Influence: The Trust acts on staff feedback.	3.07	3.08
Recognition: I feel satisfied with the extent the organisation values my work.	3.21	3.16
Resources: I have adequate materials, supplies and equipment to do my work.	3.24	3.60
Perceived Fairness: Overall the Trust is fair in the way it treats and rewards its staff.	3.28	3.21
Perceived Fairness: Decisions about people are made using fair procedures.	3.28	3.18

	Positive finding in relation to other groups (group results		**Finding that is typical of all groups for this survey** (finding that is		**Negative finding in relation to other groups** (group results scored

	scored significantly higher than other groups for this survey)		typical of all other groups for this survey)		significantly lower than other groups for this survey)

Compared to the last survey (Feb 21 Q4), there has been a significant improvement in:

No significant increases

Compared to last year (Jan 20 Q4), there has been a significant improvement in:

No significant increases

Compared to the last survey (Feb 21 Q4), there has been a significant improvement decline in:

	Last Quarter	This Quarter
Item	**March 2021 Q4**	**May 2021 Q1**
Work Relationships: My manager encourages those of us who work for him/her to work as a team.	4.27	3.76
Work Relationships: I am satisfied with the level of support I get from my work colleagues.	4.27	3.83
Clarity: I always know what my work responsibilities are.	4.41	3.90
Influence: The Trust encourages staff to suggest new ideas for improving services.	3.93	3.31

Compared to last year (Jan 20 Q4), there has been a significant decline in:

	Last Quarter	This Quarter
Item	**Jan 20 Q4**	**May 2021 Q1**
Trust: I feel satisfied that I have the right amount of responsibility	4.20	3.72
Work Relationships: My manager encourages those of us who work for him/her to work as a team.	4.23	3.76
Work Relationships: I am satisfied with the level of support I get from my work colleagues.	4.43	3.83
Work Relationships: The people I work with cooperate to get the job done.	4.43	3.83
Clarity: I always know what my work responsibilities are.	4.31	3.90
Clarity: The Trust communicates clearly with staff about what it is trying to achieve.	3.89	3.38
Influence: My manager involves me in deciding on changes introduced that affect my work area/team/department.	3.98	3.41
Influence: The Trust encourages staff to suggest new ideas for improving services.	3.97	3.31
Influence: The Trust acts on staff feedback.	3.62	3.07
Recognition: I feel satisfied with the extent the organisation values my work.	3.67	3.21

Comparisons

The following tables show the results for each groups of staff at a glance.
There are two ways to read the results:

- From top to bottom: see the results for a specific group across all staff engagement measures.
- From left to right: see how each staff engagement measure differs between the groups.

The key below outlines how each group is scored:

	Positive finding in relation to the overall organisation results for this quarter (group results scored significantly higher than organisation results)		**Finding that is typical of the overall organisation results for this quarter** (finding that is typical of all other groups for this survey)		**Risk in relation to the organisation results for this quarter** (group results scored significantly lower than organisation results)

All results are compared to the overall organisation results for this quarter.

Table 9: Results comparison by Division

Division	Corporate	Surgery	E&F	Specialist Services	Medicine	Community Adults	Community Children
Sample Size	**157**	**201**	**70**	**194**	**180**	**72**	**29**
Engagement Enabler							
Clarity	3.72	3.60	3.89	3.66	3.68	3.56	3.68
Influence	3.57	3.23	3.58	3.29	3.41	3.49	3.34
Mindset	3.74	3.56	3.85	3.63	3.62	3.59	3.72
Personal Development	3.72	3.48	3.94	3.47	3.51	3.40	3.71
Perceived Fairness	3.55	3.37	3.47	3.36	3.46	3.52	3.51
Recognition	3.62	3.14	3.68	3.19	3.24	3.31	3.43
Resources	3.70	3.77	3.86	3.78	3.73	3.53	3.60
Trust	4.02	4.01	4.30	3.99	4.01	3.88	3.98
Work Relationships	4.06	3.82	4.16	3.88	3.83	4.03	3.81
Engagement Feeling							
Dedication	3.98	4.06	4.12	3.99	4.05	4.07	3.97
Energy	3.39	3.35	3.59	3.33	3.36	3.28	3.16
Focus	3.99	3.96	4.15	3.95	3.99	4.03	3.93
Engagement Behaviour							
Adaptability	3.94	3.94	4.08	3.86	3.96	3.95	3.88
Advocacy	3.95	3.87	3.90	3.90	3.88	3.97	3.93
Discretionary Effort	4.09	4.02	4.09	4.02	4.06	4.14	4.11
Persistence	4.05	4.05	4.17	4.00	4.09	3.99	4.05

Table 10: Results comparison by Staff Group

Staff Group	AHPs	Nursing and Midwifery	Medical and Dental	Admin and Clerical	Central/ Corprate	Estates and Ancillary	General Management	Scientific and Technical	Other
Sample Size	**85**	**310**	**49**	**308**	**30**	**34**	**34**	**17**	**46**
Engagment Enabler									
Clarity	3.63	3.60	3.59	3.77	3.67	3.77	3.73	4.02	3.40
Influence	3.54	3.26	3.43	3.44	3.43	3.52	3.57	4.00	3.15
Mindset	3.64	3.54	3.66	3.73	3.84	3.77	3.70	4.19	3.38
Personal Development	3.50	3.56	3.66	3.54	3.60	3.90	3.69	4.03	3.20
Perceived Fairness	3.59	3.33	3.59	3.48	3.60	3.42	3.46	3.98	3.30
Recognition	3.44	3.20	3.34	3.34	3.60	3.44	3.51	3.82	3.17
Resources	3.62	3.75	3.88	3.75	3.50	3.69	3.84	3.97	3.63
Trust	3.87	3.94	4.05	4.14	3.96	4.14	4.04	4.33	3.87
Work Relationships	3.97	3.88	3.91	3.92	4.14	4.09	4.01	4.53	3.68
Engagement Feeling									
Dedication	4.06	4.09	4.12	3.95	3.93	3.93	4.30	4.37	3.85
Energy	3.31	3.25	3.71	3.42	3.28	3.47	3.60	3.79	3.12
Focus	4.02	3.96	4.17	3.96	3.88	4.12	4.22	4.29	3.80
Engagement Behaviour									
Adaptability	3.99	3.87	3.97	3.95	3.92	4.00	4.16	4.15	3.82
Advocacy	3.86	3.87	3.96	3.95	3.84	3.93	3.97	4.35	3.73
Discretionary Effort	4.15	4.03	4.07	4.02	4.26	3.99	4.25	4.16	4.09
Persistence	3.98	3.98	3.99	4.12	4.15	4.18	4.12	4.24	4.03

Table 11: Results comparison by Job Grade

Job Grade	AFC Bands 1-4	AFC Bands 5-7	AFC Bands 8a-9	Medical and Dental
Sample Size	**387**	**393**	**83**	**45**
Engagment Enabler				
Clarity	3.71	3.60	3.76	3.62
Influence	3.33	3.36	3.70	3.48
Mindset	3.71	3.55	3.77	3.69
Personal Development	3.54	3.50	3.83	3.71
Perceived Fairness	3.43	3.37	3.71	3.68
Recognition	3.29	3.26	3.63	3.43
Resources	3.78	3.64	3.84	3.91
Trust	4.14	3.88	4.10	4.10
Work Relationships	3.90	3.90	4.11	3.99
Engagement Feeling				
Dedication	3.99	4.03	4.16	4.12
Energy	3.35	3.27	3.59	3.77
Focus	3.93	3.97	4.24	4.18
Engagement Behaviour				
Adaptability	3.93	3.88	4.16	4.00
Advocacy	3.95	3.85	3.90	4.00
Discretionary Effort	4.01	4.06	4.29	4.07
Persistence	4.06	4.00	4.28	4.03

Table 12: Results comparison by Site

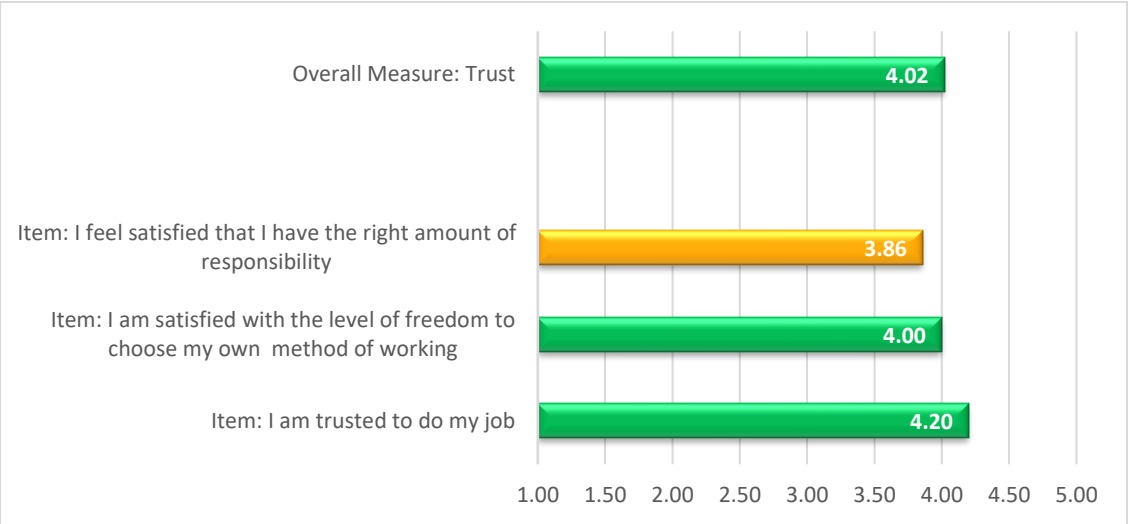
Site	RAEI	Wrightington	Leigh	Community Base	Other
Sample Size	**421**	**132**	**88**	**116**	**156**
Engagment Enabler					
Clarity	3.70	3.64	3.72	3.55	3.69
Influence	3.39	3.28	3.39	3.38	3.50
Mindset	3.66	3.63	3.66	3.59	3.67
Personal Development	3.61	3.46	3.59	3.45	3.60
Perceived Fairness	3.48	3.37	3.36	3.47	3.46
Recognition	3.33	3.18	3.32	3.27	3.45
Resources	3.77	3.68	3.78	3.58	3.77
Trust	4.06	3.99	4.13	3.87	3.97
Work Relationships	3.89	3.84	3.98	3.94	4.04
Engagement Feeling					
Dedication	4.07	3.92	4.07	4.06	3.97
Energy	3.41	3.31	3.31	3.30	3.37
Focus	4.04	3.93	3.90	4.00	3.96
Engagement Behaviour					
Adaptability	3.94	3.83	4.01	3.93	3.96
Advocacy	3.89	3.97	3.88	3.90	3.93
Discretionary Effort	4.06	4.03	4.06	4.12	4.04
Persistence	4.08	3.97	3.99	4.06	4.06

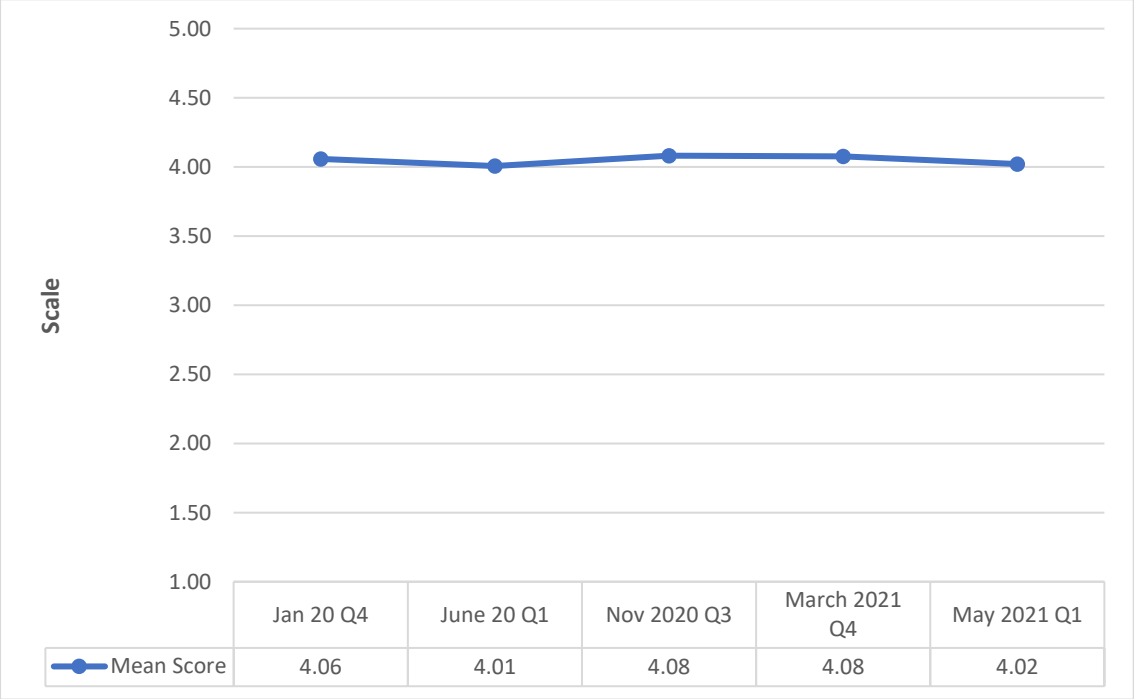
Table 13: Results comparison by Length of Service

Length of Service	Less than 1 Year	1 - 2 Years	3 - 5 Years	6 - 10 Years	Over 10 Years
Sample Size	**62**	**77**	**102**	**113**	**559**
Engagment Enabler					
Clarity	3.81	3.76	3.70	3.55	3.66
Influence	3.51	3.62	3.31	3.29	3.38
Mindset	3.84	3.85	3.71	3.51	3.62
Personal Development	3.65	3.68	3.60	3.48	3.55
Perceived Fairness	3.81	3.76	3.43	3.32	3.39
Recognition	3.65	3.60	3.33	3.19	3.27
Resources	3.88	3.88	3.74	3.69	3.71
Trust	4.11	4.20	4.05	3.94	4.00
Work Relationships	4.08	4.13	3.94	3.85	3.89
Engagement Feeling					
Dedication	4.21	4.10	3.93	3.92	4.05
Energy	3.73	3.55	3.22	3.18	3.36
Focus	4.09	4.05	3.91	3.83	4.02
Engagement Behaviour					
Adaptability	4.10	4.05	3.82	3.89	3.92
Advocacy	4.21	4.11	3.80	3.66	3.92
Discretionary Effort	4.01	4.06	3.95	4.11	4.08
Persistence	4.10	4.06	3.96	4.07	4.06

Trust

Scale				
1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree





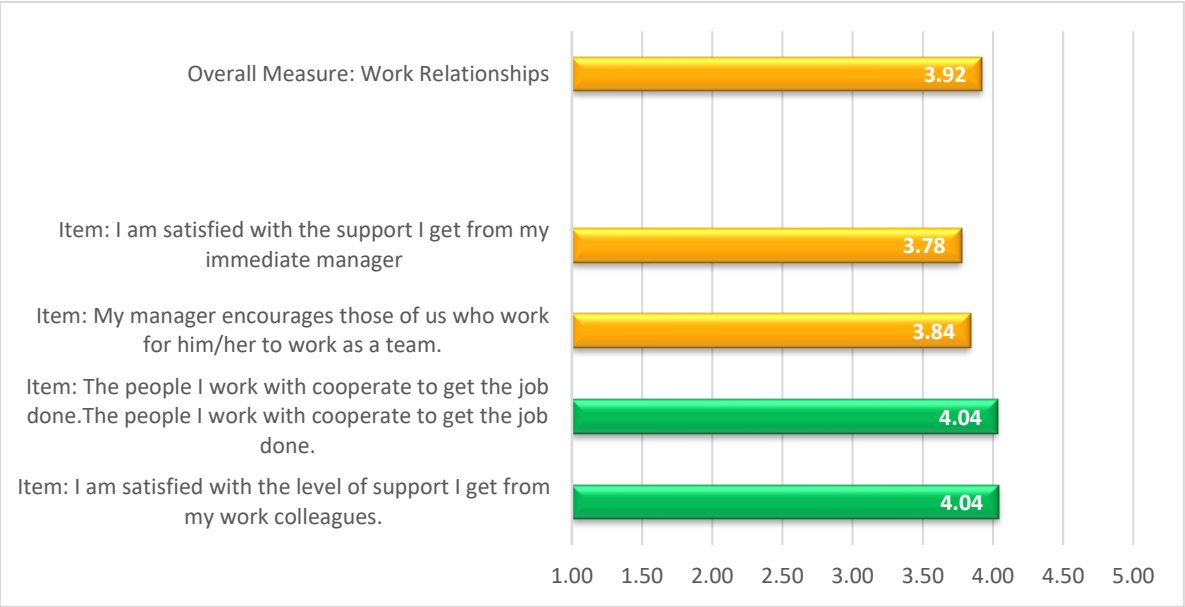
Comments:

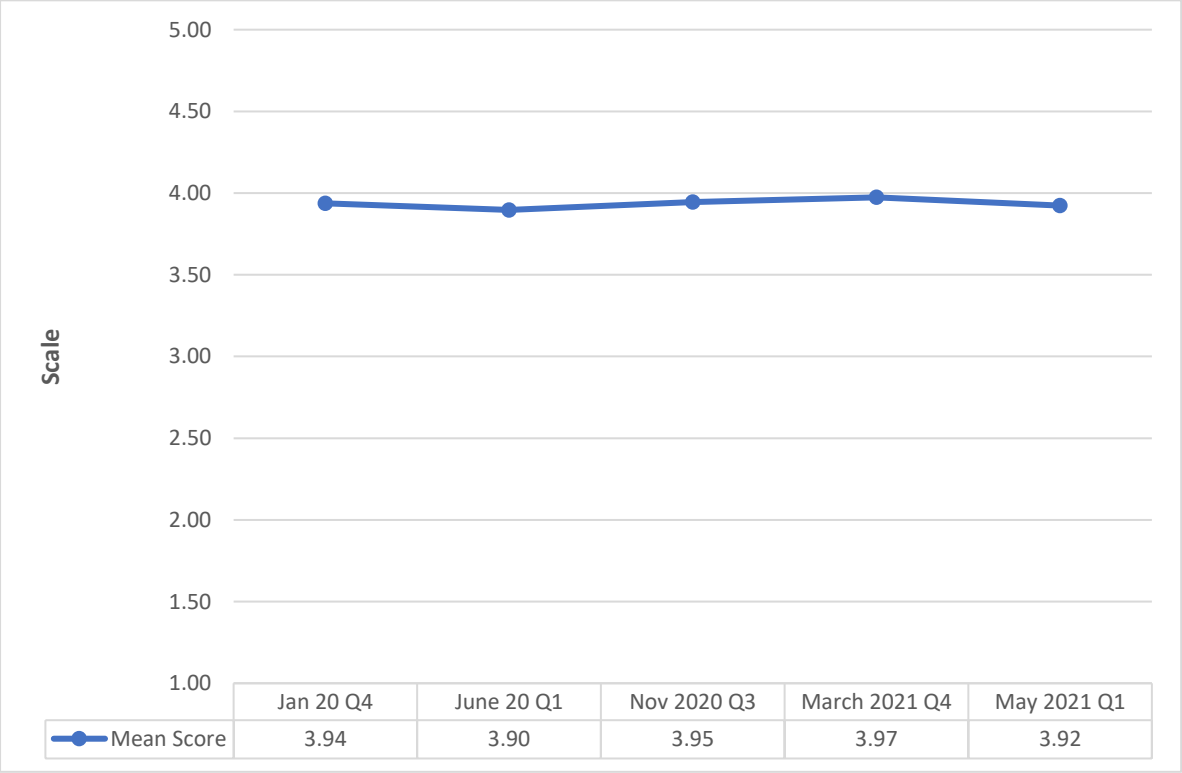
I feel very micromanaged

Also as before there is a definite ageist culture especially in my area of work. Our manager does not seem to trust anyone over a certain age, we are pushed out and not given any opportunity to do other work within our area.

Work Relationships

Scale				
1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree





Comments:

Positive support from colleagues

Yet my colleagues are a joy to work with and do a great job despite all the problems presented, lack of support, rude and bullying language and poor leadership. This is a credit to them and seeing the purpose of what they do.

Negative support from colleagues

Some of my answers are clear cut but others are split because some people are pulling together, whereas others are behaving appallingly.

Currently redeployed as my ward closed. It has not been a very good experience as I feel I have not been welcomed into the team

Negative support from manager(s)

It still staggers me the lack of diverse leadership within the Trust. All the senior leaders might as well be cloned as they all act and behave so similarly. There is little trust in individuals and the lack of support at times leaves me feeling desperately low and only wanting to do the minimum.

Management need to look into how things are done such as 'jobs for the boys', putting people who are lazy and unqualified into positions of management, knowing that they are not very good at one job so will move them into another instead of sorting problems out.

With staff working at home as well in the office it makes communicating more difficult. Managers are very busy and I feel I have less access to my line manager now agile working is in place, no catch up time is in the diary, conversations are cut short as they need to go to a meetings or answer a phone call.

We do not have a ward manager, our sisters have changed and keep changing.

The rapid implementation of changes within the team and the way communication has failed to inform staff of plans for the future as caused catastrophic stress and anxiety amongst the staff of all bands from 3-7 leading to a significant number of staff not only going off sick but leaving for other jobs. Support from the current manager is non-existent and the attitude and language that they use in relation to staff is disrespectful and unprofessional. I am saddened by the transformation of the team over the last 18 months.

Senior Managers are not interested in their team members, only interest is in themselves and what works best for them and their career paths. The past 12 months working at WWL is the worst by far, Senior Managers have left members of their team feeling isolated and demotivated as they have shown little or no concern towards them.

I think some managers are employed, implement policies and procedures and then leave before seeing them through.

Senior management come over as very intimidating and after moving around the Trust it has become apparent that there is a bullying culture within this Trust, a lot of unfairness and a lot of preferential treatment.

I feel there has been a lack of senior staff visibility during the pandemic, especially during the first wave when times were very uncertain and worrying.

I feel the lack of support from senior management in general is lacking.

Managers appear to be run off their feet and unable to devote any time to discuss issues with staff. (Obviously this happens at busy times but should not be happening day in and day out, which it is). Feel that we get put to the back of the queue and our issues are not dealt with during the working day. Consequently, our queries are left until last minute (10 minutes before we are due to leave we are given tasks). It isn't ideal and is really not the way to manage.

Senior management do not respect staff and are not supportive during challenges.

Other comments relating to Work Relationships

I am aware of and have witnessed staff being abusive, aggressive, threatening, and disrespectful to their colleagues, in some cases Senior Managers. Although these incidents are reported and investigated, nothing ever seems to happen to the culprits. It is right that when this behaviour is highlighted, it is dealt with correctly which should lead to dismissal in some cases – threatening behaviour surely must constitute misconduct and/or gross misconduct? However, like most other public services, we have become too scared of dealing with these issues because someone might get offended or upset. Behaviours like this would not be accepted in the private sector or the military – please can a more real approach be considered? Keep it fair but firm!

There have been improvements is the overall ethos of the Trust recently in terms of dealing with difficult individuals. They can have such a devastating impact on a department in terms of team working and staff morale. Senior managers have seemed reluctant to challenge these colleagues but that seems to be changing with the new CEO.

I hope that our team will recover from years of abuse at the hands of one such individual when they are dealt with appropriately.

Issues around poor behaviours are really having an impact - if these aren't tackled and managers are expected to behave professionally and with respect, I really worry for the organisation.

There is a distinct lack of leadership which causes issues. Staff members who are rude are not talked to about their behaviour. When issues are taken further up to the clinical lead they are not dealt with and the issues continue.

My comments are for the wider team in general beyond the Nursing team. As a Nursing Team we work well together. Our line manager is very supportive. However, the non-nursing staff are destructive and are poorly managed, causing a lot of problems in the overall working Team. Higher management than line management are aware of this but appear to do nothing as nothing changes.

Staff who have been uncivil for a very long time, have never been challenged appropriately.

The management of the department needs to be looked into seriously.

I feel supported by my immediate manager and the majority of my colleagues. Although higher management does not appear supportive at times, I will always give this trust 100%.

Issues of diversity training need to be addressed in my department.

Issues with personal behaviours that cause disruption and anxiety to the team should be dealt with. This has been highlighted many times but the issues haven't been sorted.

Too many chiefs and not enough Indians.

Management attitude towards senior clinicians deplorable. (Really sorry to make this comment)

I was redeployed last year and felt like I was sent to Wigan infirmary and forgotten about!

Generally, I feel happy in my work and within myself. However sometimes on my ward I feel a little less supported and included due to having only been here 6 months. They have friendship groups and it can be difficult to fit into these groups as a new comer. My ward manager is very nice however she does not seem to have time to discuss things with me if I wanted too and I have heard her responses to other members of staff (new staff) who have approached her or other senior members (whilst on breaks certain people get talked about with others) which makes me feel uncomfortable and like my discussion wouldn't be confidential. As a working environment though I am happy within my role. I love working for the Trust and I love my job and I am proud to work here. I feel like I may be more comfortable on a different ward though.

New staff need to be recognised more and assisted more with easing into the routines on the ward.

Don't feel the Trust deals with difficult individuals that cause trouble on numerous occasions well. Seem to accept unacceptable behaviour without challenging it.

My comments around staff attitudes is only a minority of nurses working on the wards, I wonder if this is due to added pressures with the pandemic. The issues our team have had with the ward with staff attitude have been raised and are being acted upon with the ward manager.

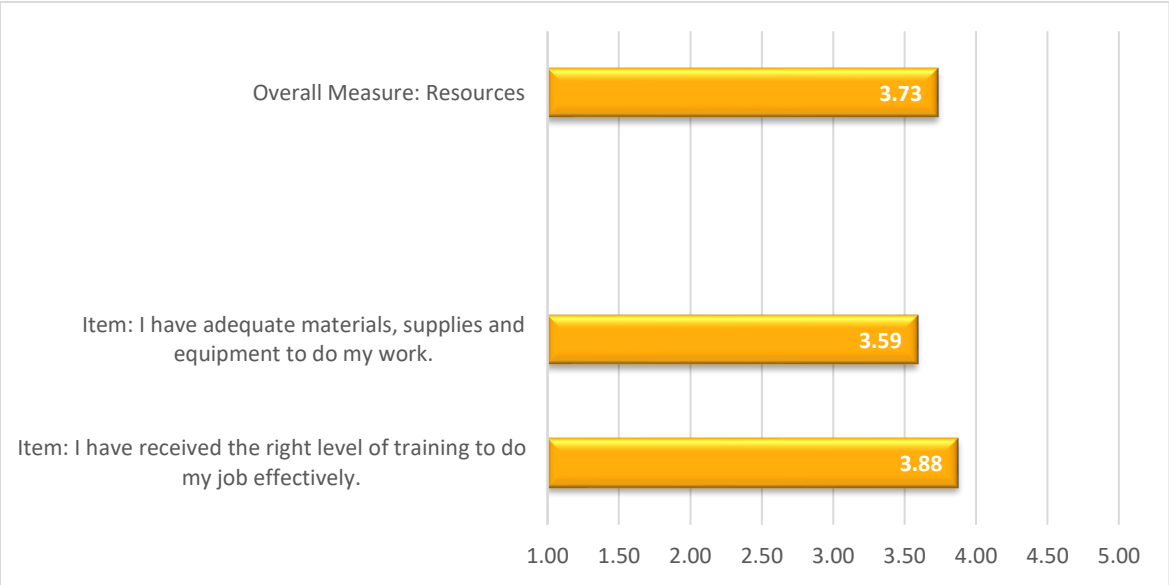
Rude staff on other wards, including senior staff, afraid to work bank shifts on other wards due to reports of 'clicks' and disrespect towards bank staff. not knowing who you are working with each shift, no support when issues arise with staff, don't feel confident to raise issues.

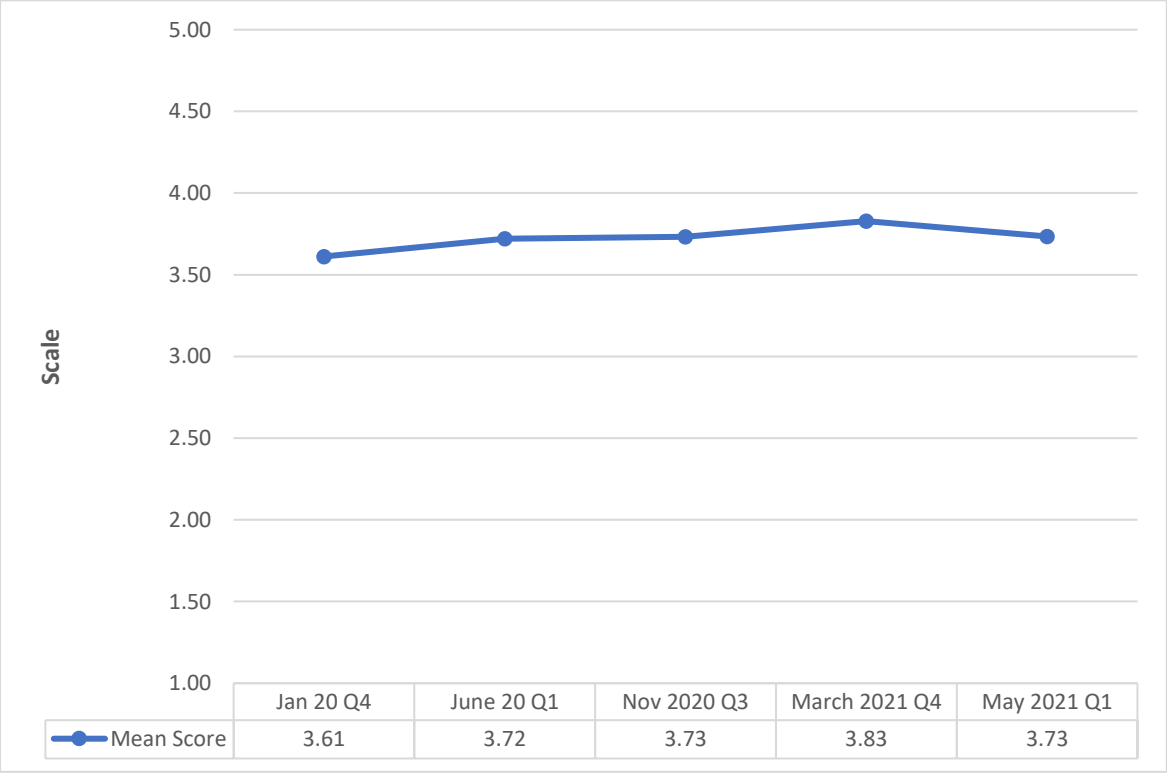
Things are bad at the moment and with each passing month getting worse. It is good leadership that is missing. Sometimes it feels like a boys club rather than a health care provider. Also there is so much talk, far too many meetings and yet nothing gets done. People seem happy to create documents, policies, SOP's, do the politics then sit back and wait for something to happen-leaving a few of us to pick up the pieces and flog ourselves to support patients. I used to love to come to work but now it keeps me awake at night wondering how tomorrow I will be bullied, harassed and talked down to. I am seriously considering leaving, even to go and work in a shop!

My immediate manager and the manager of the admin team are hardworking well-respected people, who ask for and listen to our comments about team working and other issues, but some of the non-admin team have, over the years, treated myself and my colleagues shockingly, and staff have left because of it. When it was brought up with their immediate manager it was felt that nothing was done for years. It was only when a few of us got together and insisted something was done was the bully really spoken to - apparently, they did not know how shocking their behaviour was. It took 2 managers to get the other manager to actually re-dress the problem, if it hadn't, I would have gone to HR directly. We all know it won't last.

Resources

Scale				
1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree





Comments:

The training received to do their job effectively

I recently attended a wellbeing course through work this gave me some excellent skills to help me cope with workload and it showed how much the organisation are helping staff wellbeing

Having adequate resources, supplies and equipment

I feel that poor IT is a massive contributor to my frustrations and that of others. I certainly feel that both when working at home and from the office I could be much more productive if the IT systems were better. This also applies to the printers which are another source of frustration.

The main issue over the last few months has been that of IT. There are many days in which we are unable to access outlook, the intranet etc and this directly impacts our ability to do our job. This is not only frustrating for us but also directly impacts those that we work for and support.

The current IT issues have severely impacted on my ability to perform my role. The systems are slow, email has been challenging, the printers consistently broke and connection from home to hospital systems has been frustrating. A simple task is taking double the time to perform. The IT staff are fantastic in responding and I understand the challenges of such a big IT system but is there any light at the end of the tunnel in this improving? On this note can I just say that IT colleagues are fantastic in supporting and responding to problems.

The linen room for the Trust has a very long backlog in supplying uniforms for new starters. It would be really helpful if this could be speeded up. It may help some staff feel part of their new team more if they had their new uniforms in less than 6 months.

I believe that the resources need to be improved for the staff in the community so they have the adequate supplies to carry out their jobs. Also, I have been working for the Trust for six and a half months and have still not received part of my uniform.

Having an adequate working environment

Do not have enough storage for equipment.

Not enough bed space for patients belongings.

Ward too small and not adequate or equipped for stroke patients.

I am currently working from home, sat on the sofa with a laptop on my knee, as I do not have alternative facilities

I work in a room that is far too small!

My team does not have the appropriate estates to allow us complete our work in a timely and stressless manner. I do not feel I have the necessary tools & equipment to complete my work as there are not enough computers or telephones in our office for the large staff team that we have. This causes delays to taking lunch breaks and working in a timely manner due to hot desking with an inadequate number of work stations. The office is also large and loud and difficult for staff when completing ax's on the phone with patient. There are lots of members of our team but our break room can only sit a few people at a time due to current social distancing rules meaning that if the lunchroom is full you have to wait in the corridor because the office will also be full with staff working. Since closing the canteen space at Wrightington we don't have an appropriate environment to eat lunch. We also change in the toilets as there are no staff changing rooms available to use.

Uniform issues, scrubs are required on this unit we work in the middle of outer buildings which is like working in a greenhouse. It doesn't look professional to have sweat patches on your uniform or running

down your face, we can't have fans on and the windows don't open, again this has been asked before and nothing has happened.

Having adequate staffing levels

There is far too much investment in health and wellbeing as a team, which could be much better spent on the front line supporting exhausted colleagues, it would also deliver more in the name of Health and Wellbeing than the current system ever would. I for one don't need an extra mile badge or anyone to tell me how well I'm doing the job I'm paid to do, I'd much rather have the admin or physical support of more staff to help me reduce and control my burden.

There are many changes in ED, there have been more and more areas opened up yet with the same number of or same difficulties in having enough medical and nursing staff to cover them. This often leads staff going without breaks (I always take my break, it is an important part of my wellbeing and ability to do my job effectively). The staff are under immense pressure due to the numbers of patients presenting in ED, personally I feel that management are expecting the same level of care with more areas to cover and same number of staff/and often poor skill mix. The increased use of agency nurses in ED is often a problem and provides great inconsistencies, they don't know the Trust, they don't know the systems. Agency staff should be filling sporadic gaps not staffing the whole department. I often feel that to management the time on the screen is more important than the patient's needs. This puts pressure on Doctors and clinicians and ultimately we take responsibility for that patient's care and often moving them out of the department to avoid a breach of the 4 hour target seems more important than the patient in the bed.

We are struggling to keep up with the increase of patients. More staff would help to spread the workload as some days I do feel burnt out trying to complete input for patients.

Short staffed, no money in budgets, using bank staff to fill gaps, not working consistently with colleagues due to staffing issues

Having to work additional hours

To keep on top of my growing clerical workload, I am regularly having to work 7 days a week.

I need to work significant unpaid hours to complete my workload

Other comments relating to Resources:

It is alright being fully staffed but when the skill mix is wrong it doesn't work/ you should be able to recruit your own staff not be told who you are having

All problems and negativity in this job lead to WWLs committed position of throwing money at Allscripts which is without doubt the single dumbest thing I have ever seen in my professional working life. Time and time again Allscripts have proven to be cowboys and yet leadership appears hell bent on piece meal outsourcing to them.

Although we are made aware of wellbeing courses or accessing help relating to health/wellbeing there is no time to access these as they are often in works time and there are not many people in our team. Our caseload is often over 100.

I left a position on the acute wards to join a team in an outpatient service. Here is an immeasurable difference between the working conditions in both places and the level of morale between the two.

The nurses on the acute wards are overworked and treated quite badly in that nurses are trying to do the work of many other colleagues - ward clerks, housekeepers, porters (e.g. nurses go down to the basement on night shifts to get mattresses or feed or IV pumps) and domestics. The result is that vulnerable patients are deprived of quality nursing attention and care.

Less than two years ago, on a quiet Saturday my nursing colleagues and I kept record of how many times we had to travel to the desk to answer the phone and the door - 69 times in all. That was 69 times nurses were drawn away from the bedside..... It is an uneconomic use of nursing staff and greatly affects morale...

The Trust needs to take Health & Safety more seriously.

I believe that a combination of working from and home and in the office has a positive effect on staff for many reasons, one being the time you gain from not travelling to and from the office.

Could we have the option of an electronic scheme through our wages? Like vivup (was at Bridgewater)

Further help and resources should be available to staff returning from bereavement leave.

Too much work not enough time to do the job properly. Constant pressure from senior managers of other departments to rush people through. BACKLOG used as an excuse for unsafe pressures

It is fine asking for our opinions and ideas but they are accepted on the basis of cost saving or increased throughput. Extra funding is required and Senior Management need to represent the NEEDS of the NHS to the Government.

I do feel now we are returning to our own jobs that we have been left with a shortage, as our caseload has grown in numbers and complexity. We have been through a service redesign during this time and we have a dual role that is difficult to find the time to do with less staffing. As usual not enough hours in the day.

Parking is an issue. Waiting for a bus to get to your car after a long day is irritating.

We could really do with more space and more laptops/PCs to be able to do our documentation in a more timely way, especially with social distancing rules and when we have additional staff eg. students. We need more space to meet with families. We need more storage for therapy and moving and handling equipment.

I am diabetic and the canteen facilities are poor. No facilities at weekend apart from very expensive vending machines with crisps chocolate and drinks.

Overall I enjoy working at WWL but accept that there will always be frustrations associated with my role. This can sometimes lead to challenging conversations when the resource and capacity that is at my disposal cannot meet the demands of the Trust.

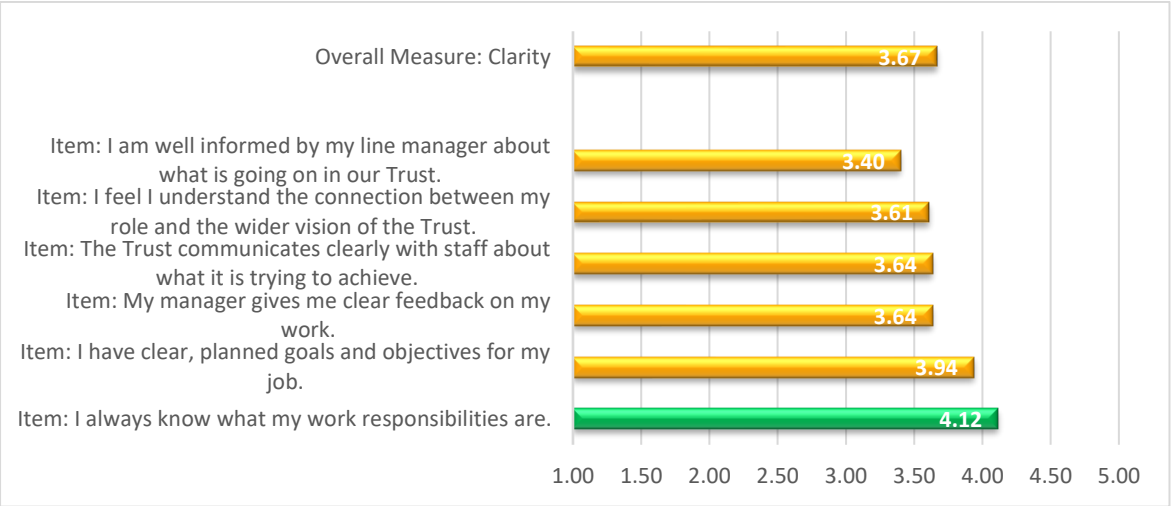
The main issues in my workplace which have an adverse impact of the health of myself and my colleagues is the limited space we have to complete our work. Currently we work from an office which used to be a patient bathroom which is used as a joint office/patient treatment room. This is not good for our physical or mental health with the room often being overcrowded for the number of staff who work in the team making it difficult to complete administrative tasks or access our stroke resources. We do have a plinth in our office for treating patients, but we do not use it as often as we would like to due to fact that staff cannot access the office during a treatment session. I feel we could achieve so much more with our patients if we had more space and access to therapy gym as they do at Alex Court. Another issue with impacts our efficiency as a team is the lack of working computers on the ward. I

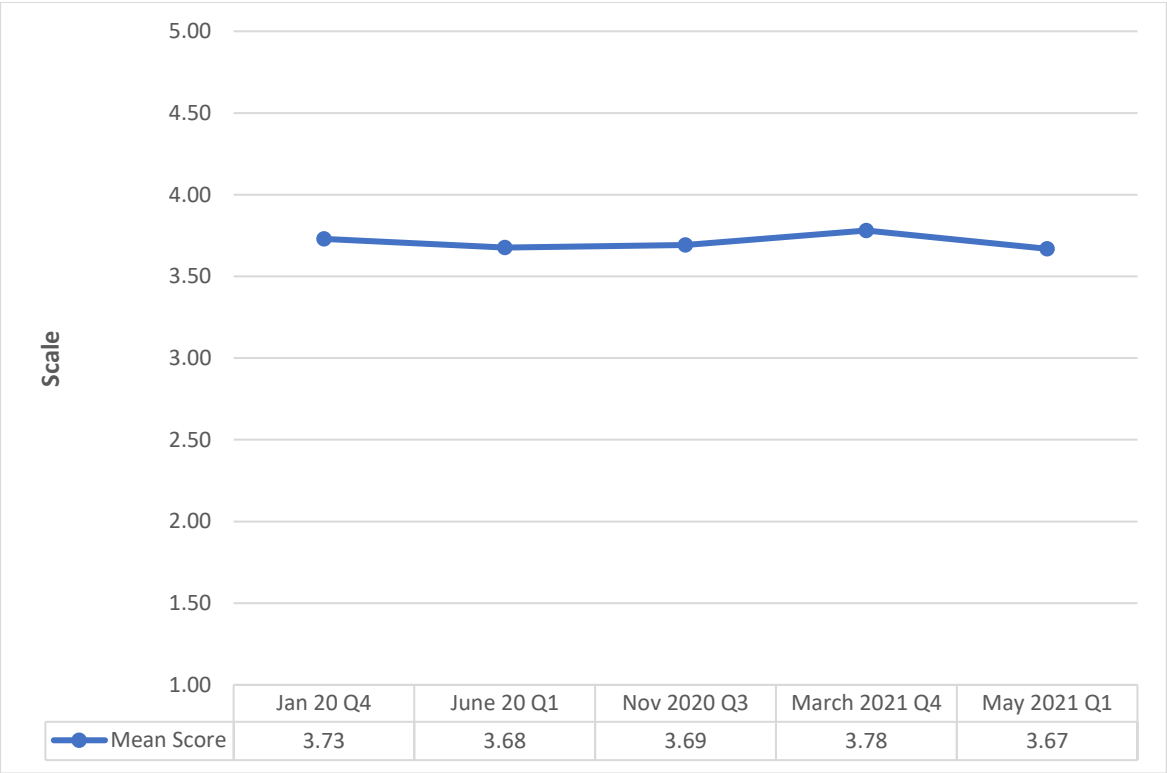
often experience IT issues in logging on to the laptops which I find wastes time. I personally find this very frustrating as I feel I could be more productive if I could guarantee access to a reliable computer during the day.

Rather than focussing on the outcome for patients awaiting elective surgery, Operational team & managers appreciate the time and resources to achieve this safely in the interests of both patients and staff wellbeing

Clarity

Scale				
1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree





Comments:

Unclear about their role and role objectives

There needs to be more clarity and transparency about job roles

Understanding of what is going on in the organisation

Colleague and I have never attended a team meeting with the department in the past six months. Well we have never been invited to one so not sure if they even go ahead within the department. Consequently you aren't aware of what is going on.

Other comments relating to Clarity:

This survey is too long. Why are Catholic and Christian separate?

I do not know who my manager is, as I appear to have several managers with conflicting demands.

There is a lot of comments on staff wellbeing - where can we find these resources? Thank you.

Our line manager shares no information with us in relation to the development of our department. There are no departmental policies which causes issues for new starters and inexperienced junior members of the team. There is no documentation to refer to for guidance within our department

The rapid implementation of changes within the team and the way communication has failed to inform staff of plans for the future as caused catastrophic stress and anxiety amongst the staff of all bands from 3-7 leading to a significant number of staff not only going off sick but leaving for other jobs.

I feel as a trust we have had lots of senior roles changed over recent times. We now need some guidance on what is most important for our trust and where all our long term goals sit. I am currently doing a role I did not apply for due to changes in the structure of our team and decisions need to be made.

The impact of changes in senior managers has been apparent - no communication. There appears to be a loss in direction due to lack of senior leadership. It feels that teams are working in silos rather than as part of one team. No co-ordinated approach

Told things will get better soon, not sure I believe they will ever get better

With constant changes in the community and not really knowing what is happening has been very hard. I do feel there needs to be more transparency, we hear the words enough but do not see the actions of this.

Very poor communication - The Trust appears less personable, and etiquette and decency to inform fellow colleagues of what is going on has been lost. We invest in Engagement but this isn't necessary - invest in each other - you don't need people giving you bulletins about what's going on, we receive these via social media

I often feel unaware of major decisions being made.

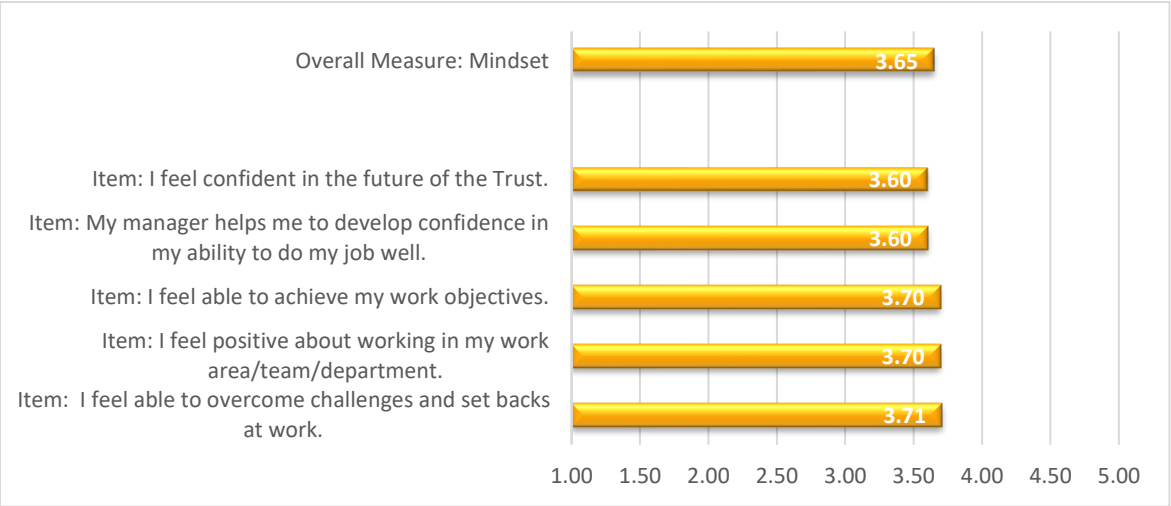
I was redeployed last year and felt like I was sent to Wigan infirmary and forgotten about!

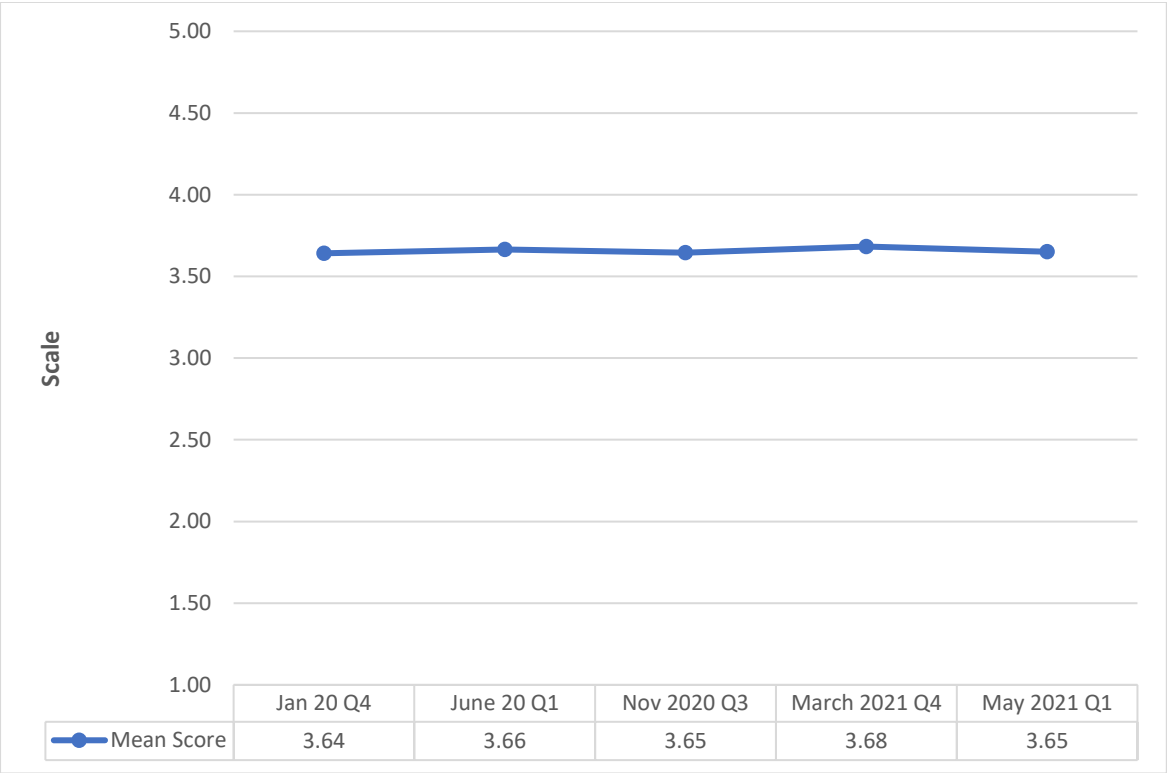
Redeployment wasn't the best experience in the last 12 months - 2 x redeployed and both handled poorly (poor communication, poor organisations, no clear instructions)

It can be extremely challenging working with teams outside of your own department as they have pressures that you don't see and they don't understand the demands of your work either. Can be extremely frustrating and demoralising!

Mindset

Scale				
1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree





Comments:

Feeling positive about their work

I have found a great difference in my work/life balance since working from home. I now come into the office 2 days a week and find that productivity is greater throughout the whole of the team.

The team and working environment is always positive.

Not feeling positive about their work

I am currently under review. It is stressful and my morale is at an all time low. This has contributed to my answers in the survey.

This used to be a great place to work. It felt like family. It was enjoyable, it was fair and people took time to look out for each other. We've more jobs for people who never go near a patient and spend their time trying to justify their role by coming up with more and more ways for Managers to take on more work.

Finding it difficult to work sometimes due to disability, however cannot afford to give up work.

Having worked for this organisation for many years, I feel moral is at a low, it is no longer a nice place to work. Most of the people I know of in this trust cannot wait to get out.

The Trust would be a great place to work if only they cared about the way staff feel about being shipped around like a number and not a professional. Odd times it is understandable but not every time you come to work being stressed that you may go and have to work in an area you have never worked before such as A+E or an admissions ward. These areas work in certain ways that general staff have no idea how it works and if you have not even done it as a student it is too stressful. I have a PIN no I worked hard for and to feel I could lose it because I have been sent somewhere I do not know is very scary. I do not work bank shifts for this reason. I like to know what my role is and where I am working.

Sorry this has been so negative I have never filled one of these out like this before.

I cannot express how disappointed I am with the organisation and morale right now. My line manager has failed to support me, failed to communicate and I feel I have nowhere to turn. I dread coming into work every single day. WWL has always felt like a family to me now I feel like an outcast. The new Chief exec is good, I like and respect him and the Trust vision is excellent but this does not filter down through the middle-management levels to clinical staff. For the first time in many years I am actively seeking alternative employment and cannot wait to leave WWL.

No pay rise for over ten years is insulting (please do not patronize me by stating the new increment system is a pay rise, because it is not).

I feel that the good will has gone.

A lot of things need to improve.

After 12 months shielding and working from home every day I go into work I feel physically sick. It has changed everything for me. I can cope with work changes but attitude changes are more difficult to cope with

If I am unwell and need to take time off work, I worry that I could lose my job. I try not to have time off, the medication that I take causes side effects. I have also been diagnosed with anxiety and depression, which is under control. I do not have any confidence in my manager, and constantly worry regarding my job.

Feeling able to overcome challenges and setbacks

I was badly injured in an accident outside of work and now have a disability. WWL have been a tower of strength to improve and adapt my working area so I could return to work. I cannot fault how much they have supported and helped me get back to a normal work life.

Not confident in the future of the organisation

I feel very disheartened in my role and there feels to be a lack of stability within the organisation

Other comments relating to Mindset:

Please consider that some of my answers are impacted by my current problems with mental health. I am usually an anxious person, and also suffer with low mood and depression. I can be anxious at work and this can come across very obviously towards colleagues but that doesn't bother me too much. Suffering with depression is very debilitating for me. I find myself able to suppress my emotions at work, and then when I get home, I tend to get upset due to feeling overwhelmed, possibly due to suppressing my emotions as I said. On my days off, I tend to go back to bed, and just want to sleep my time away. And when I am at work, I can't wait to leave when it is the end of my shift because I just want to be in my 'safe' place that I call home with my partner - who is very supportive of how I am currently feeling at present. I know that overcoming depression is a very long process, but I know that it is affecting me a lot.

It's been the hardest year of my career with COVID, my answers reflect how I am feeling now. Burnt out, exhausted and behind on my work

I am working at Leigh on my own ward, at the moment we are not up to full capability but hopefully it will be increasing soon, so it's a little frustrating

I will retire in my work place

In the last 14 months the medical and nursing profession has experienced an unprecedented time. . Many of my negative comments are due to a lack of nursing management structure due to changes in the team. I now have a permanent line manager whom I am happy with and hope things improve.

Working in the Trust for the past year due to covid has been mentally and physically exhausting. With our loss of team working and "hot desking" just add to the already very hard situation.

Part of this survey has been completed with a previous role in the Trust in mind

I recently developed an impairment. Even though my colleagues know about my problem, I need to remind them about my problem every time I work with them, which I found a bit embarrassing.

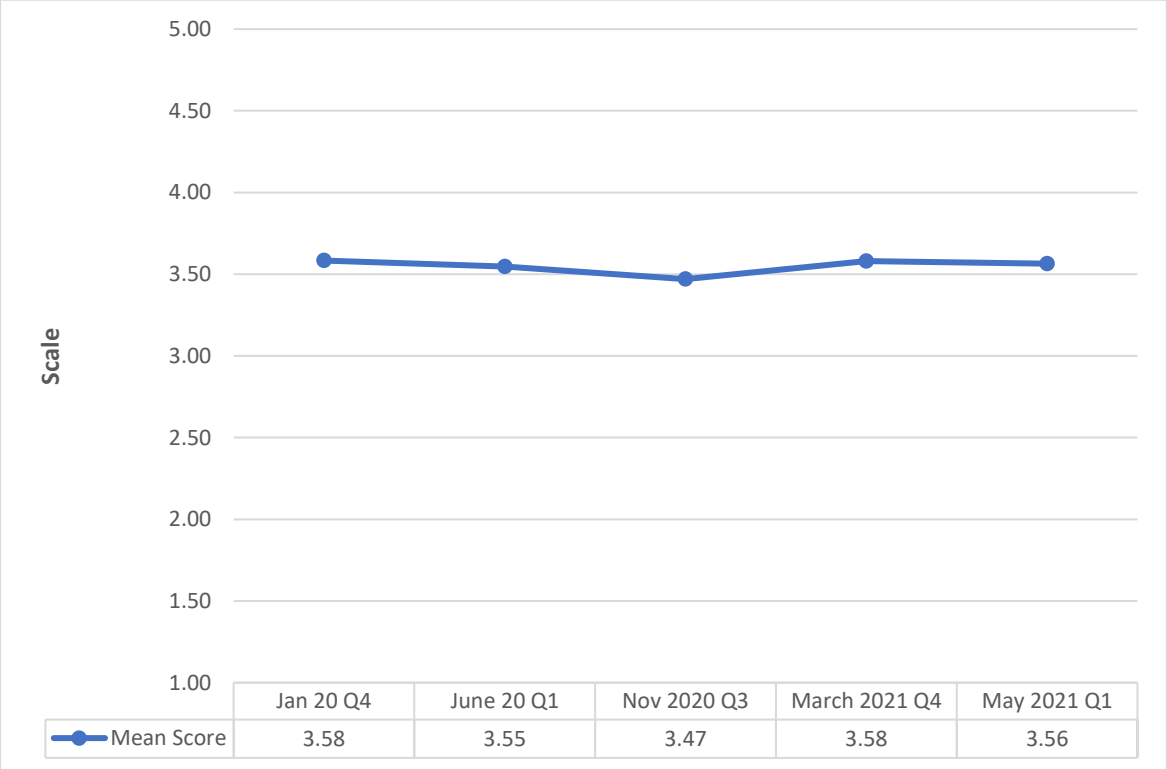
I have just returned back to practice in health visiting after a period of redeployment and am presently finding it difficult to step back into my old role. There are many challenges in health visiting which lay outside the remit of the Trust (working with Social Care). Some aspects of my role are extremely frustrating and time consuming and I often feel l like I am going round in circles. The present system of record keeping means that I spend more time writing records than having patient contact which is also quite frustrating. Health visiting is becoming a much more complex and difficult job than previously and this hasn't been helped by COVID. The job makes me feel very anxious at times and I often worry about things that I may not have done. Having said this, there are many positive aspects to the role which I appreciate and value such as the team I work with and the level of support available to me from my line manager.

This last year as been challenging and that is reflect in my answers

I have found my experience to be very different at different hospitals within this trust, the answers given on this survey relate to my current experience at RAEI only and not to my substantive post at WRI.

Personal Development

Scale				
1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree



Comments:

Satisfaction with opportunities to learn and professionally develop

There have been no opportunities for training or development

I have asked the Trust for help in training to be able to stay with the Trust as bank staff while I am at university, sadly this has not been provided. I would prefer to stay with the Trust however without the experience I might not be able to do so.

As for training this online is not as enjoyable as meeting with other staff and some of this is not relevant to Community staff.

Within the therapy team we are top heavy with Physiotherapists there are many band 7s and several 8as and there are only 2 band 7 Occupational Therapists and no 8a OTs, I find the opportunity to progress in OT very limiting and being in the minority we are constantly having to justify our role in each area, which can feel very tiring and is leading to staff leaving the Trust due to lack of job satisfaction.

There are very minimal chances of career progression & no encouragement from management.

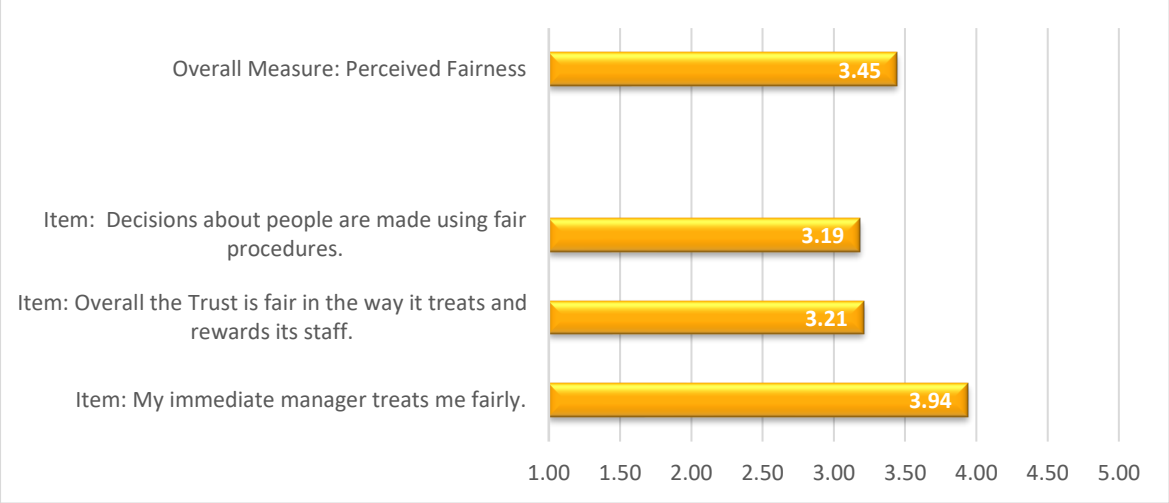
I feel that there are not many training opportunities for clerical staff within the Trust. Any courses that become available seem to be for nursing staff. I think that staff should be able to access courses offered by the local colleges/higher education with study leave and financial support from the WWL to widen their career prospects and give them options to change jobs within the Trust.

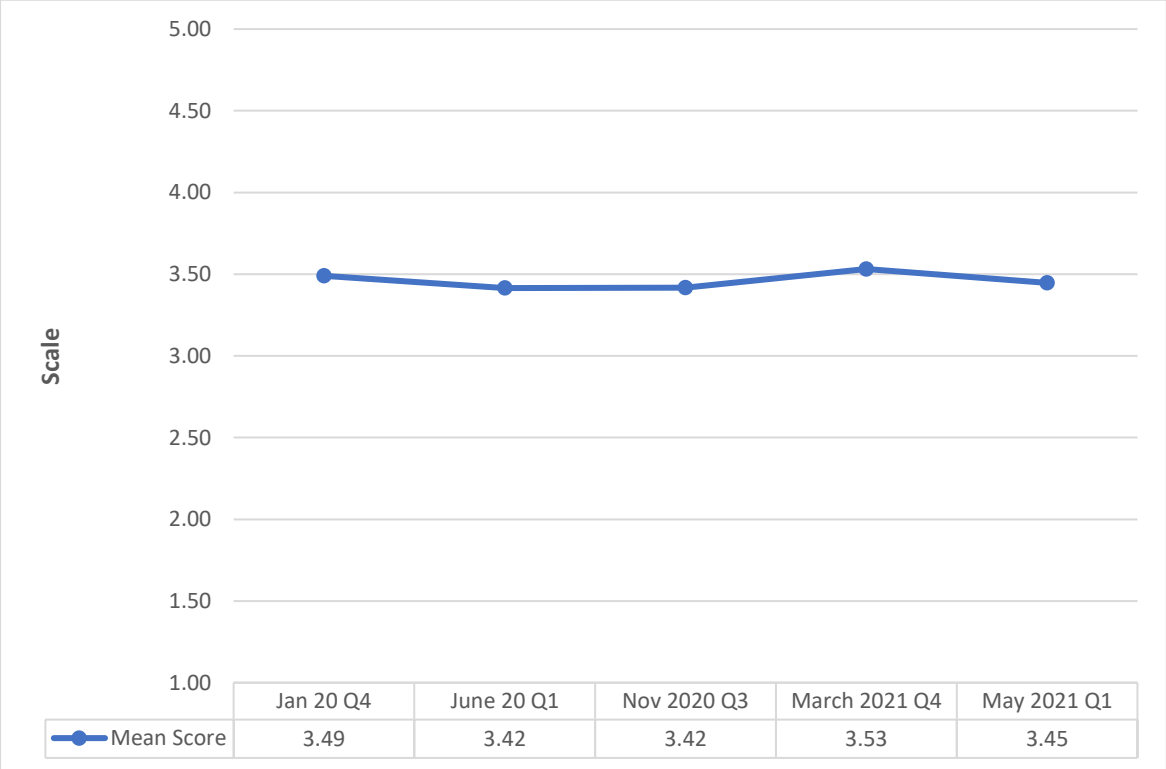
No opportunities for in house training or support (especially when working regular night shifts - night staff are forgotten, any training is delivered during the day)

I feel well supported by the organisation to develop in my areas of interest and move forward with my personal objectives.

Perceived Fairness

Scale				
1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree





Comments:

Not treated fairly by the organisation

I think the banding needs looking at a lot of us are on a band 2 and do band 3/4 work

I feel the sickness procedure is also unfair as long-term anxiety, and the physical symptoms of this (e.g. upset stomach/ insomnia etc). are not taken into account within the matrix so I am being told I am letting the team down when I am forced to be off sick - it also means that I am on my 1st warning again. I feel that my mental health issues are often used as a stick to beat me with in terms of sickness leave. The whole team are worried about taking time off or calling in sick because we are 'letting the team down' and 'causing stress to others'.

The NHS isn't a good place to work anymore, you are not supported, you are just a number, it depends who you are or what banding you are

Lower bands are paid less, yet do the most work and are not listened too.

During the past 16 months of being redeployed to a number of areas, it is apparent that if your face doesn't fit you get absolutely nowhere. If this was a predominantly male organisation half of the way we have been treated would not have been allowed to happen. I find this very disappointing to say the least. On return to my normal place of work, I feel we have been made to answer to certain circumstances that we would never have been made to answer to before.

Other comments relating to Perceived Fairness:

There is far too much demand on Managers in the Trust and not enough accountability for the actions of individuals who don't want to work by the rules or directions of the Trust

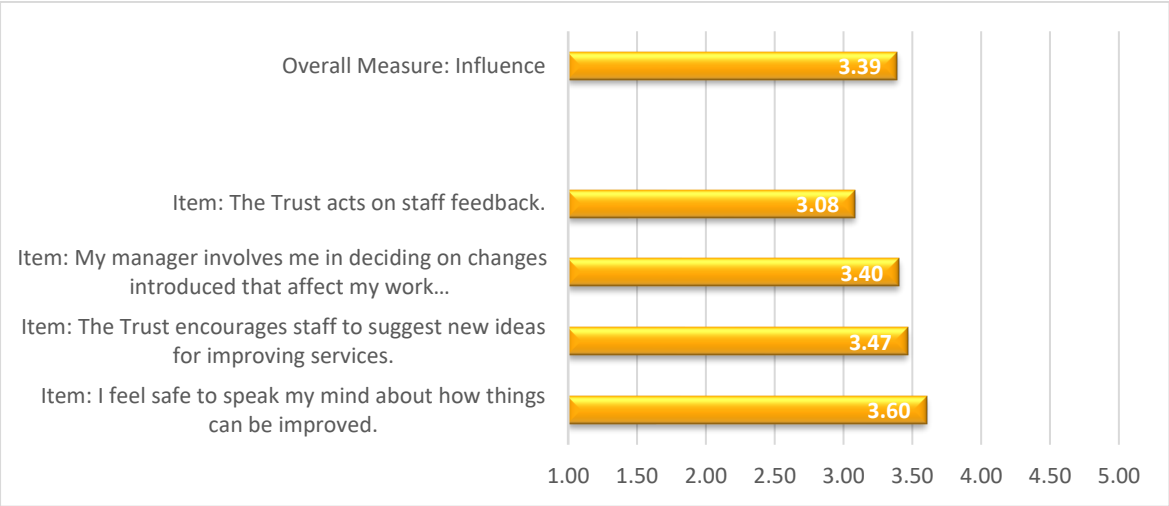
NHSP staff- why don't NHSP staff that do consistent hours for the Trust on the unit have access to all job applications, why are they internal this doesn't give some very good staff who actually want to work for the Trust a chance.

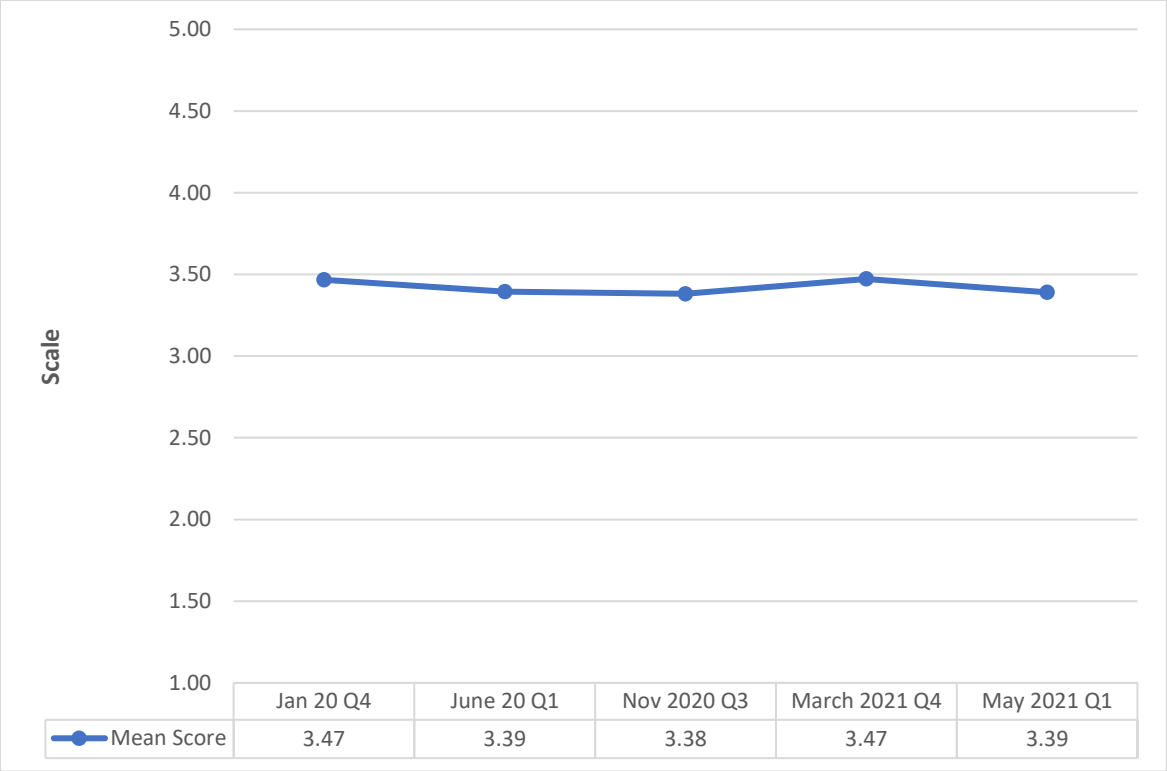
Blame culture if things not completed

Despite overall positives of working for WWL - the repeated frustration within the Trust is Management still failing to monitor, discipline and in some cases dismiss the same staff who consistently underperform, are continuously unreliable, who promote disruption and low morale within Teams and in opinion do not deserve to receive the salary from the Trust. That and unauthorised breaks and multiple smoking breaks on a supposed 'smoke free sites' that is also not monitored by Security for persons smoking on premises.

Influence

Scale				
1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree





Comments:
Feeling listened to

Staff need to be listened to and treated with respect.

Working environment is problematic and not fit for purpose - concerns raised have not been addressed. Feel that we have not been treated equitably. Others have a voice that's listened too whilst ours have not.

No matter how many times our staff have explained that the team lead is not training, communicating with or supporting us, this has fallen on deaf ears. 3 staff have left the department due to the lack of effective leadership. Any attempt to speak up is met with contempt or dismissal. The work environment is tense and unbearable. It's sad because the rest of the team are good members of staff who are being worn down by one bad apple.

I feel we are all just a number and nobody is bothered about our wellbeing or listens to our concerns.

Feeling involved in decision making

I do not feel like a big happy family and I think there are decisions made without including the staff.

My department is currently going through significant changes and senior management were not consulting with staff or protecting staff until the union was involved. Staff feel undervalued and replaceable.

Acting on staff feedback

Management at team leader level need to listen to their staff, take on board issues raised an act appropriately.

It's nice that staff engagement send out lots of positive things but they don't work in admin teams with so much infighting. It's a shame because I think there is a WWL family, it's just that we are not part of it. Nothing ever seems to happen with the feedback surveys. Because it's a difficult situation it's just ignored. What's the point?

I think that there are systems in place so that as a Trust we can say we have them but there isn't any real support when staff have a major problem or in fact that anyone really cares!

Will any of this be taken into consideration - I doubt it.

Issues with personal behaviours that cause disruption and anxiety to the team should be dealt with. This has been highlighted many times but the issues haven't been sorted.

Uniform issues, scrubs are required on this unit we work in the middle of outer buildings which is like working in a greenhouse. It doesn't look professional to have sweat patches on your uniform or running down your face, we can't have fans on and the windows don't open, again this has been asked before and nothing has happened.

I also feel that completing these surveys would appear to be futile after years of simple changes never to be addressed, acknowledged or implemented for simple cleaning up of the site from within.

Other comments relating to Influence:

As a manager I often feel helpless when trying to escalate sickness as there is so much discretion allowable in the policy and some staff know exactly how to play the game

Good survey but repetitive questions

Would like to see the organisation return focus, and funding to Quality Improvement. Relaunch Quality Faculty. Revive Quality Champions. Focus on human factors and simulation training. Reward your ward

managers. Consider 8a ward leader role whose focus is quality. More local Quality Leads needed in all areas not just ICU or maternity.

It is a pity that we don't have staff meetings to discuss our work, bring up problems, solve problems. At least I would feel part of a team.

Religion and sexuality is no one's business except for the individual.

These comments cannot be answered honestly with the five tick boxes. Not sure if this will help, no black and white answers to this survey. Lots of grey areas within the Trust.

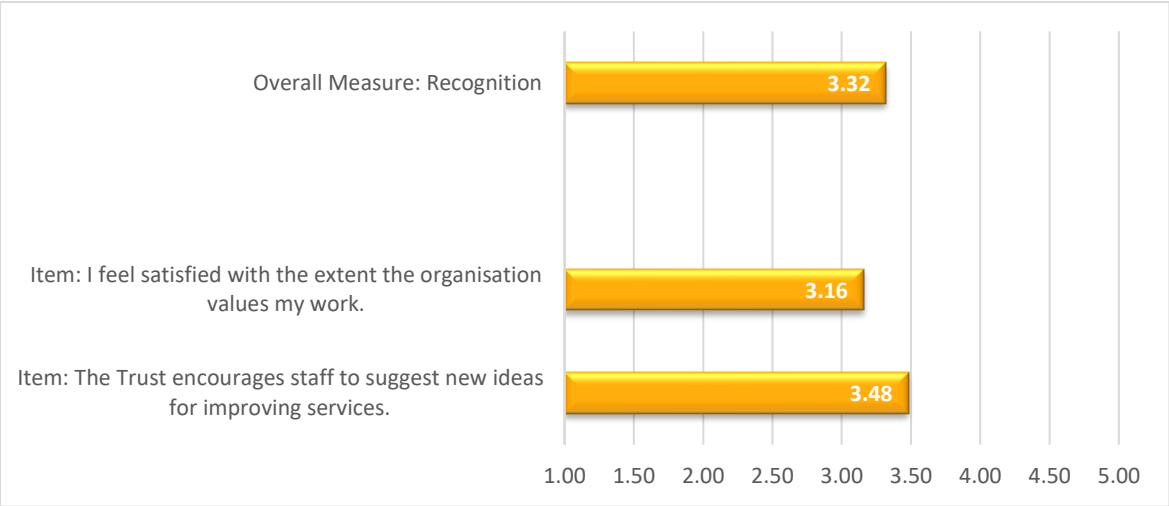
This survey could be a little shorter - some of it is repetitive and may put people off completing it

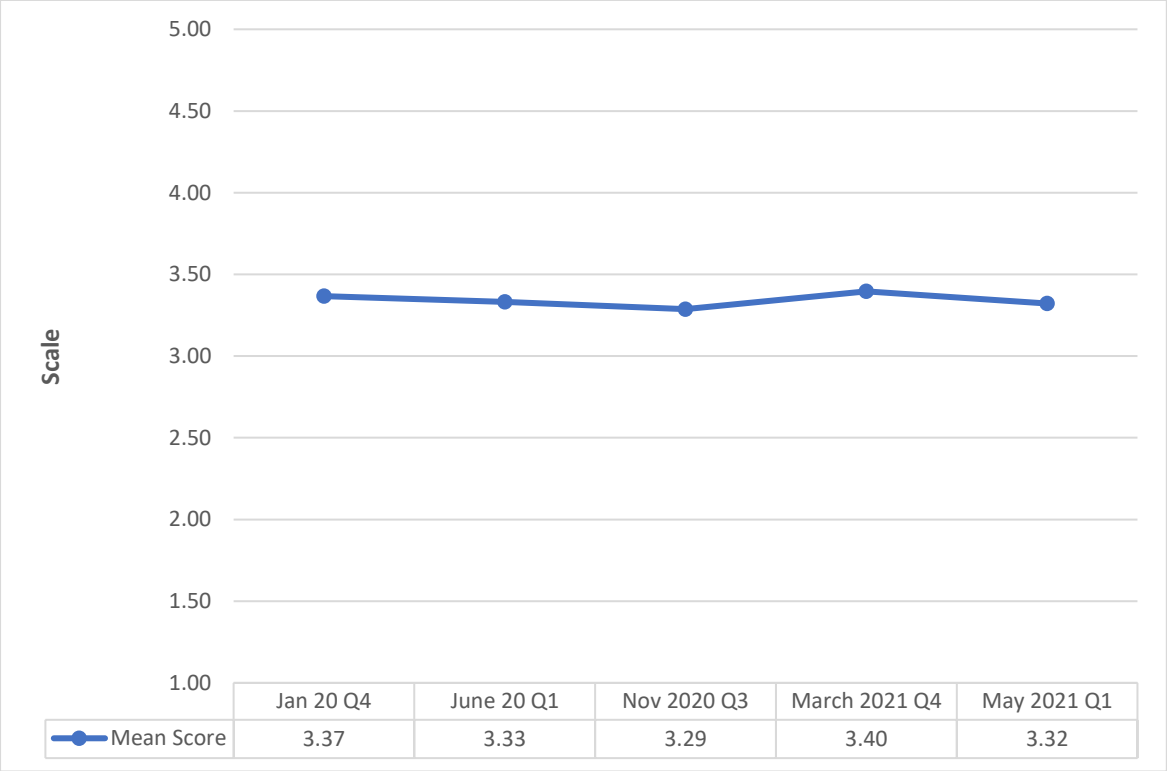
My mindset is I come to work do my work to the best of my ability and go home. I have not been happy with how things have not been adhered to in our department during the COVID pandemic, social distancing being one, don't have any confidence reporting issues, lots of things not done correctly. Feel if I did wouldn't be treated confidential.

Don't feel confident to raise issues.

Recognition

Scale				
1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree





Comments:

Valued/ recognised by the organisation

Attendance management - Reward those of us who don't take time off sick

I have worked for the NHS for many years. Most of this has been at Wigan. I have given everything to my job and have always been proud of working for WWL. I see this as my hospital. I have chosen to retire and return but the hours I wanted were not agreed. This was a decision which appears to have been made partially by accountants who have never met me and senior nurses who do not know my history. These people may not even stay to work in the Trust for long yet get to make decisions about people like me who have committed themselves over many years. This has left me feeling that I have no value within the WWL family. I am but a number. This would not have happened in the past. I have a high level of clinical skill and luckily, I am valued by my team. My vocation to the population of Wigan will not change once I reduce my hours and I have turned this situation into a positive as I will seek the extra hours of employment in other areas of interest, at a time that suits me. My loyalty to my patients will never waiver but I cannot show my loyalty to a Trust that seems to be faceless.

There are more people off sick with stress and anxiety now because of their job and loyalty means absolutely nothing anymore.

Acknowledgement for those who are not just nursing staff, working from home etc would go a long way for those who have been in the office throughout the pandemic and not picking and choosing their hours to suit their lifestyles!

I enjoy my job and feel confident working within my small team but I sometimes think that as a team that doesn't complain, ask for help and gets on with the job never gets any recognition or praise.

Happy to work in the Trust, but there is no show of loyalty & no appreciation for the dedication & work done

I feel after bending over backwards in the last 12 months.....it still isn't good enough.

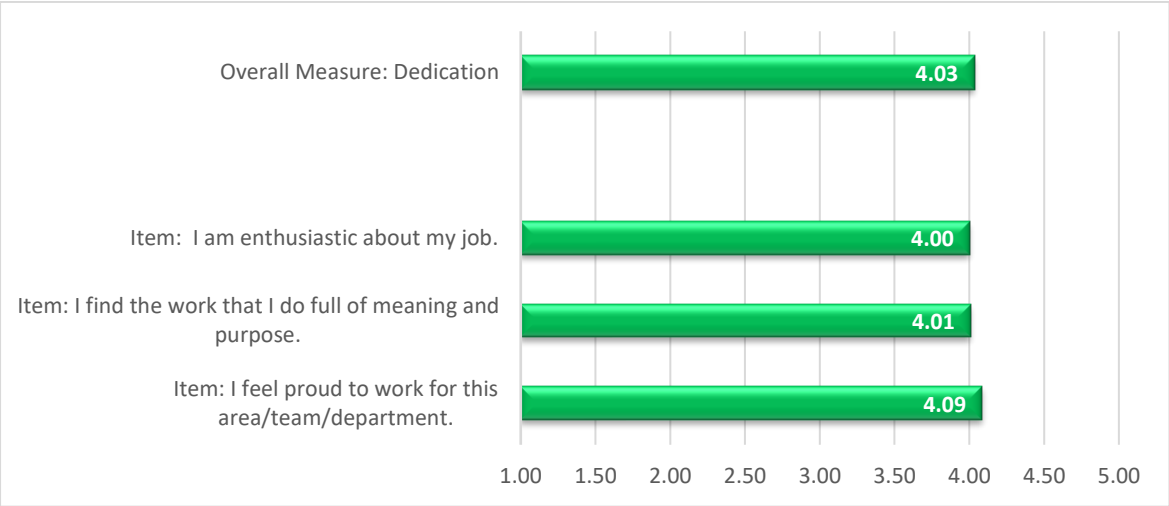
The Trust should find a way to reward staff who have just worked so hard through the pandemic I feel like it's just been forgotten about & we should just get on with life now

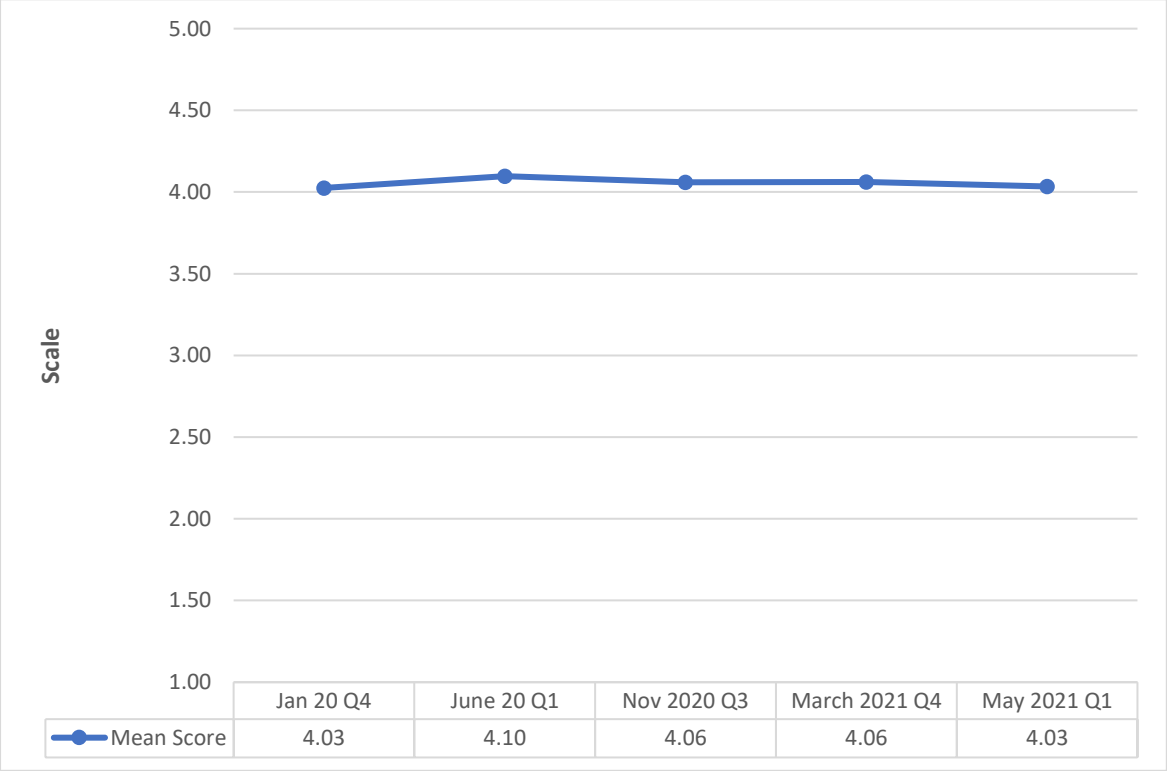
We are not part of WWL, as the hospital base is a different work environment totally from ours.

New staff need to be recognised more

Dedication

Scale				
1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree





Comments:

Feeling enthusiastic about their job

I enjoy working for WWL and have been a part of the teams for many years now. I work at RAEI Wigan hospital and really enjoy my job role and will continue to deliver great patient care to all my patients I look after.

As a working environment though I am happy within my role. I love working for the Trust and I love my job and I am proud to work here.

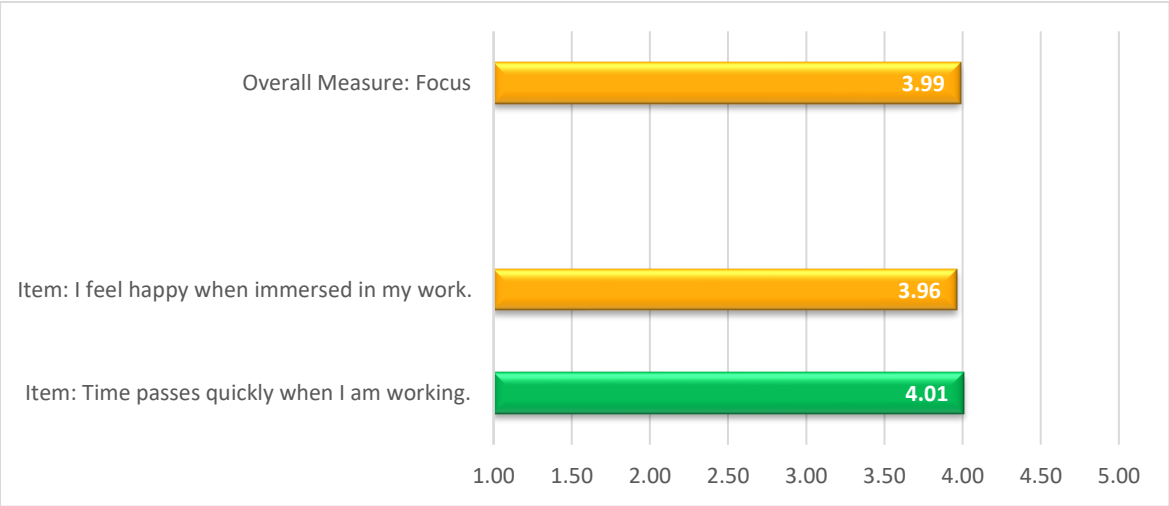
Overall, I enjoy working at WWL but accept that there will always be frustrations associated with my role.

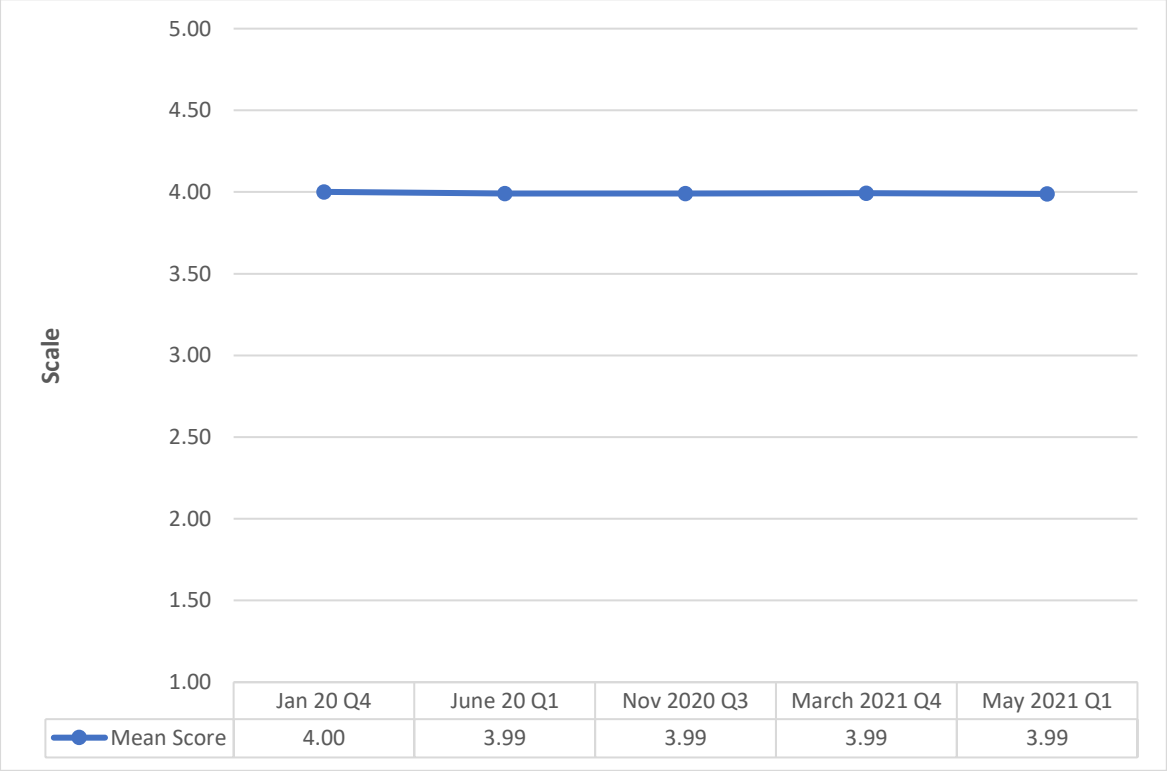
Feeling proud of the job they do

I feel confident and proud to work at WWL and I believe the organisation has worked extremely effectively and everyone has pulled together during this unprecedented pandemic.

Focus

Scale				
1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree



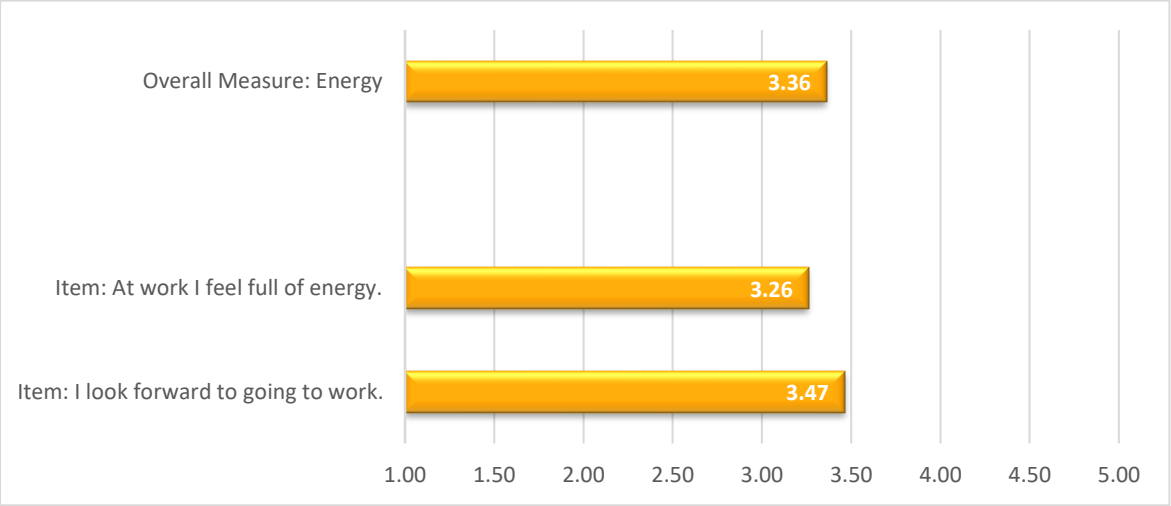


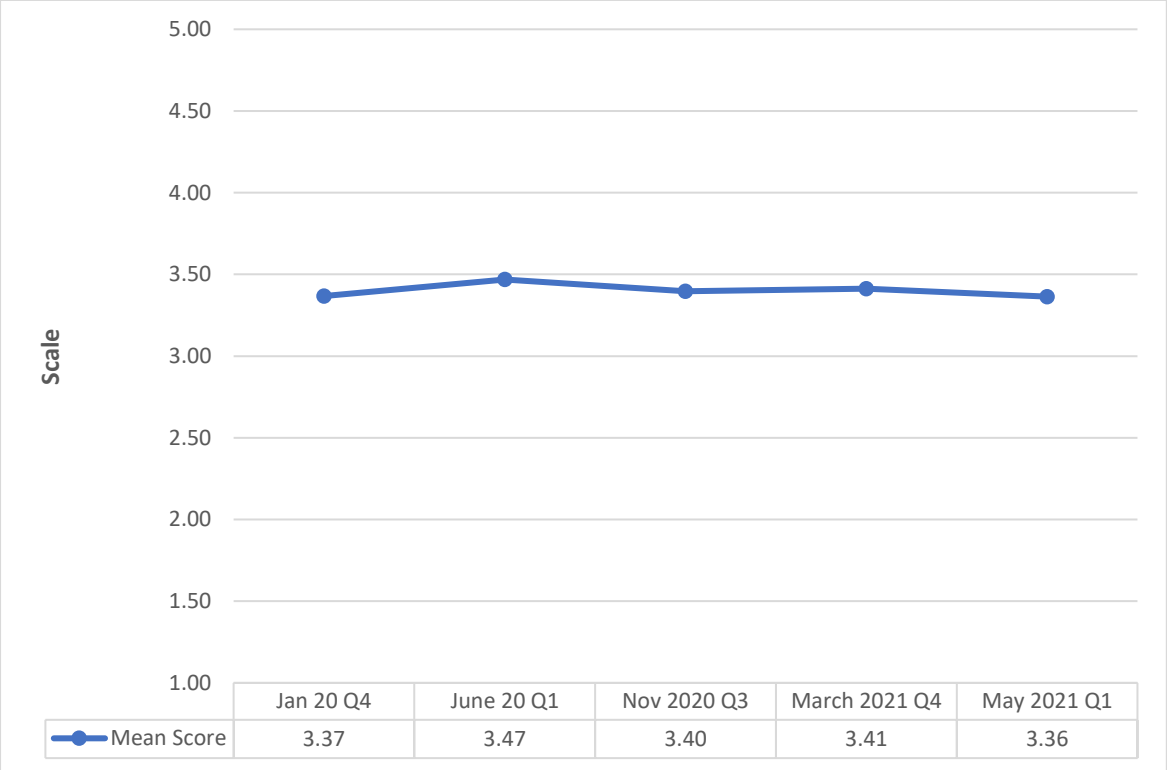
Comments:

None

Energy

Scale				
1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree





Comments:

Feeling full of energy at work

A lot of my answers are based on how I have been since contracting COVID, the tired aspect unfortunately has not left me, I am usually more exuberant but cannot seem to sustain that feeling at the moment.

I have had covid and have been diagnosed with covid. Some of my answers reflect that I am suffering with chronic fatigue.

I have a condition which makes me feel tired quite often. I have usually been well supported with any issues I have had.

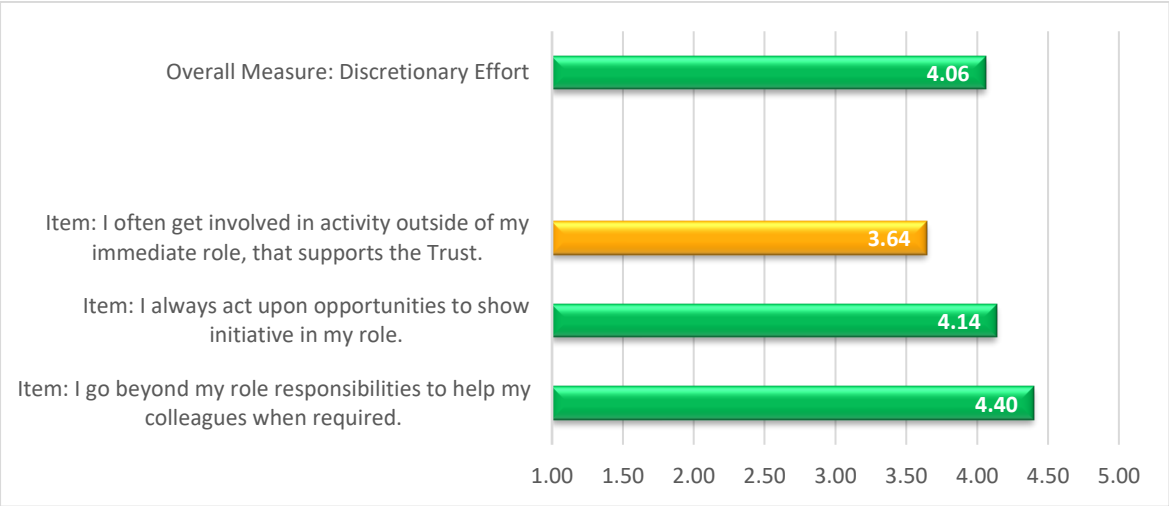
Other comments relating to Energy:

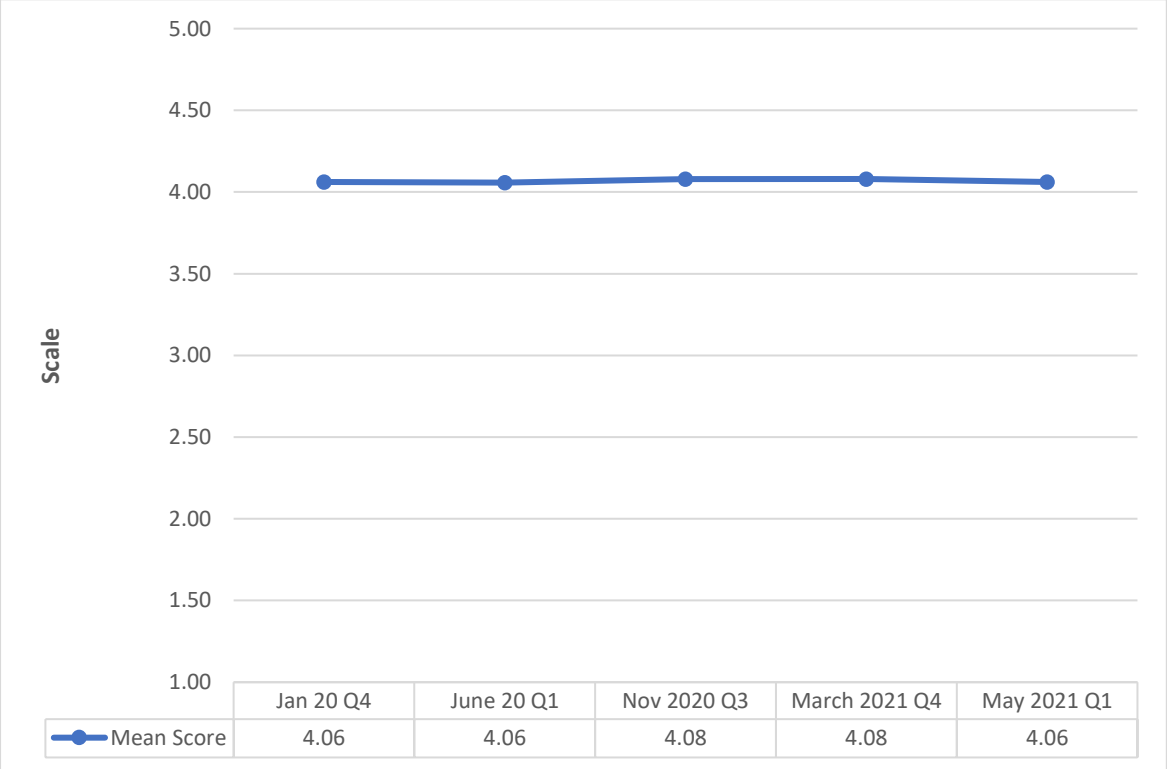
In the burnout question, instead of exhaustion from stress I feel exhausted from being bored at work and becoming deskilled. Tired of not being listened to or having any control so just accept this is how things are

My ward particularly has been extremely demanding since October when we all got covid there have been a number of significant changes.

Discretionary Effort

Scale				
1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree



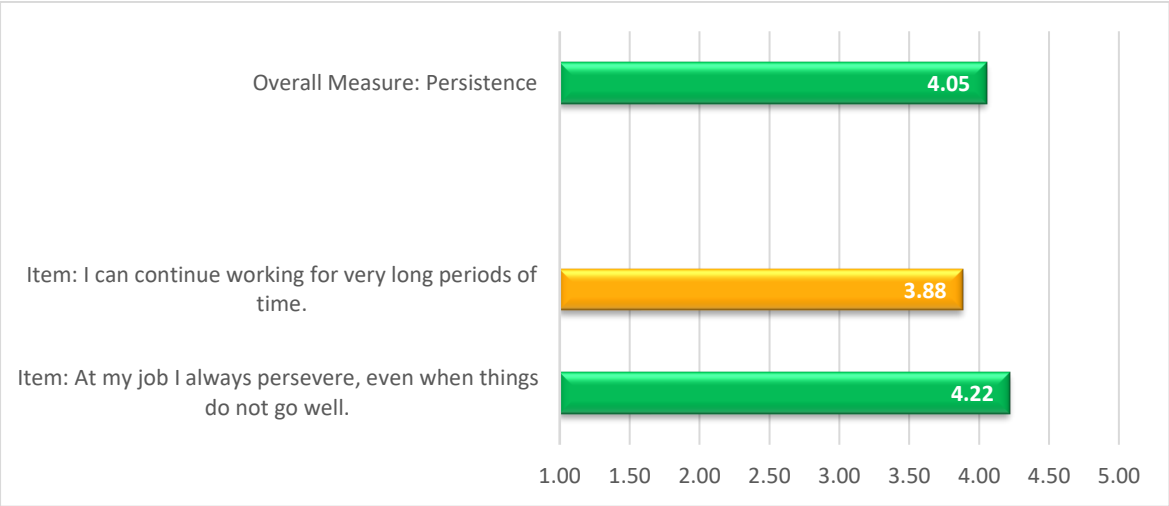


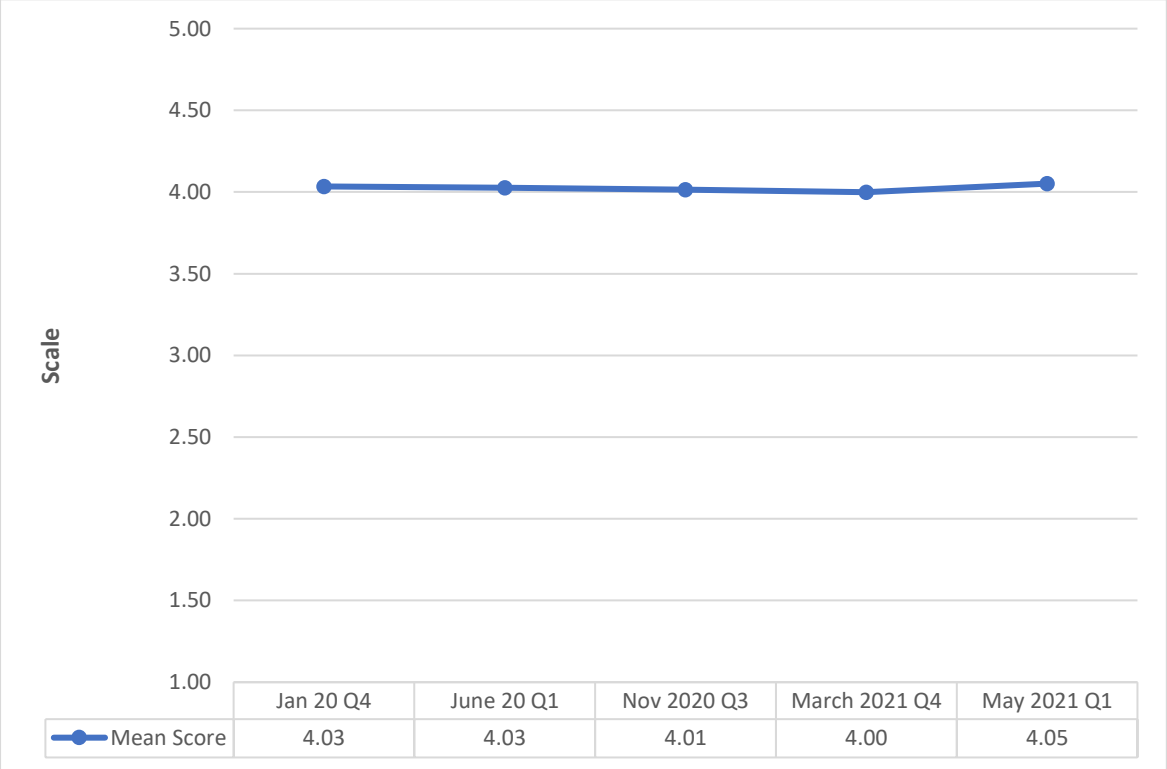
Comments:

None

Persistence

Scale				
1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree



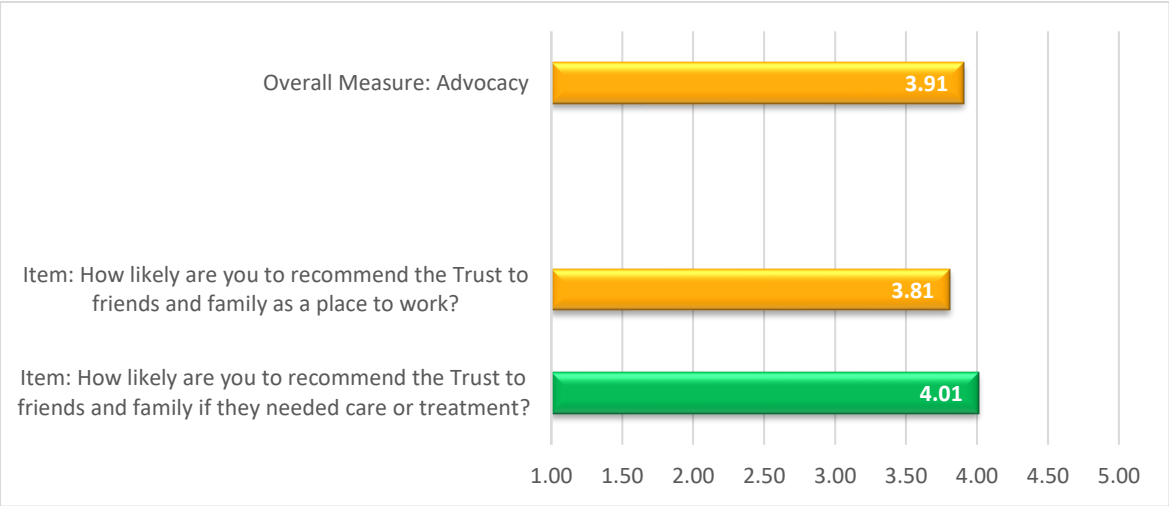


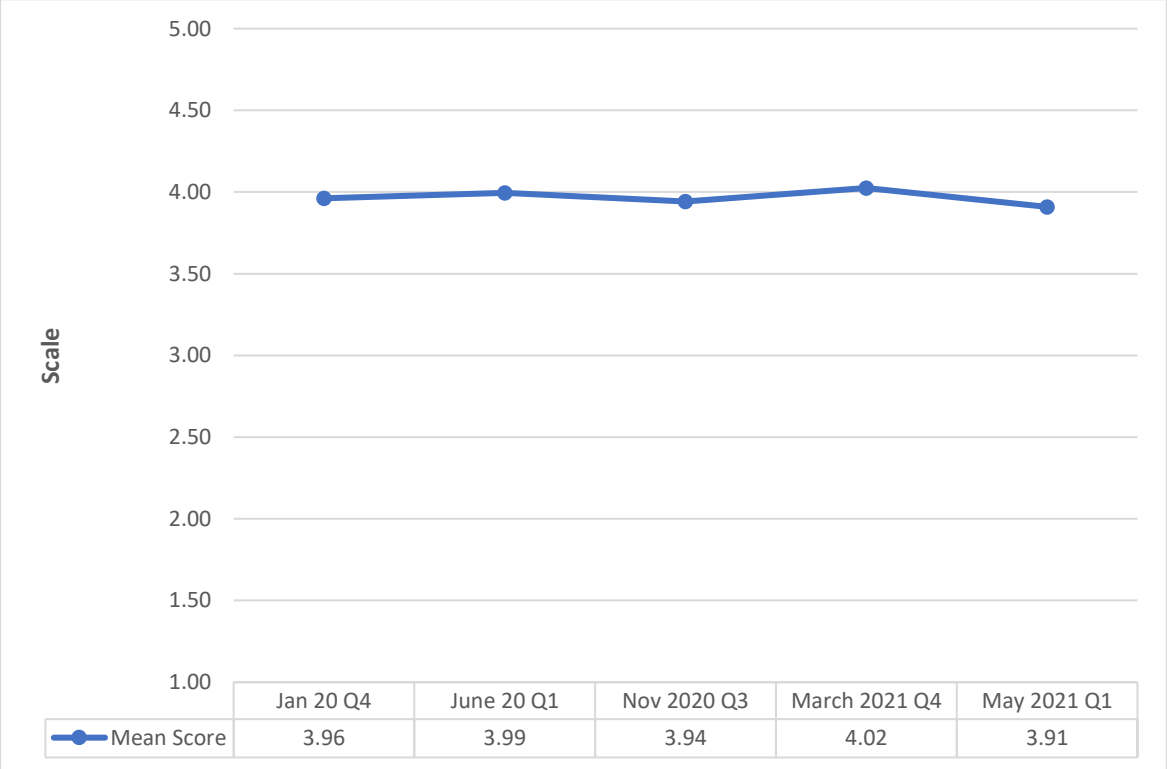
Comments:

It's been a challenging year and continues to be so with lots of changes

Advocacy

Scale				
1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree





Comments:

Recommending the Trust to family and friends as a place to work

Fantastic trust to work for, however it is a shame the way the NHS is being crucified

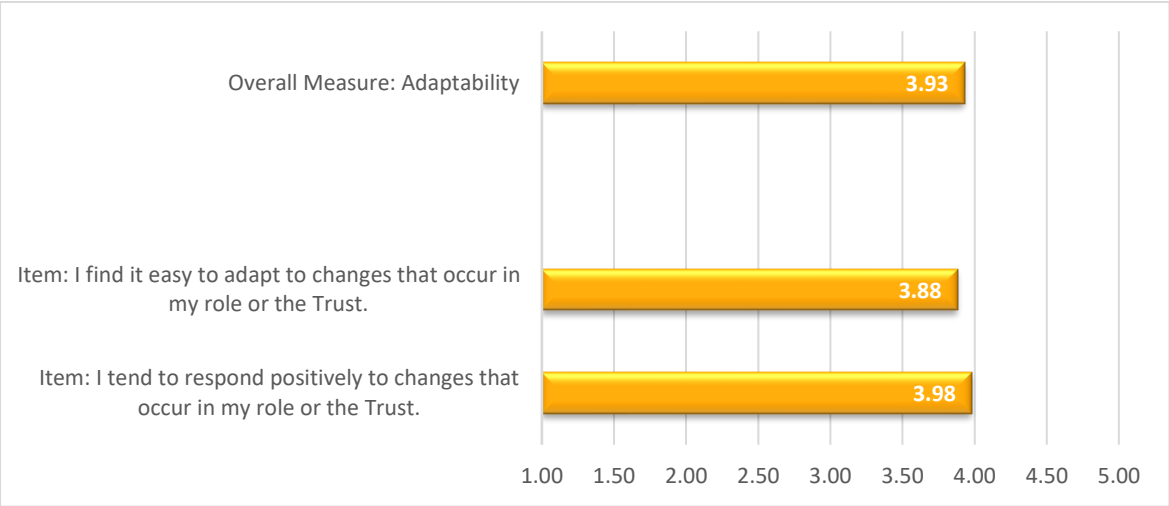
Recommending the Trust to family and friends as a place to receive care

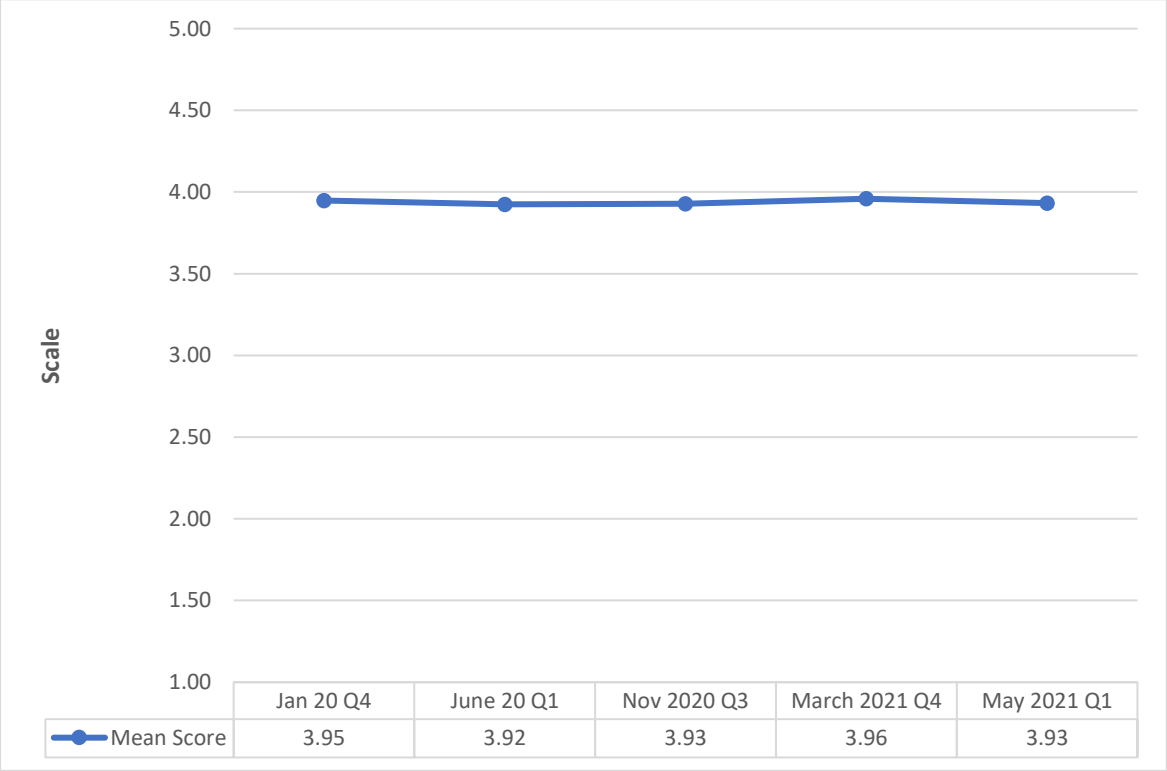
The foundations of this trust were built on care, support, compassion, and looking after its staff and patients

Over the last few months a family member has required emergency care and ongoing treatment at this hospital and the care that they and I have received has been amazing, something I will always be grateful for as both a staff member and a relative.

Adaptability

Scale				
1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree





Comments:

Adapting to changes within the Trust

For the last 12 months I have been able to work from home and some of the questions/replies took this into account. I feel a lot happier and more relaxed. Although the odd member of staff can be a bit unpleasant at times it is a lot easier to deal with not being in a small office having to deal with the

atmosphere that that can bring with it. I am hoping for my own anxiety levels and stress my working arrangements will carry on. Had I still been in the office the answers would have been completely different. My now working arrangements also help with childcare/school holidays so has helped me a lot over the last 12 months.

Because of changes made to our Team, the support of our clients will be diluted. Therefore, questioning whether we are providing appropriate/effective care/support, this is a concern for me

Redeployment wasn't the best experience in the last 12 months - 2 x redeployed and both handled poorly (poor communication, poor organisations, no clear instructions)

It has been a challenging time, we have had to all pull together as a wider service.

Title of report:	Guardian Quarter 4 report 2020/21
Presented to:	Board of Directors
On:	28 July 2021
Presented by:	N/A – consent agenda
Prepared by:	Shams Khan, A&E Consultant
Contact details:	E: Shams.Khan@wwl.nhs.uk

Report

This report has previously been considered by the People Committee and is presented to the Board for information.

Exception Report Break down

	H&R	Education	Both
General Medicine	13	16	2
Surgery	28	4	3
A&E	2	1	
Paeds		2	
T&O		1	

Totals

General Medicine	31
Surgery	35
Paeds	2
T&O	1
H&R	48
Education	20
Both	5
Total Exceptions	73

Overall, exception numbers look constant. I note that in general medicine, the balance has shifted to equal education and H&R while surgery remains an H&R issue. I have noted that several H&R

exceptions are actually education and we have forwarded these on to Professor Kumar and Cheryl Dagnall. I note the very positive action that has been already taken between an Educational Supervisor, Medical Education and Division of Surgery in addressing some of this.

The majority of exceptions again relate to the complex nature of medical and surgical patients and relate to ward rounds over running due to complex actions required or due to patients becoming more unwell. Medical and surgical ward rounds in general do not lend themselves to fixed tasks which take a fixed time. This is reflected in the reports themselves.

Whilst in previous reports, I have highlighted issues with locum staff, sickness and covid, these issues themselves are not the sole cause of breaches in hours and rest. Regardless of staffing levels and sickness, breaches occur due to the complex information that needs to be provided to families and patients and also in handling the complex results that often return late in the day and are not appropriate to be handed on to an on call team nor, in the view of the managing doctor, should be left to the following day.

The solutions to this are not straightforward and not necessarily as simple as having a changed rota or extra staff; they should be considered by division of medicine and surgery with their own trainees. Junior Doctor Forum will give the opportunity for information to be shared and plans to be made for H&R and TMEC can do the same for Education.

I did not see as many exceptions relating to locums in this quarter. I did note numerous exceptions where the trainee left half an hour later due to hand over. I did wonder if between divisions, this could be dealt with outside of exception reporting: for example, if this occurred due one evening and a rota co-ordinator could allocate time back sufficiently quickly there would be no need for TOIL or payment to be allocated via the Exception system. It would be reasonable to still report for purposes of informing and I would ask trainees and supervisors to not inadvertently lose track of more important breaches such as 13 hours of rest or 72 hours per week.

One issue that did arise is in information sharing – there are trainees who belong to this Trust but are hosted by another Trust. An example is FY psychiatry. The rotas are beyond the control of this Trust but the trainees at present struggle to exception report. We have facilitated the ability to exception report on our own system but this information would then need to be passed on to the relevant DME or guardian of that Trust for appropriate action. It may be preferable for the trainee to be added to that Trust's system for exception reporting and the information sharing to happen the other way. This would allow the host Trust to respond quicker to Exceptions and also to deal with remuneration directly. 2016 TCS does allow the role of the ES to be delegated to the CS in this circumstance.

There are some significant Education exceptions reported in surgery and I applaud the manner in which Medical Education, Division of Surgery and the trainee approached this.

The exceptions for Division of Medicine and Surgery are being shared with consultant representatives to allow for more bespoke management and this will be discussed at the Junior Doctor Forum.

Examples of Surgical Exceptions

Handover didn't start until after the shift ended due to work pressures and the need for the list to be updated first. Following the delayed handover I had long documentation to complete (had to write in retrospect) because the day had been so busy/I'd been called to help in theatre for 2-3 hours in the afternoon.
Only FY1 covering the wards (across several wards); number of patients = 20. We had to abandon the morning ward round as the SpR was called to emergency theatre. Second ward round of the day (grand round) finished at 4pm with no time for writing on the laptops during the round. Therefore; I had to stay to complete writing the ward round notes and any urgent outstanding jobs.
SpR was in theatre all day; and could not help on the wards. There was a very unwell patient who deteriorated just before 17:00. I stayed to assess the patient and organise a management plan; which I gained advice from the on call medical SpR for and then handed this over to the on call team.

Examples of Medical Exceptions

Myself and the other doctors on the ward were required to stay late on the CPAP unit on this day. A 31 year old with COVID was brought onto the ward from resus for a trial of CPAP; she was very unwell and needed a review and various jobs actioning. We also had to wait for the consultant to arrive on the ward and review this patient and action the jobs. At the same time another patient's clotting result returned very deranged so I needed to call the on call haematologist to discuss a management plan.
Ward pressure requiring to stay late
As I was leaving the ward at 5 pm; a nurse ran towards me saying the family had run out crying saying the patient was not breathing for about 15 seconds.I attended to the patient first and sorted out the patient which took me almost 40 minutes. I then tried to get the on-call F1 doctor involved and informed him about the patient. As patient was deteriorating; this needed senior attention. I then rang for senior med reg to help with this patient. As the med reg was very busy and couldn't come down personally he guided me over the phone as he knew this patient from previous admission. By the time this happened it was almost 6.10 pm. Also the family was there. As the parent team it would be much more professional and appropriate for me to update the family as the oncall team is not familiar with the patient. Sat down with family at 6.15pm to update them about patient. However; they broke into tears and started expressing their wishes about 'letting her go' and not doing anything that could hurt the patient any further. This conversation took about 20 minutes and they wanted to discuss with the rest of the family to ensure it was a unanimous decision. As there were very emotional; I offered to stay a little longer for them to come back with their decisions and questions. Documented every incident; conversations; senior advice and finally left the ward at 7.00 pm.

Vacancies

Vacancies on training rotas lead to pressures that contribute to exceptions.

Vacancies					
	Grade				
Speciality:	FY1	FY2	St1/2	St3+	Notes
A & E			1		GPST
Anaesthetics				3	Intensive Care Medicine
Medicine				1	Cardiology
Paediatrics			1	1	GPST
Rheumatology				1	Vacancy needs to be raised by division
Surgery			2		Upper Gi/Collorectal - both out to advert
T & O		1	1	1	ST3 Foot & ankle, FY2 RAEI (A), GPST

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Register of referrals received by the Clinical Ethics Group
Presented to:	Board of Directors
On:	28 July 2021
Presented by:	Not applicable – consent agenda
Prepared by:	Alison Jones, PA to Medical Director
Contact details:	T: 01942 822026 | E: alison.jones@wwl.nhs.uk

Executive summary

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

The Board will note that there has been one new referral since the last Board meeting.

Link to strategy

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

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

There are no financial implications arising out of this report.

Legal implications

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

People implications

There are no people implications in this report.

Wider implications

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

Recommendation(s)

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

Register of referrals made to the Clinical Ethics Group
23 April 2020 to 22 July 2021

Ref.	Date of referral	Time of referral	Urgent or routine referral	Date CEG convened	Time CEG convened	Summary of case	CEG recommendation	Issues escalated to management
CEG-001	1 May 2020	2045hrs	Urgent	1 May 2020	2120hrs	Request for elderly parents to be allowed to visit patient receiving end-of-life care where death was considered to be imminent. Balancing risk to the visitors against desire to visit their relative.	Recommended that visiting be permitted provided risks are explained and PPE is available and can be provided.	Noted that there are conflicting visiting policies in existence. Management to address and have one single policy.
CEG-002	3 May 2020	0942hrs	Retrospective for assurance	7 May 2020	0800hrs	Request to review the care of a now deceased patient, with particular reference to the DNACPR decision-making.	Noted that the referral did not require consideration of ethics in the current sense but comments on the case provided to the Medical Director by way of peer review. No concerns around decision-making or documentation identified.	Nil
CEG-003	3 Jun 2020	0900hrs	Retrospective for assurance	4 Jun 2020	0800hrs	Request to consider the use of best interests around antibody testing for patients without the capacity to consent	Matter referred to the Executive Scrutiny Group with feedback from the Clinical Ethics Group	To be considered by Executive Scrutiny Group
CEG-004	29 Jul 2020	1815hrs	Retrospective for assurance	6 Aug 2020	0800hrs	Request to consider applicability of duty of candour in a historic case.	Clinical Ethics Group view on the case was provided to the referring clinician.	Nil
CEG-005	10 Jul 2021	1129hrs	Urgent	10 Jul 2021	1300hrs	Request to support clinical decision making.	Clinical Ethics Group view on the case was provided to the referring clinician.	None related to the case but identified the need to recirculate info about the group and its role

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

CHARITABLE TRUST COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

1.1. Wrightington, Wigan And Leigh Teaching Hospitals NHS Foundation Trust ("the Foundation Trust") is the sole trustee of the Wrightington, Wigan and Leigh Health Services Charity, registered charity number 1048659, ("the Charity").

1.2. The Charity has powers under section 11 of the Trustee Act 2000 to appoint and delegate to agents. This power includes appointing a committee, membership of which is not necessarily restricted to its directors.

1.3. The Charity also has powers of advancement, as set out under section 32 of the Trustee Act 1925, as amended by section 9 of the Inheritance and Trustees' Powers Act 2014.

1.4. The Committee is authorised by the Board to act within its terms of reference. Members of the Charitable Trust Committee act as agents of the Foundation Trust. All members of staff are directed to co-operate with any request made by the Committee.

1.5. The Committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Foundation Trust with relevant experience and expertise, if it considers this necessary for or expedient to the exercise of its functions.

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

2. MAIN PURPOSE

2.1. The Committee will enable the Board to obtain assurance around the appropriate administration of charitable funds.

2.2. Its key duties are as follows:

(a) Set the purpose and strategy of the Charity, including any relevant associated policies;

(b) Determine the Charity's investment strategy, in line with the Trust's strategic direction and priorities;

(c) Approve the set up of any new sub funds;

(d) Set budgets; spending priorities and criteria for individual spending decisions, in respect of each fund;

(e) Agree business case expenditure from each fund, as per the Foundation Trust's Standing Financial Instructions, in line with the Committee's own strategy and overall affordability;

(f) Agree all material fund raising initiatives;

(g) Produce an annual report, in line with Charity Commission guidance, outlining all the Charity's key achievements and areas of specific patient/public interest

2.3. The Committee will provide its annual accounts to the Audit Committee.

3. MEMBERSHIP

3.1. The membership of the Committee shall consist of:

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

(b) Chief Finance Officer;

(c) Chief Nurse;

(d) Deputy Chief Executive;

(e) Director of Communications and Stakeholder Engagement; and

(f) Director of Strategy and Planning

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

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

4. SECRETARY

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

5. ATTENDANCE

5.1. The Associate Director of Financial Services and Payroll is required to attend meetings of the Committee.

5.2. A Governor representative will be appointed and entitled to attend meetings of the Committee.

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

5.4. Representatives of the Charity's Independent Reviewer shall be entitled to attend all meetings, if desired.

6. FREQUENCY OF MEETINGS

6.1. Four meetings per year will be scheduled.

6.2. If there is limited business to transact, the Chair will take the decision on whether the meeting should proceed, provided that there are a minimum of two meetings per year.

7. MINUTES AND REPORTING

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

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

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

7.4. The following groups shall report to the Committee:

(a) Divisional charitable fund groups;

(b) Sub funds

8. PERFORMANCE EVALUATION

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

9. REVIEW

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

Title of report:	Statutory, mandatory and recommended posts
Presented to:	Board of Directors
On:	28 July 2021
Presented by:	Not applicable – consent agenda
Prepared by:	Director of Corporate Affairs
Contact details:	T: 01942 822027 | E: paul.howard@wwl.nhs.uk

Executive summary

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

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

Link to strategy

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

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

There are no financial implications associated with this report.

Legal implications

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

People implications

There are no people implications arising from this report.

Wider implications

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

Recommendation(s)

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

Statutory, mandatory and recommended posts

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

Last updated: July 2021

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

Post	Description	Required by	Post holder
Designated Doctor for Safeguarding Children	To support other professionals in their agencies to recognise the needs of children. This should be explicitly defined in job descriptions. To provide Safeguarding Supervision to the Named Doctor for Safeguarding Children.	The Children Act 1989 and 2004; Working Together to Safeguard Children 2015 and 2018 (statutory guidance)	Shirley Castille (provided via CCG commissioning arrangements)
Named Doctor for safeguarding adults	To support other professionals in their agencies to recognise the needs of adults. This should be explicitly defined in job descriptions.	The Care Act 2014	Dr Muhammad Akram, ED Consultant
Named Doctor for Looked After Children		The Care Act 2014	Dr Godinho
Named nurse for safeguarding adults	To support other professionals in their agencies to recognise the needs of adults. This should be explicitly defined in job descriptions	The Care Act 2014	Paula Johnson and Nicola-Compton-Jones, Named Nurses for Safeguarding Adults
Named nurse for safeguarding children	To support other professionals in their agencies to recognise the needs of children. This should be explicitly defined in job descriptions	The Children Act 1989 and 2004; Working Together to Safeguard Children 2015 and 2018 (statutory guidance)	Sarah Rhodes, Named Nurse for Safeguarding Children
Named midwife for safeguarding	To support other professionals in their agencies to recognise the safeguarding needs of pregnant women and the unborn/newborn child. This should be explicitly defined in job descriptions	The Children Act 1989 and 2004; Working Together to Safeguard Children 2015 and 2018 (statutory guidance)	Sharon Heap, Named Midwife for Safeguarding
Responsible Person	To ensure the correct processing of blood or blood components, including storage and distribution and providing information as required	Blood Safety and Quality Regulations 2005	Jim Wesson, PAWS
Medical Physics Expert (Nuclear medicine) Radiation Protection Advisor (Ionising Radiation and Lasers)	An individual with the knowledge, training and experience to act or give advice on matters relating to radiation physics applied to exposure	Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R)	Emma Birch and Christie Theodorakou, Medical Physics Experts

Post	Description	Required by	Post holder
Radiation protection supervisor	To secure compliance with the regulations in respect of work carried out in areas made subject to local rules.	Part 3, Section 14 Ionising Radiation Regulations 2017 and Health and Safety Executive Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R)	Lee Unsworth (lead RPS, with specific RPSs for different modalities)
Superintendent pharmacist	A pharmacist who has been notified to the registrar	Section 71 Medicines Act 1968	Mike Parks, Chief Pharmacist
MANDATORY POSTS			
Caldicott Guardian	A senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly	Health Service Circular HSC 1999/012	Sanjay Arya, Medical Director
Guardian of Safe Working	To oversee work schedule review process and to address concerns relating to hours worked and access to training opportunities	2016 terms and conditions of service for doctors and dentists in training	Shams Khan, A&E Consultant
Accredited Security Management Specialist	Focal point for the local delivery of professional security management work carried out to a high standard within a national framework	Direction to NHS bodies on Security Management Measures 2004	Jason Carr, Security and Car Parking Manager
Accredited Local Counter-Fraud Specialist	To manage fraud, bribery and corruption risks across the organisation and ensure the Trust is compliant with the NHS Counter Fraud Authority (NHS CFA) requirements and the expectations detailed in the Government's Functional Standards (GovS 013), relating to Fraud, Bribery and Corruption.	NHS Counter Fraud Authority (NHS CFA) requirements and the expectations detailed in the Government's Functional Standards (GovS 013) 2021	Collette Ryan, Fraud Specialist Manager
Senior Information Risk Owner	Executive director or member of the senior management board with overall responsibility for an organisation's information risk policy, accountable and responsible for information risk across the organisation.	David Nicholson letter dated 20 May 2008 (Gateway reference 9912)/Data Security and Protection Toolkit	Richard Mundon, Director of Strategy and Planning

Post	Description	Required by	Post holder
Senior Independent Director	To provide a sounding board for the Chair and to serve as an intermediary for other directors when necessary. Should be available to governors if they have concerns that contact through the normal channels of chairperson, chief executive, finance director or secretary has failed to resolve or for which such contact is inappropriate.	Provision A.4.1 NHS Foundation Trust Code of Governance	Lynne Lobley, NED
Named nurse for looked after children	A registered nurse with additional knowledge, skills and experience that has a particular role with looked after children and is the lead professional for these children	Looked After Children: Knowledge, Skills and Competences of Health Care Staff (Intercollegiate Role Framework March 2015)	Michelle Nicholls, Named Nurse for Children in Care
Company Secretary	The secretary of the foundation trust or any other person appointed to perform the duties of secretary	Foundation Trust Constitution	Paul Howard, Director of Corporate Affairs
Resuscitation Officer	Responsible for coordinating the teaching and training of staff in resuscitation. One WTE per 750 members of clinical staff is recommended.	Resuscitation Council (UK) Quality Standards for cardiopulmonary practice and training	Janet Woods, Shahid Solaman and Matt Sawyer
Medication error lead	A board-level director to have the responsibility to oversee medication error incident reporting and learning	Patient Safety Alert NHS/PSA/D/2014/005 MHRA/NHS England March 2014	Sanjay Arya, Medical Director
UK Visa and Immigration Authorising Officer	Senior and competent person responsible for the actions of staff and representatives who use the Sponsorship Management System	UK Visas and Immigration	James Baker, Deputy Director of Human Resources
Health inequalities lead	Named executive board member responsible for tackling inequalities	Bullet C4(4), letter from Simon Stevens and Amanda Pritchard dated 31 July 2020 (“Phase 3 letter”)	Sanjay Arya, Medical Director

Post	Description	Required by	Post holder
RECOMMENDED POSTS			
Learning from Deaths Champion	To ensure that processes are robust, focus on learning and can withstand external scrutiny, that quality improvement becomes and remains the purpose of the exercise and that the information published is a fair and accurate reflection of achievements and challenges	National guidance on learning from deaths (National Quality Board, March 2017)	Martin Farrier, Associate Medical Director
Sustainability Improvement Champion	An person to take responsibility for leading the spread efforts and helps to ensure the sustainability of interventions already implemented.	Sustainable Development Unit guidance	Tony Warne, NED
NED Lead for Freedom to Speak Up	A nominated non-executive director to receive reports of concerns directly from employees (or from the Freedom to Speak Up Guardian) and to make regular reports on concerns raised by staff and the organisation's culture to the Board	Freedom to Speak Up Review 2015	Clare Austin, NED
NED lead for mortality	To have oversight of the mortality process	National guidance on learning from deaths (National Quality Board, March 2017)	Steven Elliot, NED
NED lead for safeguarding	To ensure appropriate scrutiny of the organisation's safeguarding performance and to provide assurance to the board of the organisation's safeguarding performance. Core competencies around training and understanding set out in the guidance	Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff, Fourth Edition, January 2019, p.61	Rhona Bradley, NED
NED lead for end of life care	A lay member of the board with specific responsibility or a role for end of life care.	End of Life Care Audit - Dying in Hospital 2016	Steven Elliot, NED

Post	Description	Required by	Post holder
NED lead for EPRR	To support the Accountable Emergency Officer to endorse assurance to the board that the organisation is meeting its obligations with respect to EPRR and relevant statutory duties under the Civil Contingencies Act 2004 and the National Health Service Act 2006 (as amended)	NHS England Core Standards guidance for Emergency Preparedness, Resilience & Recovery (EPRR), p.17	Robert Armstrong, Chair
NED lead for procurement	A non-executive director to sponsor the procurement function	NHS Procurement: Raising our Game, p.19 (DHSC gateway reference 17646)	Mick Guymer, NED
Designated board member for Maintaining High Professional Standards (MHPS)	Representations may be made to the designated Board member in regard to exclusion, or investigation of a case if these are not provided for by the NHS body's grievance procedures. The designated Board member must also ensure, among other matters, that time frames for investigation or exclusion are consistent with the principles of Article 6 of the European Convention on Human Rights.	Maintaining High Professional Standards in the Modern NHS (2003)	Clare Austin, NED
NED lead for resuscitation	A non-executive director given designated responsibility on behalf of the board to ensure that a resuscitation policy is agreed, implemented and regularly reviewed within the clinical governance framework	Health Service Circular 2000/028	Lynne Lobley, NED
Wellbeing Guardian	To look at the organisation's activities from a health and wellbeing perspective and act as a critical friend, while being clear that the primary responsibility for our people's health and safety lies with Chief Executives or other accountable officers.	NHS People Plan	Ian Haythornthwaite, NED
MRI responsible person	A person with day-to-day responsibility for safety in the MRI centre	MHRA guidance	Barry Burgess, Cross-Sectional Imaging Manager

Post	Description	Required by	Post holder
Freedom to Speak Up Guardian	A person appointed by the organisation's Chief Executive to act in a genuinely independent capacity	Freedom to Speak Up Review, Feb 2015	Lynda Hancock, FTSUG (temporary cover)
Freedom to Speak Up Executive Lead	At least one nominated executive director to receive and handle concerns	Freedom to Speak Up Review, Feb 2015	Alison Balson, Director of Workforce
Medication Safety Officer	A person notified to the Central Alerting System to support local medication error reporting and learning and to act as the main contact for NHS England and MHRA.	Patient Safety Alert NHS/PSA/D/2014/005 MHRA/NHS England March 2014	Kim Ferguson, Medicine Safety Officer
Board-level lead for Net Zero	Board-level lead	Delivering a Greener NHS, 2021	Alison Balson, Director of Workforce
WWL POSTS			
NED for FOI internal reviews	To provide an independent perspective to internal freedom of information reviews	Internal approach	Mick Guymer, NED