# Board of Directors public meeting

*Wed 31 March 2021, 13:30 - 15:30*

**via Videconference**

# Agenda

## 9. Declarations of interest

*Information* *Robert Armstrong*

## 10. Minutes of previous meeting

*Approval* *Robert Armstrong*

Minutes - Public board - Jan 2021.pdf (9 pages)

## 11. Chair and Chief Executive's Report

*Information* *Robert Armstrong / Silas Nicholls*

Chief Executive's report - Mar 2021.pdf (5 pages)

## 12. Patient story

*Discussion* *Rabina Tindale*

Verbal item

## 13. Committee chair's reports

*Discussion* *Committee Chairs*

Verbal item

## 14. Board assurance framework

*Approval* *Robert Armstrong*

14. BAF - Performance - March 2021.pdf (2 pages)
14. BAF - People - Mar 21.pdf (3 pages)
10. BAF - Patients - Mar 2021.pdf (2 pages)
BAF - Partnerships - Mar 2021.pdf (2 pages)

## 15. Performance report

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

15. Performance Report.pdf (4 pages)

## 16. Strategy 2021/30

*Approval* *Richard Mundon*

16. Trust Board March 2021 - Our Strategy 2030.pdf (2 pages)
16. Strategy Updated Version as at 230321 Low Res.pdf (18 pages)

## 17. Approach to disciplinary policy

*Discussion* *Alison Balson*

17. Disciplinary process policy review.pdf (6 pages)
17. Disciplinary Policy 2021.pdf (28 pages)

## 18. Mortality update: Q3 2020/21

*Discussion* *Sanjay Arya*

18. QS Mortality Report Q3 2020 - 2021 Final.pdf (8 pages)

## 19. Safe staffing report

*Discussion* *Rabina Tindale*

19. Safe staffing Report March 2021 (3).pdf (18 pages)

## 20. Corporate objectives FY2021/22

20. Trust Board March 2021 - 202122 Corporate Objectives.pdf (6 pages)

## 21. Consent Agenda

### 21.1. Appointment of Deputy Chief Executive

21.1 Appointment of Deputy Chief Executive.pdf (2 pages)

### 21.2. Review of risk appetite statement

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

### 21.3. Infection prevention and control board assurance framework

21.3 IPC Update and BAF.pdf (30 pages)

### 21.4. Register of Clinical Ethics Group referrals

21.4 Register of CEG referrals.pdf (3 pages)

### 21.5. Public finance report

21.5 Board Report 20-21 February month 11 Public.pdf (2 pages)

### 21.6. Gender pay gap report

21.6 Gender Pay Gap report.pdf (6 pages)

### 21.7. Modern slavery statement 2021/22

21.7 Draft modern slavery statement 2021-22.pdf (2 pages)

### 21.8. Use of the common seal

21.8 Use of the common seal.pdf (4 pages)

### 21.9. Register of directors' interests

To follow

21.9 Register of directors' interests - attachment.pdf (2 pages)

### 21.10. Fit and proper persons as directors report

To follow

21.10 Directors' fit and proper person checks.pdf (4 pages)

### 21.11. Board Diversity Policy

21.11 Board diversity policy.pdf (5 pages)

### 21.12. Community Health Investment Partnership (CHIP) Scheme

21.12 Community Health Investment Partnership (CHIP) Scheme.pdf (7 pages)

## 22. Questions from the public

## 23. Date, time and venue of next meeting

Wednesday 26 May 2021

**WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST**

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

**HELD ON 27 JANUARY 2021, 2PM**

**BY VIDEOCONFERENCE**

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

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**11/21 Chair and quorum**

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

**12/21 Apologies for absence**

No apologies for absence were received.

**13/21 Declarations of interest**

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

**14/21 Minutes of previous meeting**

The minutes of the previous meeting held on 25 November 2020 were **APPROVED** as a true and accurate record. Confirmation was provided that all actions on the action log had been completed.

**15/21 Chair and Chief Executive's report**

The Chief Executive presented an update to the Board on the current situation at the Foundation Trust with regard to the third wave of the COVID-19 pandemic.

The Chief Executive detailed that Wigan has been one of the highest affected areas, and although a decline in COVID-19 admissions had started to be seen, significant pressures remained in critical care and general acute beds. Although pressure at the Foundation Trust was added to as a result of large numbers of staff off with unplanned absence or shielding, there are 100 more nurses back from absence in January than in comparison with November 2020.

As a result of the impact of the third wave of the pandemic Greater Manchester has implemented its surge plan, which means that 300 critical care beds are required across the region, which has had a significant impact on staffing at the Foundation Trust. Mutual aid agreements are in place both across the region and nationally. Staff at the Foundation Trust continue to be redeployed using a risk-based and skills-based approach. The process for redeployment has been refined with each wave, and staff continued to be provided with psychological support.

As a consequence of the impact of the third wave of the pandemic, a decision has been made to restrict the Elective Recovery Programme. Patients on waiting lists will be rescheduled in order of priority.

The Chief Executive provided an overview of the Foundation Trust's COVID-19 vaccination programme to date. As at 22 January 2021, the Foundation Trust has administered 7,000 vaccines, 5,500 of those to WWL staff and the remainder to priority groups such as primary and social care staff. As a hospital hub, the Foundation Trust has been asked to extend the scope of its vaccination programme to cover 6,000 additional people such as frontline social care staff from across the borough and frontline primary care staff. The Chief Executive thanked the Director of Strategy and Planning and his team for their hard work in facilitating the vaccination programme.

The Chief Executive detailed the five key priorities for the NHS in the North West as follows:

1. Create immediate capacity through safe discharge
2. Maximise the pace of roll-out and delivery of the COVID-19 vaccination programme
3. Ensure rigour and professionalism of infection prevention and control processes across all settings
4. Participate fully in system gold mechanisms to support each other, increase critical care surge capacity and protect urgent non-COVID-19 work for as long as possible
5. Support staff through strong communication and providing health and wellbeing and pastoral support

With regard to the financial position, the Board heard that in the first half of the FY2020/21, all COVID-19 expenditure had been matched each month and therefore the Foundation Trust had reported a break-even position throughout. In the second half of the year, a COVID-19 expenditure 'pot' had been provided at a system level, which meant a £3m deficit each month. Concerns have been raised with NHS England and NHS Improvement, and the Regional Finance Director. The Foundation Trust continues to authorise COVID-19 expenditure and will closely monitor the situation through the Finance and Performance Committee and the Board of Directors.

Nationally, safe staff reporting to the Board has been paused.

The Chief Executive detailed that the Foundation Trust has applied to the Department of Work and Pensions for 30 6-month kick start placements for those who are unemployed between the ages of 16-24 year olds to work in COVID-19 support roles.

The Board heard that temporary registers have reopened for international recruits and domestic students in the last 12 weeks of their undergraduate nursing course.

The Chair reiterated the success of the Foundation Trust's vaccination programme to date. The Director of Strategy and Planning added that 100% of WWL staff have been offered the vaccine, of which there has been an 80% uptake.

The Medical Director of Mental Health and Clinical Integration provided an update that the specification for the specialist long COVID-19 clinics in was due to be signed off. She added that over 50% of mental health pathways and specialist pathways are in place to cover all localities within Greater Manchester.

With regard to psychological support for staff, the Medical Director of Mental Health and Clinical Integration was pleased to inform the Board of Directors that the Foundation Trust has established a strong programme to support staff.

The Board received the report and noted the content.

**16/21 Situation Report**

This item was discussed as part of the Chair and Chief Executive's update.

**17/21 Committee Chairs' Report**

Mrs Lobley opened this item and provided an update following the People Committee meeting in December 2020. The Committee received an update from the Guardian of Safe Working, recruitment and retention, redeployment and staff engagement.

With regard to recruitment, the Committee received assurance that the Foundation Trust is working with an agency, in particular with a view to improving the local uptake of vacancies.

Mrs Lobley informed the Board that funding for Continued Professional Development (CPD) has been allocated for each nurse and midwife.

Prof Warne provided an update following the Quality and Safety Committee meeting in December. Discussions at the meeting had focused on the acquisition of pressure ulcers, safeguarding, workforce issues and Infection Prevention and Control. The Committee had been pleased to release the update that pressure ulcers had improved within the community, and a system wide action plan has been developed.

Prof Warne referred to the Infection Prevention and Control (IPC) update on the meeting agenda, which is also discussed by the Committee. He acknowledged the hard work undertaken by the IPC Team, in particular in light of frequently changes to guidance. The Committee intends to streamline its agenda for the next meeting with a view to alleviating pressure on the divisions at this stage of the pandemic.

The Finance and Performance Committee met on 25 January 2021, at which time members discussed concerns around staffing and recruitment. An update was provided surrounding the Foundation Trust's up to date financial position.

The Audit Committee is next due to meet in February 2021. My Haythornthwaite detailed the action of a task and finish group involved in the tender process for the provision of external audit services on behalf of the Council of Governors.

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

**18/21 Board Assurance Framework**

The Board received an update on the Board Assurance Framework (BAF).

Mrs Lobley opened this item, and detailed that the People Committee had agreed that the delivery confidence remained at red on this occasion, with a view to reducing to amber-red should further delivery against the high risks for recruitment and nurse staffing develop.

With regard to the Partnership BAF, the risk remained at amber which reflected the uncertainty around future structures. The Director of Strategy and Planning was pleased to note that, collaborative working across the Wigan Borough had increased throughout the pandemic.

Prof Warne informed the Board that the Quality and Safety Committee had agreed to increase delivery confidence the risk to amber-red. He stated that although progress is being achieved across many areas, a significant degree of assurance is needed across others.

Mr Guymer detailed that the Performance delivery confidence remains on red. He highlighted that the biggest concern of the Committee had been around funding allocations and the shortfall experienced throughout the second half of the FY2020/21.

The Board of Directors received the updates against each area of the BAF.

**19/21 Performance Report**

The Board received an update on performance at the Foundation Trust.

The Interim Chief Nurse opened this item by noting that the key themes across quality and safety continue to be hospital onset COVID-19 infections, hospital acquired pressure ulcers and unsafe discharges. In addition, there has been two cases of MRSA, which will be reviewed by the Quality and Safety Committee at its next meeting, alongside the key themes.

The Chief Operating Officer detailed that each of the constitutional standards remain at red. She detailed the impact had on elective recovery when the critical care surge plan was activated, and noted the need for a Greater Manchester approach in terms of elective recovery planning. Given the pressures on emergency elective and cancer cases, a national focus has been placed both regionally and locally on discharge. The Foundation Trust has managed to reduce patients who no longer require treatment in an acute setting and are waiting for discharge by 50%. The Foundation Trust continue to work with primary care and NHS111 to place an emphasis on reducing hospital admissions. The Chief Operating officer detailed that the Community Assessment Unit is due to open in February 2021, which will contribute to the expansion of same day emergency care.

The Medical Director informed the Board that there has been an increase in Hospital Standardised Mortality Ratio (HMSR). Although the Summary Hospital-level Mortality Indicator (SHMI) remains high at 115, it is reflective of a downward trend.

Mrs Lobley suggested that an additional scorecard is provided for the COVID-19 pandemic, to note the areas of management. The Chief Operating Officer outlined that the scorecard could be combined with the Infection Prevention and Control Board Assurance Framework.

The Board received the update and noted the content.

**20/21 Infection Prevention and Control Board Assurance Framework**

The Interim Chief Nurse presented the Infection Prevention and Control (IPC) update and Board Assurance Framework (BAF) which had been circulated with the agenda.

With regard to COVID-19, the Interim Chief Nurse detailed how the BAF action plan continued to be updated in light of the regular updates to national guidance, and that although guidance issued on 21 January 2021 is yet to be assessed, it is anticipated that changes to the standard operating procedures will be required. The Interim Chief Nurse was pleased to report that hospital onset infections have reduced.

The Interim Chief Nurse emphasised that the IPC Team are a fundamental team within the organisation, and commended their hard work throughout the pandemic.

In response to a question from Mrs Lobley, the Interim Chief Nurse detailed that not all patients are compliant with measures. With the exception of patients who are unable to wear facemasks, such as those with a respiratory disease, patients are encouraged where possible to comply.

Prof Austin referred to previous concerns around non-compliance of measures by staff. The Director of Workforce confirmed that the Foundation Trust has worked with Trade Unions to inform a mechanism where non-compliance can be addressed via a disciplinary process should it be considered necessary.

The Board of Directors received and noted the update provided.

**22/21 Ockenden Report**

The Interim Chief Nurse presented an update on the Ockenden Report which had been circulated with the agenda. Ockenden is an interim report around maternity services, which sets out 12 urgent clinical priorities, of which seven immediate and essential actions are required. The update presented an action plan which detailed the areas where the Foundation Trust is compliant, and partially compliant. A task and finish group has been established which meets fortnightly to consider the progress of the action plan.

An update will be presented to the Board of Directors at each meeting, as required.

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

Dr Elliot left the meeting.

**23/21 Bi-annual staffing review**

The Interim Chief Nurse, the Chief Operating Officer, the Medical Director and the Director of Workforce jointly presented an update around safe staffing.

The update detailed how nurse staffing remains one of the highest risks at the Foundation Trust, and therefore an increase focus will be placed on the correlation between low staffing rates and patient harm, in particular what staffing models will be required following the pandemic.

The Director of Workforce detailed that the 166 vacancies at the Foundation Trust is reflective of the national shortage. She provided an update on the progress made for recruitment over the last 12 months, alongside expected turnover, protected class retirement, domestic recruitment, expansion in nursing students, and ongoing international recruitment plans. As part of the long term retention programme at the Foundation Trust, a commitment was made to fast track 130 development positions, and the Board of Directors heard the progress against the same at various stages. The Director of Workforce detailed development plans for leadership, retirement pathways, supporting staff, behaviour framework and psychological safety and culture.

The Medical Director presented an update to staff around how safer staffing will reduce harm for both patients and for staff. He outlined the need to improve triangulation of all data whilst focusing on all elements of clinical care, which is linked to the Quality Strategy with a view to embedding lessons learned throughout the organisation.

The Chief Operating Officer detailed how future planning will align the impact of COVID-19 and requirements needed as a result of the pandemic alongside expansion at the Foundation Trust. Factors include Infection Prevention and Control guidance, waiting list backlogs, patients with a higher acuity and increased length of stays.

Both Mrs Lobley and Prof Austin welcomed the report. Mrs Lobley suggested that safe staffing is linked to the Foundation Trust's aims towards a Care Quality Commission (CQC) rating of 'outstanding'.

The Medical Director for Mental Health and Clinical Integration was pleased to note the holistic and integrated approach to safe staffing. She agreed with Prof Austin that the update focused on nursing, and suggested that input from all professions for clinical and non-clinical are considered going forward.

The Interim Chief Nurse noted that whilst there is a national reporting tool for safe staffing, the presentation provided a better way of working.

The Chair was pleased to receive the update. He outlined how the holistic approach had provided a review of the past and the present, and plans for the future.

The Board received the presentation and noted the update provide.

**24/21 Consent agenda**

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

1. THAT the COVID-19 risk appetite statement be received and noted

2. THAT the finance report be received and noted

**25/21 Any other business**

The Chief Executive noted that it was the Interim Chief Nurse's last Board meeting. On behalf of the Board, he thanked her for her hard work and contributions to the Foundation Trust.

**26/21 Date time and venue of the next meeting**

The next meeting of the Board of Directors held in public will be held on 31 March 2021, 2.00pm by videoconference.

# Action log

| Date of meeting | Minute ref. | Item | Action required | Assigned to | Target date | Update |
|---|---|---|---|---|---|---|
| --- | --- | --- | --- | --- | --- | --- |

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

| | |
|---|---|
| **Title of report:** | Chief Executive's report |
| **Presented to:** | Board of Directors |
| **On:** | 31 March 2021 |
| **Presented by:** | Chief Executive |
| **Prepared by:** | Paul Howard, Director of Corporate Affairs |
| **Contact details:** | T: 01942 822027 E: paul.howard@wwl.nhs.uk |

**Executive summary**

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

**Link to strategy**

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

**Risks associated with this report and proposed mitigations**

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

**Financial implications**

There are no financial implications associated with this report.

**Legal implications**

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

**People implications**

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

**Wider implications**

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

**Recommendation(s)**

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

The WWL Way

## 1. Changes to the executive team

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

1.2. I am delighted to welcome Rabina Tindale who joined us on in February 2021 as our new Chief Nurse. Rabina was previously Deputy Chief Nurse at University College London Hospitals NHS Foundation Trust and will be joining us at her first WWL Board meeting this month. My thanks also go to Morag Olsen who so ably acted as our interim Chief Nurse whilst waiting for Rabina to join us.

1.3. Our new Director of Communications and Stakeholder Engagement, Anne-Marie Miller, joined us on 1 March 2021. This is a new post for us here at WWL and we are looking forward to working with Anne-Marie in further improving the way we communicate and engage with our many stakeholders, both internally and externally.

1.4. Colleagues will already be aware that Sandeep Ranote's secondment as our Medical Director for Mental Health and Integrated Care comes to end today. I am delighted to say, however, that Sandeep will continue to work across the Wigan system on the wider integration agenda and will still work closely with us here at WWL as we progress this important area for the benefit of our patients. I would like to thank Sandeep for the work she has undertaken whilst with WWL and I am looking forward to continuing to work with her.


**Rabina Tindale**
Chief Nurse

**Anne-Marie Miller**
Director of Communications and Stakeholder Engagement

**Sandeep Ranote**
Medical Director for Mental Health and Integrated Care

## 2. COVID-19 vaccination progress

2.1. Our COVID-19 vaccination programme continues to be delivered and I would like to thank all involved in the vaccination programme for their hard work and dedication to this most important cause. We have a real multidisciplinary approach to the vaccinations, with Allied Health Professionals joining medical and nursing colleagues to vaccinate our staff. I would also like to call out the efforts of all support and managerial staff – whether you have been booking appointments, registering people at clinics, supervising waiting rooms, organising rotas, inputting data or overseeing the whole programme, I offer you my heartfelt thanks.

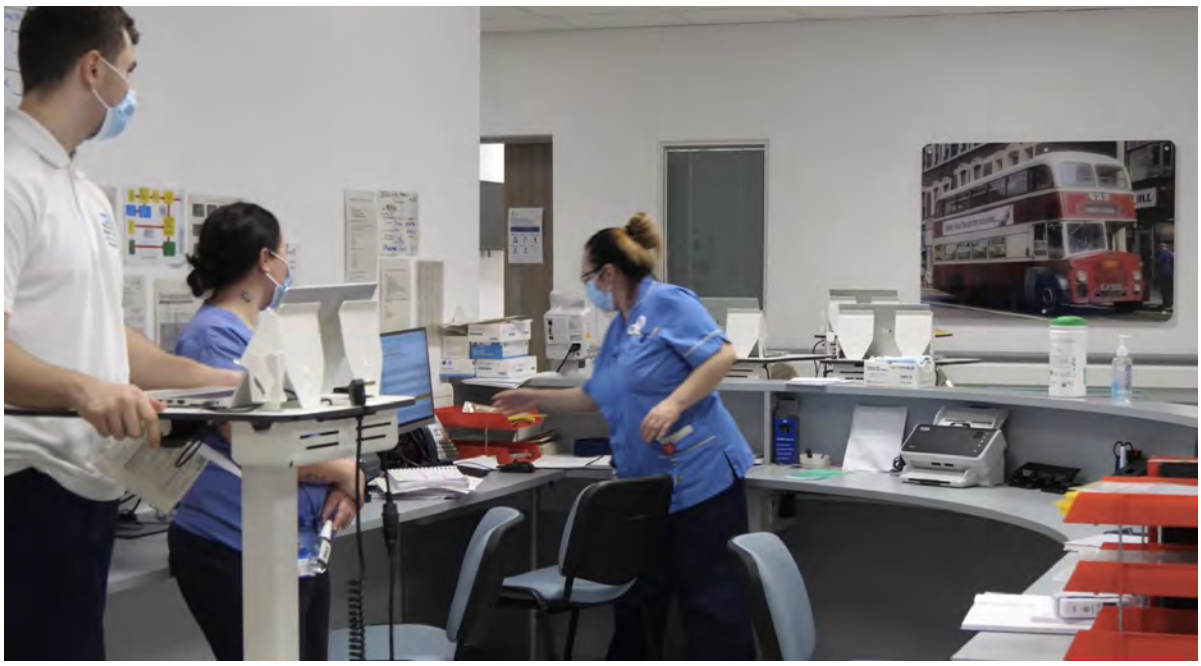
2.2. On 10 February 2021 we were delighted to celebrate a real milestone, as we administered our 10,000th vaccination to Melissa, a local Clinical Nurse Manager at Marie Curie.


2.3. As a borough we are also celebrating an even bigger milestone, as together with Wigan Borough GPS we have administered over 100,000 vaccinations to staff and patients across the borough. The total number of residents vaccinated, including those vaccinated by community pharmacy and clinics outside of Wigan, stands at an amazing 145,000. Again, I want to call out the support given to the programme – we have be supported by over 300 volunteer marshals and support staff and hundreds of vaccinators covering 2,375 shifts. Over 99% of Wigan residents aged 80 and over have now had their first vaccination, as have 95% of those aged 60 and over.

**3. Community Assessment Unit**

3.1. I am delighted to confirm that our new Community Assessment Unit opened earlier this month. The unit will care for some of our most elderly and frail patients in a therapy-led way which is intended to reduce the pressure on admissions and meet the needs of our ageing population, ensuring that they can return home more quickly and with an appropriate care plan in place. This is a vital component in our ability to provide the right care, in the right place, at the right time.

3.2. The Unit was opened by Reg Nash, an Age UK Wigan Borough trustee and one of our appointed governors. Speaking at the event, he said 'This is a fantastic achievement and testament to everyone involved in the project. The facility provides a wonderful environment for our patients to receive care and has provided the opportunity to develop new ways of working. The therapy-led, holistic approach enables patients to make the most of their potential to continue to live an independent and fulfilling life.'




## 4. Jean Heyes Reablement Unit at Leigh Infirmary

4.1. Work has also started on a new £1m development at Leigh Infirmary. The Jean Heyes Reablement Unit will be a welcome addition to the site and will provide an intermediate care inpatient facility with dedicated rehabilitation and reablement input to support patients to reach their potential following a period of illness or injury. The unit has been commissioned following receipt of national funding and will comprise a 24-bed inpatient facility with a dedicated gym and kitchen to support intensive rehabilitation.

## 5. National Day of Reflection

5.1. To mark the National Day of Reflection on Tuesday 22 March 2021 and as a sign of respect, our Tree of Hope on the Royal Albert Edward Infirmary site was lit up yellow and leaders from across the health and social care economy joined together to show their respect. Across WWL, staff participated in a minute's silence. Support was available from our Chaplaincy and Spiritual Care Team, with message trees being made available for staff and patients to hang messages of reflection, memorial or hope.

## 6. New website

6.1. Colleagues will wish to note that we have now launched our new and improved website. Along with a brand-new look and feel, the website was built with our patients and public in mind, improving functionality and the overall user experience. With the pandemic bringing a renewed urgency for information to be easily and readily accessible, our new website could not have come at a better time for our patients, our public and our staff.

## 7. Recommendation

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

# Performance:
## We aim to be in the top 10%

| | | | | | |
|---|---|---|---|---|---|
| **Executive lead(s):** | Chief Operating Officer<br>Chief Finance Officer | **Reviewing committee:** | Finance and Performance Committee | **DELIVERY CONFIDENCE** | **WEIGHTED DASHBOARD** |
| **Strategic importance:** | Delivery of operational and finance performance underpins clinical care, facilitates the patient journey and enhances the patient experience, and affects the organisation's financial performance. | | | | MONTH: 4.08 YTD: 4.09 |
| **Sources of assurance:** | ▪ Scrutiny by Finance and Performance Committee<br>▪ Scrutiny by Board of Directors<br>▪ Use of internal and external auditors<br>▪ Escalation of emerging risks<br>▪ Divisional performance reviews<br>▪ REMC | | | ROLLING TREND: Jan 2021, Sep 2020, Aug 2020, Mar 2020 | ROLLING TREND: 4.23 (Jan 2021), 3.30 (Sep 2020), 2.35 (Aug 2020), 2.88 (Mar 2020) |

| Individual risks scoring ≥20 | Original Score | Mitigations | Current score |
|---|---|---|---|
| Risk of failure/vulnerability of back-end infrastructure resulting in no access to IT systems | 20 | HIS upgrade now completed. A business case had been drafted surrounding the Tannex upgrade for the consideration of BCOG. | 20 |
| Potential closure of RAEI theatre 1 and 2 following annual verification report | 15 | Refurbishment of theatres 1 & 2 has progressed. The risk will be recast once re-opened. | 20 |
| Potential risk of Theatre 6 failure following next revalidation, resulting in one lamina flow theatre at RAEI | 15 | Theatre passed its revalidation tests. Advisory repair work being considered. The risk will be recast once theatres 1 & 2 have reopened. | 20 |
| Patients with data entries under 'service lines' on SystemOne with no assurance that their pathways are being managed appropriately | 15 | WWL were set to take full control of the risk from Bridgewater but the dedicated team were redeployed due to COVID-19 | 20 |
| Risk of incurring penalties should NHSI activity level targets fail to be met | -- | Divisional plans have been set out. Not yet on risk register. | -- |
| Reduced radiology capacity to manage the Covid-19 backlog and new patient referrals | 16 | Significant numbers completed. Discussions continue with GM for an overall operation plan | 20 |
| Rising SHMI rate | 20 | Risk escalated to Executive Team and Q&S Committee | 20 |
| Risk that GM Funding will not fully cover expenditure resulting in cash balances being heavily depleted | 20 | Risk added to the corporate risk tracker at the January 2021, and escalated verbally to the F&P committee meeting at its meeting. | 20 |
| There is a concern that due to national pressures within the clinical waste industry, the clinical waste service may be withdrawn, alongside additional concerns that costs for the disposal of clinical waste could increase. | 16 | Risk escalated to the Executive Team. Internal plans have been established. | 20 |

## NARRATIVE

Currently on track

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

## PERFORMANCE: WEIGHTED DASHBOARD

Performance data as at: **28 February 2021**

| Performance | Measure | Result | 1 (Green) | 2 (Amber-Green) | 3 (Amber) | 4 (Amber-Red) | 5 (Red) | Weight | Month | Year | Source |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 4-hour standard | 95% of patients should be admitted, transferred or discharged within 4 hours of arrival at A&E | 91.86% M<br>87.38% Y | ≥95% | 94.9-90% YTD | 89.9-80% Month | 79.9-70% | ≤70% | 2 | 3 x 2 = 6 | 2 x 2 = 4 | BI (Feb 2021) |
| 12-hour operational standard | No patient requiring emergency admission will wait 12 hours in A&E | 6 M<br>325 Y | 0 | | | | ≥1<br>M & YTD | 2 | 5 x 2 = 10 | 5 x 2 = 10 | BI (Feb 2021) |
| Ambulance handover standard | All handovers between ambulance and A&E must take place within 15 mins with none waiting >60m | > 60m M<br>> 60m Y | ≤ 15 mins | 15-30 mins | | 30-59 mins MTD | >60 mins<br>M & YTD | 1 | | | BI (2020) |
| Cancer treatment times | 85% should wait no more than 62 days from urgent referrer to first definitive treatment | 66.36% M<br>75.77% Y | ≥85% | | | | ≤84.9%<br>M&YTD | 2 | 5 x 2 = 10 | 5 x 2 = 10 | BI (Feb 2021) |
| 18-week RTT | 92% on incomplete RTT pathways (yet to start treatment) should wait no more than 18 weeks | 64.79% M<br>58.94% Y | ≥92% | | | | ≤91.9%<br>M & YTD | 1 | 5 x 1 = 5 | 5 x 1 = 5 | BI (Feb 2021) |
| 52-week RTT | Zero tolerance for patient waits over 52 weeks on an incomplete pathway | 1075 patients waiting 52 weeks + | 0 | | | | ≥1 | 2 | 5 x 2 = 10 | 5 x 2 = 10 | BI (Feb 2021) |
| Diagnostic waiting times | 99% of service users waiting for a diagnostic test should receive it within 6 weeks of referral | 90.28% M<br>65.72% Y | ≥99% | | | | ≤98.9% | 1 | 5 x 1 = 5 | 5 x 1 = 5 | BI (Feb 2021) |
| Paper switch off programme | *By 1 Oct 2018, NHS E-referral will be used for all relevant consultant-led first OPD appointments* | Complete | 100% | | | | ≤99.9% | 1 | 1 x 1 = 1 | 1 x 1 = 1 | Complete |
| Control total achievement | Forecast position: Achieve finance control total before PSF | Forecast 4 quarter | Achieve 4 quarters | 3 quarters | 2 quarters | 1 quarter | 0 quarters | 4 | --- | --- | Forecast |
| Control total achievement | Forecast position: Achieve A&E control total trajectory | No longer applicable | Achieve 4 quarters | 3 quarters | 2 quarters | 1 quarter | 0 quarters | 2 | --- | --- | Forecast |
| Use of resources risk rating | Forecast position: Achieve use of resources risk rating as per plan | Forecast 4 quarter | Achieve 4 quarters | 3 quarters | 2 quarters | 1 quarter | 0 quarters | 4 | --- | --- | Forecast |
| Transformation | SAVI delivery against target | % M<br>% Y | Achieved | Fail by <10% | Fail by 10-20% | Fail by 20-30% YTD | Fail by >30% MTD | 3 | --- | --- | Finance report |
| IT | Completion of agreed IT priorities in line with plan | 85% M | 100% | 90-99% MTD | 80-89% | 70-79% | ≤70% | 2 | 3 x 2 = 6 | --- | IT department |
| Total | | | | | | | | 13 | 53(/13) | 45(/11) | |
| Average | | | | | | | | | **4.08** | **4.09** | |

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

# People:
## Everyone has the opportunity to achieve their purpose

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

| Individual risks | Original Score | Mitigations | Current score |
|---|---|---|---|
| HR 84 - Ability to recruit and retain to required staffing levels for service delivery and service development plans | 20 | Recruitment & retention plan and trajectory<br>International recruitment campaign – supported by NHSEI funding bid process<br>Workforce plan<br>Programmes of work to improve the experience of work<br>Virtual recruitment event – January<br>Links with Jobcentre Plus to recruit HCAs and Care Makers | 20 |
| HR82 - Declines in safety culture and staff confidence in reporting errors, near misses and incidents | 16 | Psychological safety work programme commenced – diagnostic completed and action plans developed for implementation | 16 |

| | | | |
|---|---|---|---|
| HR128 – HCA Banding | 20 | Collective grievance submitted.<br>Risk primarily around financial impact.<br>Score of risk reassessed as, whilst there is financial impact it is not felt to be significant enough to warrant a score of 20. | 15 |

## NARRATIVE

**De-escalated risks:**

A number of risks have been de-escalated from the corporate risk register for directorate monitoring. This is primarily due to plans being in place to commence key programmes of work to address the risks and moving these into implementation.

**Employment essentials**

- Virtual recruitment event preparation ongoing
- Options appraisal around international recruitment and business case for nursing international recruitment requirements over the next three years
- Disciplinary policy review complete – aligned to just culture methodology
- ESR hierarchy data cleanse continues (required for roll out of Empactis absence management system)
- Central absence team now contacting nurses and AHPs when absent and recorded on e-roster, offering support and to facilitate safe and effective return
- E-roster roll out team now in post

**Steps 4 wellness**

- Transfer of counselling service from OH to psychological support team scheduled in April
- More than 120 well-being champions in post
- Vaccination programme now 80% of WWL staff have received first dose
- Psychological support targeted activities in place (steps 1-3). Discussions with GM Resilience Hub regarding gaps around step 4 provision and business case development to complete service delivery model

**Go Engage (being re-named Your Voice)**

- Civility programme commencing and just culture plans in advanced development
- Listening events continue as scheduled with feedback provided to participants on actions
- National Staff Survey results published – issues remain regarding interactions with line managers. Leadership development will be essential in 2021/22

**WWL Route Planner (being re-named Learn and Grow)**

- Learning Needs Analysis almost complete (statutory and mandatory training, job specific requirements, core skills, leadership development and 360). Business case to be developed for funding shortfall after full LNA is approved.
- Targeted programme of work in 2021/22 around nursing, midwifery and AHP talent mapping and succession planning

## PEOPLE: WEIGHTED DASHBOARD

| Performance | Measure | Result | 1 (Green) | 2 (Amber-Green) | 3 (Amber) | 4 (Amber-Red) | 5 (Red) | Weight | Month | Year | Source |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Go Engage | Friends and family test (work) | 69.04% | ≥95% | 72-94% | 68-71% | 64-67% | ≤63% | 2 | 3 x 2 = 6 | 3 x 2 = 6 | Workforce team |
| Employment Essentials | Turnover | 7.96% | ≤8.00 | 8.01-8.5% | 8.51-9% | 9.01-9.9% | ≥10% | 1 | 3 x 1 = 3 | 3 x 1 = 3 | Workforce team |
| Employment Essentials | Leavers with less than 12 months' service | 28.07% | ≤10% | 11-14% | 15-20% | 21-24% | ≥25% | 1 | 5 x 1 = 3 | 5 x 1 = 3 | Workforce team |
| Route Planner | PDR completion | 72.7% | ≥95% | 86-94% | 78-85% | 73-77% | ≤72% | 1 | 5 x 1 = 4 | 5 x 1 = 4 | Workforce team |
| Steps 4 Wellness | Energy levels | 3.47 | ≥4.00 | 3.7-3.99 | 3.61-3.69 | 3.47-3.6 | ≤3.46 | 1 | 4 x 1 = 4 | 4 x 1 = 4 | Workforce team |
| Go Engage | Cultural enabler score | 32.67 | ≥36 | 35.01-35.9 | 34.01-35 | 33.61-34 | ≤33.6 | 2 | 5 x 2 = 10 | 5 x 2 = 10 | Workforce team |
| Total | | | | | | | | 8 | 30 | 30 | |
| Average | | | | | | | | | 3.75 | 3.75 | |

## Patients:

## Every patient receives the best possible care

| | | | | | |
|---|---|---|---|---|---|
| **Executive lead(s):** | Chief Nurse<br>Medical Director | **Reviewing committee:** | Quality and Safety Committee | **DELIVERY CONFIDENCE**<br>**CURRENT MONTH:** | **WEIGHTED DASHBOARD**<br>**MONTH:** 1.81 **YTD:** 3.66 |
| **Strategic importance:** | Provision of safe, effective, high-quality and evidence based care is at the heart of everything we do. | | | | |
| **Sources of assurance:** | ▪ Scrutiny by Quality and Safety Committee<br>▪ Scrutiny by Board of Directors<br>▪ Use of internal and external auditors<br>▪ Escalation of emerging risks<br>▪ Divisional performance reviews<br>▪ REMG | | | **ROLLING TREND:**<br>Dec 2020 · Sep 2020 · Aug 2020 · Mar 2020 | **ROLLING TREND:**<br>Dec 2020: 1.86 · Sept 2020: 2.27 · Aug 2020: 2.08 · Mar 2020: 2.23 |

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

## PATIENTS: WEIGHTED DASHBOARD

| Performance | Measure | Result | 1 (Green) | 2 (Amber-Green) | 3 (Amber) | 4 (Amber-Red) | 5 (Red) | Weight | Month | Year | Source |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Harm free care | %VTE Assessments undertaken within 24 hours of admission (indicative data) | **96.60%M 96.34%Y** | ≥95% | 94% - 90% | 89%-85% | 84%-80% | <80% | **1** | 1 x 1 = 1 | 1 x 1 = 1 | Perf. Report (Feb 2021) |
| Harm free care | No. Serious Falls | **0 MTD 2 YTD** | 0 MTD | | | 2 or 3 | >3 YTD (4) | **2** | 0 x 2 = 0 | 5 x 2 = 10 | Perf. Report (Feb 2021) |
| Patient Safety | % of 'red sepsis' patients receiving antibiotics within 1 hour in A&E | **85.7%** | ≥95% | 94% - 90% | 89%-85% | 84%-80% | <80% | **1** | 3 x 1 = 3 | --- | A&E Monthly Audits |
| Patient Safety | No. of Never Events | **0 MTD 1 YTD** | 0 MTD | | | | 1 YTD | **3** | 1 x 3 = 3 | 5 x 3 = 15 | Perf. Report (Feb 2021) |
| *Patient Safety* | *100% compliance with appropriate frequency of observations* | **70.7%** | 100% | 99-95% | 94-90% | 89-80% | <80% | **1** | 5 x 1 = 5 | --- | NEWS quarterly Audits (3,6,9,12) |
| Infection Control | No. of MRSA | **0 MTD 1 YTD** | 0 | | | | 2 | **3** | 5 x 3 = 3 | 1 x 3 = 3 | Perf. Report (Feb 2021) |
| Infection Control | No. of C. diff Lapses in Care | **1 MTD 6 YTD** | 0 | 1 MTD | 2 | 3 | >4 YTD | **2** | 2 x 2 = 4 | 5 x 2 = 10 | Perf. Report (Feb 2021) |
| Patient Experience | % of patients recommending WWL for care | **92%** | ≥95% | 94% - 90% | 89%-85% | 84%-80% | <80% | **2** | --- | --- | Monthly FFT (2020) |
| Patient Experience | % of patients feeling involved with decisions about their discharge | **90.77%** | ≥95% | 94% - 90% | 89%-85% | 84%-80% | <80% | **1** | --- | --- | Perf. Report (2020) |
| *Patient Experience* | *% of complaints responded to within the timescale agreed with the patient* | **38.18%M 43.18%Y** | ≥95% | 94% - 90% | 89%-85% | 84%-80% MTD | <80% MTD/YTD | **1** | 5 x 1 = 5 | 5 x 1 = 5 | Perf. Report (Feb 2021) |
| *Mortality* | HSMR | **115.3%M 102.6% Y** | ≤100 YTD | 101-105 | 106-110 YTD | 111-115 M | >115 YTD | **3** | 1 x 4 = 4 | 3 x 5 = 15 | Perf. Report (Feb 2021) |
| *Mortality* | *SHMI* | **115%** | ≤100 | 101-105 | 106-110 | 111-115 | >115 | **1** | --- | 5 x 1 = 5 | Perf. Report (Feb 2021) |
| *Mortality* | No. of PFDs | **0** | 0 | 1 | 2 | 3 | >4 | **2** | 1 x 2 = 2 | 1 x 2 = 2 | Perf. Report (Feb 2021) |
| *Medicines Management* | % of critical medicines prescribed within 24 hours of admission or before the patient is transferred to a new area | **83.3%** | 100% | 99-95% | 94-90% | 89-80% | <80% | **1** | 4 x 1 = 4 | --- | Pharmacy (Sep 2020) |
| *Medicines Management* | % of completed medicines reconciliation within 24 hours | **91%** | 100% | 99-95% | 94-90% | 89-80% | <80% | **2** | 3 x 2 = 6 | --- | Pharmacy (July 2020) |
| Total | | | | | | | | | (40/22) | (66/18) | |
| Average | | | | | | | | | 1.81 | 3.66 | |

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

# Partnerships:
# We work together for the best patient outcomes

| | | | | | |
|---|---|---|---|---|---|
| **Executive lead(s):** | Director of Strategy and Planning | **Reviewing committee:** | Board of Directors | **DELIVERY CONFIDENCE** | **WEIGHTED DASHBOARD** |
| **Strategic importance:** | Effective partnership working underpins our strategic direction | | | | MONTH: 2.00 YTD: 2.00 |
| **Sources of assurance:** | ▪ Scrutiny by committee<br>▪ Scrutiny by Board of Directors<br>▪ Use of internal and external auditors | ▪ Escalation of emerging risks<br>▪ Exec-to-exec meetings<br>▪ REMC | | ROLLING TREND: Jan 2021, Sep 2020, Jul 2020, Mar 2020 | ROLLING TREND: 2.00, 2.67, 2.75, 2.88 (Jan 2021, Sep 2020, Jul 2020, Mar 2020) |

| Individual risks | Original Score | Mitigations | Current score |
|---|---|---|---|
| Lack of Tier 4 CAMHS beds | 16 | Options being rethought with the new MH provider. Considering alternative escalation routes with less reliance on in-patient beds. Has impacted on physical environment in Rainbow. | 16 |
| Non-achievement of KPIs relating to cellular pathology | 16 | Some performance issues remain, but the current focus is on testing and those turnaround times have significantly improved with new equipment at Salford. A sub-group is working through pathology risks in more detail and GM continues to pursue a pathology network through the PFB CSS sub-group and DoS. The shortage of cellular pathology medical workforce nationally continues to be the main driver. | 16 |

## NARRATIVE

Partnership dynamics have been impacted materially by our response to COVID-19 where collaborative working and system by default are now in place. All cross-GM service change programmes have been suspended, although JCB have indicated a support for some continued oversight at a GM level for fragile or non-compliant services, including Healthier Together, alongside recovery. The GM Partnership is being reviewed in line with the Integrated Care White Paper. The Healthier Wigan Partnership has evolved to support both recovery activity in the local system and a programme focused on future population health gains and the Healthier Wigan Partnership Activation Board is regarded as successful.

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

## PARTNERSHIPS: WEIGHTED DASHBOARD

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

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

| | |
|---|---|
| **Title of report:** | WWL M11 Scorecard |
| **Presented to:** | Board of Directors |
| **On:** | 31st March 2021 |
| **Presented by:** | Chief Nurse, Chief Operating Officer and Medical Director |
| **Prepared by:** | Data, Analytics and Assurance |
| **Contact details:** | BI.Performance.Report@wwl.nhs.uk |

**Executive summary**

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

**Link to strategy**
Patient
Partnership
Workforce
Site and Service

**Risks associated with this report and proposed mitigations**

The WWL Way

**Financial implications**
None currently highlighted.

**Legal implications**
None identified.

**People implications**
None identified.

**Wider implications**

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

# **Report:** M11 WWL Balanced Scorecard 1 April 2020 – 28 February 2021

## QUALITY & SAFETY

| | Month | ON/OFF Track | Why? |
|---|---|---|---|
| **Patient Safety (Safe)** | | | |
| *Never Events* | *M9* | *On Track* | NE 0 in month 2 YTD |
| *Number of Serious Incidents* | *M9* | *Off Track* | SI - 8 Incidents in month, 77 YTD |
| *Sepsis - Screening and Antibiotic Treatment (Grouped)* | *M9* | *Off Track* | **Red flag:** On track (Ward & AE) **Elevated Score** : AE On Track, Ward |
| *Serious Pressure Ulcers (Lapses in Care)* | *M9* | *Off Track* | PU - 4 Incidents in month, 29 YTD |
| *Serious Falls* | *M9* | *On Track* | SF 0 in month 4 YTD |
| *Infection Prevention and Control (Grouped)* | *M9* | *Off Track* | 6 / 6 in month, 6 / 6 YTD; Metrics Off Track |
| **Clinical Effectiveness (Effective)** | | | |
| *SHMI Rolling 12 months* | *M5 2020* | *Off Track* | *Latest position: 115.4* |
| *National Patient Safety Strategy (Grouped)* | | *Under development* | |
| **Patient Experience (Caring)** | | | |
| *Complaints Responses* | *M9* | *Off Track* | 14% M8, 37.4% YTD; Target 90% |
| *Improved Discharge (Grouped)* | | *Under development* | |
| *Patient Experience* | | *Not currently collected* | |

## ACTIVITY & EFFECTIVENESS

| | Month | ON/OFF Track | Why? |
|---|---|---|---|
| A&E Performance (Single) | M11 | Off Track | 91.9% M11, 87.4% YTD; Target 95% |
| *Cancer Performance (Grouped)* | *M10* | *Off Track* | *3 / 7 in month, 3 / 7 YTD; Metrics Off Track* |
| RTT Performance (18 Weeks) | M11 | Off Track | 58.84% M11; Target 92% |
| RTT Performance (52 Weeks) | M11 | Off Track | 2703 patients waiting 52+ weeks |
| Diagnostics Patients waiting under 6 weeks | M11 | Off Track | 90.28% ; Target 99% |
| Recovery plan | M11 | *Slightly Off Track* | 89.3% of 2019 Activity; Target 90% |

## PEOPLE

| | Month | ON/OFF Track | Why? |
|---|---|---|---|
| **Employment Essentials** | | | |
| Clinical Vacancy Rate | M11 | Off Track | 6.96% M11, 9.5% M9 Target 5.0% |
| *Agency vs NHSI Ceiling* | *M8* | *Off Track* | *£643k M11, £1,096K M8, Target £502K per month;* |
| Premium Cost Spend | M11 | Off Track | £2,123K M11 (9.28% over budget) |
| **Go engage** | | | |
| Your voice scores (engagment enablers, feelings & behaviours) | Q3 | Off Track | 3.91 Q3; 3.77 Q2 Target 4 |
| Your voice response rate | Q3 | Off Track | 12.0% Q3, 19.2% Q2; Target 50% |
| **Route Planner** | | | |
| Mandatory Training over rolling 12 months | M11 | Off Track | 89.9% M11, 87.0% M9; Target 95% |
| PDR`s over rolling 12 months | M11 | Off Track | 72.7% M11, 74.5% M9; Target 90% NB. Excludes M & D Staff |
| **Steps for Wellness** | | | |
| *Sickness Abence* | *M10* | *Off Track* | *7.02% M10, 8.15% M8, Target 4% M11 data is not yet available* |
| *Time Lost due to other unplanned absence* | *M10* | *Off Track* | *3.21% M10, 4.6% M8, Target 4%; M11 data is not yet* |
| Covid Risk Assessments | M11 | Off Track | 91.11% M11, 90.23% M9, Target 95% |

## FINANCE

**Financial Position (£000s)**

| | In Month Actual £000's | In Month Revised Plan £000's | In Month Var £000's | Year to Date Actual £000's | Year to Date Revised Plan £000's | Year to Date Var £000's | Full Year Revised Plan £000's |
|---|---|---|---|---|---|---|---|
| Income | 38,938 | 33,634 | 5,304 | 390,606 | 382,449 | 8,157 | 416,083 |
| Expenditure | (34,842) | (35,903) | 1,061 | (385,910) | (387,241) | 1,331 | (423,991) |
| Surplus / Deficit | 2,981 | (3,321) | 6,302 | (7,221) | (16,469) | 9,248 | (20,637) |
| Cash Balance | 67,560 | 42,847 | 24,713 | 67,560 | 42,847 | 24,713 | 30,523 |
| Capital Spend | 1,451 | 1,388 | (63) | 17,566 | 19,016 | 1,450 | 21,500 |

Reported position : M11

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

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

# M11 WWL Balanced Scorecard 1 April 2020 – 28 February 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 in December 2020. With regards to Serious inicdents, during December 2020 4 of the 8 incidents reported to StEIS were relating to healthcare acquired Pressure Ulcers. There continues to be a high number of HAPUs reported. Following analysis there have been 28 cases to date in 2020/21, where a 'lapse in care' occurred.*
*The other 4 Serious Incidents related to 1 unexpected potentially preventable death, 1 treatment delay, 1 alleged assault and 1 safeguarding concern. It is important to note that the safeguarding concern escalated to StEIS was in relation to the care a patient received on Winstanley Ward. This incident was identified following submission of the Organisational concern in November 2020 relating to the care provided to patients on Winstanley Ward.*

*The Trust experienced its first MRSA bacteraemia since January 2019. This is currently under investigation. There were three hospital associated cases of C.difficile infection - a fall from four cases in November. There were 4 cases of Pseudomonal bacteraemia in December; three of which occurred in long stay ICU patients. This is being addressed as part of the response to a generalised increase in resistant organisms being isolated on the unit and is felt to be related to the considerable pressures placed on staff and patients by COVID.*

**Clinical Effectiveness (Effective)**

*With regards to the Trust's SHMI figures, they show a peak in the 12-month period December 19 to November 20 at 119.6, with the most current published figure showing a decline at 115.4. WWL is currently 4th worst Trust for this indicator in the country, work continues across the Borough to improve this indicator.*

**Patient Experience (Caring)**

*For the month of December, only 6 of the 43 complaints which were due a response was achieved within the timescales agreed with the complainant at the start of the process which equates to 14%. During the month of December the majority of the complaints related to clinical treatment. There were 7 complaints under the category admissions and discharges , of which 4 were discharge related. There were 4 complaints relating to communication and 4 in relation to patient care. PALs concerns logged also showed a high number relating to communication. There were no requests for records from the PHSO.*

*The newly designed paper discharge checklist was rolled out initially within the Division of Medicine at the start of 2021 however due to the amount of positive feedback received the decision was taken at executive scrutiny group for it to be rolled out on a Trust wide basis.*

## ACTIVITY & EFFECTIVENESS

In line with the reducing community prevalence, and the successful roll out of the vaccine, WWL is seeing a pattern of decreased numbers of patients admitted with COVID-19. However, as Covid demand reduces, a unique set of challenges face the organisation as we prepare to fully stand up the elective programme while still maintaining critical care surge capacity.

Throughout the last year WWL has made every effort to ensure priority elective activity continues, either here at the Trust or through the cancer hub at Christie. The principle of treating patients in greatest need will be fundamental in how we deliver services with clinical need prioritised over wait time as we move to recover

a) Restoration of the cancer and P2 activity within current standards
b) Return to 100% of 19/20 activity
c) Trajectory to eradicate over 52 week waits

Restoration of services is largely dependent on staff becoming available for repatriation to their substantive roles. This is the key enabler to restarting the elective programme and is already agreed in a planned and sequenced way which protects staff as they re-engage and reorientate themselves with areas and teams, they may not have seen for 12 months.

Reformation also plays a key role to stem demand while ensuring those waiting, wait well. WWL plays a key role in the establishment of elective surgical hubs providing protected Covid secure pathways for patients requiring elective procedures, Wrightington acting as a test case through a partnership approach with Bolton, however other GM providers and regional colleagues have also expressed a wish to access the expertise at Wrightington therefore the Trust is not limiting its scope solely to the North West GM Sector.

Advice and Guidance, Virtual outpatients, patient initiated follow up and digital transformation also play a key part in building back better giving patients and their carers more control and choice over how and when they attend appointments.
The next steps will be a detailed capacity and demand modelling including profiling of trajectories with transformation assumptions built in. There are also wider dependencies to consider supporting the Elective Recovery including:

Securing additional capacity for diagnostics
Clear critical care strategy
Workforce challenges with an anticipated increase in unavailability of staff
Wider system recovery and support for discharge including clarity on the continuation of the Hospital Discharge Fund which has proved to be significant during Covid through the commissioning of additional community beds.

## PEOPLE

**Employment Essentials**

International recruitment is stepping up considerably and this will support our nurse staffing levels during wave 3 pandemic surge and a virtual recruitment event is planned to take place in Q1. An options appraisal is being undertaken around international recruitment and business case for nursing international recruitment requirements over the next three years.

**Go Engage**

A civility programme is commencing and just culture plans are in advanced development. Listening events continue as scheduled with feedback provided to participants on actions. The 2020 National Staff Survey results have been published – issues remain regarding interactions with line managers and leadership development will be essential in 2021/22. The Q4 Your voice survey is still open and therefore no engagement score for Q4 is available. The current response rate is 18% which is an improvement from Q3.

**Route Planner**

Learning Needs Analysis is almost complete (statutory and mandatory training, job specific requirements, core skills, leadership development and 360). Business case to be developed for funding shortfall after full LNA is approved and there will be a targeted programme of work in 2021/22 around Nursing, Midwifery and AHP talent mapping and succession planning. My Route Plan appraisals have not been mandated through the pandemic due to staffing pressures. This will commence again from April 21 and it will be essential that corporate objectives are agreed to ensure staff understand how their own objectives contribute to the Trust's operational and strategic objectives. Kick start applications have been submitted to DWP for roles to support Covid, including administrative support for the vaccination clinics and for mask fit testing. Mandatory training requirements have been streamlined during the pandemic and prioritised.

**Steps 4 wellness**

*The Transfer of counselling service from OH to psychological support team is scheduled in April 21 and there has been a reduction in counselling waiting times due to additional investment of resources within the service to support driving down the waiting times. Psychological support programmes are in place for steps 1-3 and are being enhanced through both support to staff who are absent for stress related reasons and to help keep those who are in work psychologically supported, especially during wave 3 escalation. There are discussions with the GM Resilience Hub regarding gaps around step 4 provision and business case development to complete service delivery mode. The Central absence team is now contacting nurses and HCAs when absent and recorded on e-roster, offering support and to facilitate safe and effective return.*

## FINANCE

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

The Trust is reporting a £3.0m surplus in month and a £7.2m deficit year to date.

The Trust has revised the year end forecast to a deficit of £13.4m. This is an improvement of £4.7m on the forecast as at month 10 of £18.1m which reflects the full value of the non-NHS income top up received in month 11.

The Trust surplus of £3.0m in month 11 is £6.3m favourable to the revised plan.

Cash is £67.6m at the end of Month 11 which is £24.7m better than the revised plan. The adjusted cash position in month is £38.9m. This is due to the block payment for March (£28.7m) being received in advance to maintain liquidity in the provider sector.

Capital spend is £17.6m year to date plus a further 7.4m which is externally funded via PDC allocation.

Please see the monthly finance report for further commentary.

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

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

| | |
|---|---|
| **Title of report:** | Our Strategy 2030 |
| **Presented to:** | Trust Board |
| **On:** | 31st March 2021 |
| **Presented by:** | Richard Mundon, Director of Strategy and Planning |
| **Prepared by:** | Karlyn Forrest, Director of Strategic Transformation |
| **Contact details:** | T: ext. 2918 E: karlyn.forrest@wwl.nhs.uk |

**Executive summary**

The next iteration of the Trust's Strategy was originally due to be launched towards the start of 2019/20, with the decision taken to pause for two key reasons; firstly, to allow our new Chief Executive to contribute to its development and to also ensure the input and views of our newest workforce following the transfer of Wigan community service into WWL. Extensive engagement with a broad range of colleagues from within WWL, patients and partner organisations took place at the beginning of the calendar year 2020 before the launch was further delayed in March 2020 due to the pandemic. During February and March 21, and using the outcome of the work done before the pandemic, some further targeted engagement took place to finalise the Strategy that is presented within this report. This was primarily to ensure that the impact of COVID, the opportunities and challenges that it presents, and the emerging new operating environment were fully reflected in the refreshed Strategy.

There are many elements of the refreshed Strategy which are a continuation of the previous iteration. The Four Ps remain firmly at the centre of the Strategic framework, guiding the areas on which we want to focus our development and improvement and where our strategic ambitions are stated. Good strategies are those that focus on the 'how', bringing to life how the vision will be delivered. The strategic framework in the refreshed Strategy introduces three strategies priorities; Improve, Integrate and Innovate. These set out how we are going to deliver over the next decade and will be used to guide decisions that we make.

The approval and then launch of the refreshed Strategy is at a time when the need to look forward with optimism is both clear and vital, and at a time when our workforce will benefit from clarity on how WWL will recover from the current situation and the vision and direction for the future.

The approval of the Strategy will initiate a comprehensive communication plan to ensure the Strategy is visible and understood by our staff and embedded in the long-term in the work we do.

The WWL Way

The focus on delivering the Strategy through Divisional business plans, enabling strategies and the Transformation Plan will then begin in earnest.

**Link to strategy**

N/A

**Risks associated with this report and proposed mitigations**

None

**Financial implications**

None

**Legal implications**

None

**People implications**

None

**Wider implications**

None

**Recommendation(s)**

The Board is recommended to approve ‘Our Strategy 2030’.

WWL Strategy 2030

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

# OUR STRATEGY 2030

WWL's vision for the next decade

# Contents






# Foreword

**Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL) is a unique and special place – and we regard it as a privilege to hold positions of leadership for such an important organisation in the Wigan Borough. The work surrounding the launch of our refreshed WWL Strategy brings with it a mixture of quiet reflection on achievements in recent history and ambitious thinking about how we can shape the future.**

humbling experience of working with more than 6,000 exceptional colleagues during the unprecedented experiences of the last 12 months. The response mounted by our 'WWL Family' to the COVID-19 pandemic has been

ever thankful; both in providing the very best possible care for our patients and in supporting one another. We know from the many messages of support from people in the Wigan Borough that our patients and their families are

COVID-19 will have a profound impact on the country for years to come. Within this challenging context we believe that there is much to look forward to. Our new Strategy 2030 describes how we will not only recover, but An aspirational strategy is nothing without the right people and partners to deliver it – and the very traits witnessed in recent months provides us with

, we will make Our Strategy 2030 as exciting in reality as it is described within this document.

Realism and transparency are important companions for optimism. There are some real challenges facing WWL and the wider NHS including workforce shortages, waiting

has demonstrated that we are stronger together; and that we will collectively rise to the challenges that we face.

Our Strategy 2030 was developed through a thorough engagement process with patients; our WWL Family; and local partner

our future. Our Strategy 2030 will provide the touchpoint for the development of our annual corporate objectives for the decade ahead, to show a clear line of sight between our actions and the ambitions articulated here. Our Strategy 2030 is a document for us all to own and be proud of allowing our patients and our people to support the development of refreshed objectives each year.

Our Strategy 2030 describes a place where everyone should be proud to come to work; it is somewhere reliable for people when they or their loved ones need one of our services; and it is a successful organisation, always striving to be even better. Overall, it describes our overarching ambition, to be a provider of excellent health and care services for our patients and the local community.

Together, we can achieve this exciting vision of the future – and it will remain our privilege to work with you to deliver it.

**Silas Nicholls**
***Chief Executive***

**Robert Armstrong**
***Chairman***

# Introduction

**Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL) is a high-performing Trust, proud of our people, and our partnership role in the Wigan Borough. We provide a wide range of patient centred, high quality health and care services; from community services embedded within local areas, to acute care including world-class specialist services. Our achievements are a result of the commitment and hard work of our exceptional WWL family, and our collective passion to provide the very best care and experience for our patients and residents.**

We have a strong foundation to build on for the next decade, continuing to be guided by 'our four Ps' – Patients, People, Performance and Partnerships.

Many of WWL's achievements since our last strategy was launched in 2014 are key enablers for the refreshed vision of the future that we present here in Our Strategy 2030. Amongst these accomplishments is the integration of acute and community services in the Wigan Borough, welcoming more than 1000 community sta o our WWL family. We've also invested in estate developments across all our sites, including:

- Cutting edge theatres at Wrightington Hospital to host world leading orthopaedic services.
- A new diagnostic and treatment centre at Leigh In rmary.
- A Community Assessment Unit at Royal Albert Edward In rmary, enabling a new and innovative model of care, supported by technological progress including an electronic health records system.

Whilst we have gone from strength-to-strength in recent years, the start of the 2020s has brought the greatest challenges the NHS has ever faced. The COVID-19 pandemic saw our colleagues go beyond the call of duty to continue to provide excellent healthcare services to our patients and the community.

The toughest times can bring out the best qualities in people. We are incredibly proud of how everyone at WWL has responded to this unprecedented set of circumstances. As we start to emerge from th rst 12 months of COVID-19, the tireless determination of the WWL family is what gives us great con dence about what can be achieved in the years ahead.

Our key priorities in th rst year of the strategy will re ect the need to prioritise recovery from the impact of the pandemic through:

- Supporting our WWL family, who have given so much during the pandemic, to recover and recuperate; and
- Working with our partners to reduce the number of patients awaiting procedures or appointments.

We recognise that Our Strategy 2030 and vision cannot be achieved in isolation. We need to work together with our partner organisations for the best patient outcomes, delivering care that better meets the needs of our people. To create Our Strategy 2030 we engaged comprehensively with a broad range of colleagues from within WWL, patients and partner organisations to ensure a shared vision for the forthcoming decade.

Our key ambitions re ect the outline aims of the NHS Long Term Plan, published in January 2019. The Plan sets out the future journey of our national health services over the next decade to ensure the NHS i t for the future, with a strong focus on care being delivered closer to home through greater integration of primary, community and hospital care.

Recent events have accelerated some elements described in the Plan, such as evolution of the outpatient model of care towards digital consultations. This is a helpful reminder that Our Strategy 2030 will remain a dynamic document.

In the pages ahead, we will guide you through the context that WWL operates in at the time of publication – from a local to a national view, highlighting the challenges we will need to respond to and the opportunities we want to explore; the engagement and development process we've followed to create Our Strategy 2030; the strategic framework which supports the delivery of our vision; and our key ambitions for the next decade. Our key ambitions will not only build on our successes but will also involve developing new and innovative approaches to the care we provide, ensuring our sustainability.

Our Strategy 2030 sets out our vision for the next decade. Our fundamental aim is to measurably improve against the 4Ps and we will describe how we will do this through Improve; Integrate and Innovate.

**Improving**

**Integrating**

**Innovating**

# Our Story

**WWL is a medium-sized acute and community foundation trust in the North West of England, within the Greater Manchester footprint.**

On 1 April 2020 we became Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust which proudly re ects our commitment to education and training; this is the rst step towards our aim of achieving university teaching hospital status.

We provide healthcare to a local population of 326,000 and provide specialist services to a much wider regional, national and international catchment area.

Our community services are provided from a range of locations throughout the borough, including residents' homes, and our acute clinical services are based acro ve main sites: Wrightington Hospital, Royal Albert Edward In rmary, Leigh In rmary, Thomas Linacre Centre and Boston House:

- Wrightington Hospital opened in 1933 as a tuberculosis facility and post-war, was developed into an internationally renowned specialist orthopaedic hospital famous for the work of Professor Sir John Charnley who performed th rst total hip replacement in 1962. It now hosts a state-of-the-art theatre complex with scope for further development; and will be the Trust's hub for future Research and Education developments.

- Royal Albert Edward In rmary (RAEI) is our main district general hospital site, located in central Wigan. This is where our Accident and Emergency department is, as well as most of our inpatient services. There has been a hospital on this site since 1873 and it was named after the then Prince of Wales who o ially opened it in 1875.

- Leigh In rmary hosts elective diagnostic and rehabilitation services. The Hanover Diagnostic and Treatment Centre was opened on the site in 2014 by our MP. We are currently developing a Reablement Unit at Leigh which is due to open in 2021/22.

  This will provide a 24-bed intermediate care inpatient facility with dedicated rehabilitation/ reablement input to support patients to reach their potential following a period of illness/ injury.

- The Thomas Linacre Centre was formerly a grammar school in Wigan town centre and converted in 2002 by WWL for use as an outpatient clinic. It hosts 96 consultant-led clinics every week, with more than 100,000 patient visits per annum.

- Boston House is located close to Wigan town centre. It is the base for ophthalmology services and several community services, including physiotherapy.

**Our recent achievements include:**

- Winners of the 2019 Nursing Times award for Patient Safety Improvement.

- Finalist in the People & Organisational Development Initiative of the Year category of the Health Services Journal Value Awards 2020.

- Armed Forces Covenant Employer Recognition Scheme Silver Award.

- Creation of an Integrated Discharge Team (IDT) to start discharge planning on admission to hospital to improve communication with both patients and relatives and give patients a better experience at WWL.

- Rapid development of the Bryn Ward at the Royal Albert Edward In rmary to provide additional capacity during the COVID-19 pandemic outbreak, which took just 41 days to design, build and commission.

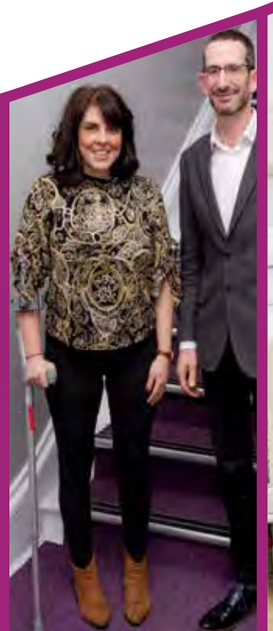
- Refresh of theatres in 2020/21 at the RAEI site to improve post-pandemic elective capacity.

- Upgrades to our accident and emergency department – alongside development of same-day emergency care facilities at the Royal Albert Edward In rmary to improve patien ows and reduce unnecessary admissions.

- Implementation of day case hip surgery, seeing Wrightington Hospital again leading the latest innovation in orthopaedic surgery; and ambulatory orthopaedic lists.

- A new purpose-built Community Assessment Unit which provides a rapid diagnosis pathway for patients as an alternative to being admitted onto a hospital ward. This is complemented by enhanced discharge support to facilitate patients in returning to their usual place of residence with reduced likelihood of readmission.





# WWL in Figures

## In 2019/2020 we saw

**38,204** day cases

**7,610** elective procedures

**484,667** outpatient appointments

**44,777** Walk-in-Centre attendances

**97,444** A&E and urgent care attendances


**94%** performance against the two week wait from referral to date first seen for all urgent cancer referrals
(Target is 93%)

**99%** performance against 6-week diagnostic standard
(Target is 99%)

**91%** performance against the 18-week referral-to-treatment pathway
(Target is 92%)

**84%** performance against A&E 4-hour wait standard
(Target is 95%)

We invested **£11m** on capital schemes, including IT systems, medical equipment and improvements to buildings

WWL spends more than **£1m** every day to provide safe and effective healthcare

The Trust has **14,977** members

The WWL family has **6,253** members of staff

There are **348** volunteers working across the Trust

WWL is **1 of 5** member groups of the **Healthier Wigan Partnership**

WWL is a local community and secondary care provider working alongside **60** GP Practices within **7** Primary Care Networks (PCNs)

# Our WWL Family

**The path to being an excellent provider of health and care services can only be achieved through our people. Prioritising the health and wellbeing of our colleagues will enable delivery of high quality and compassionate care for our population.**

The COVID-19 pandemic has reinforced how amazing our people are and how valued they are by WWL and the public. We couldn't be prouder of how they've responded to the circumstances and it has been a collective demonstration of how we can perform in the most challenging of situations.

The evidence is clear that teams which deliver the best care and outcomes for patients are those in which colleagues feel supported, respected, and valued. We also know that an environment in which colleagues feel comfortable to put forward their improvement or innovative ideas, and where they are empowered to deliver them, is one which is both attractive to work in and will lead to improvements in care and outcomes for our population.

We will continue to build on the e ective partnerships we have, to ensure that we put our community, patients, and peopl rst. Empowering our people to go and see beyond organisational boundaries will be key to this, helping to develop and deliver services that are truly centred around the needs and experience of our community.

Developing the right culture and ensuring that our current and future leaders are supported to nurture this, is therefore an essential enabling factor to unlock the maximum potential from the Improve, Integrate and Innovate priorities described on pages 26 - 31.

We are committed to making our WWL Family our priority.

We will:

- Place compassion and diversity at the heart of everything we do; creating a caring, inclusive, respectful working environment where everyone ca ourish.
- Support our people to achieve their career ambitions, providing development and training an exible career paths.
- Focus on the health and wellbeing of our people, providing activities and services that prioritise their health and wellbeing, and ensuring that there is personalised support when required.
- Ensure that our people have a voice which shapes their experience and environment, and where people feel safe to make suggestions and to call out any concerns.

We will build upon our key strengths over the coming years to secure the future workforce we need to meet the needs of our patients and residents through attracting and developing talent from our Borough, across the country and internationally.

There is much that makes WWL a unique place in which to train, work and develop and we will have a speci ocus on:

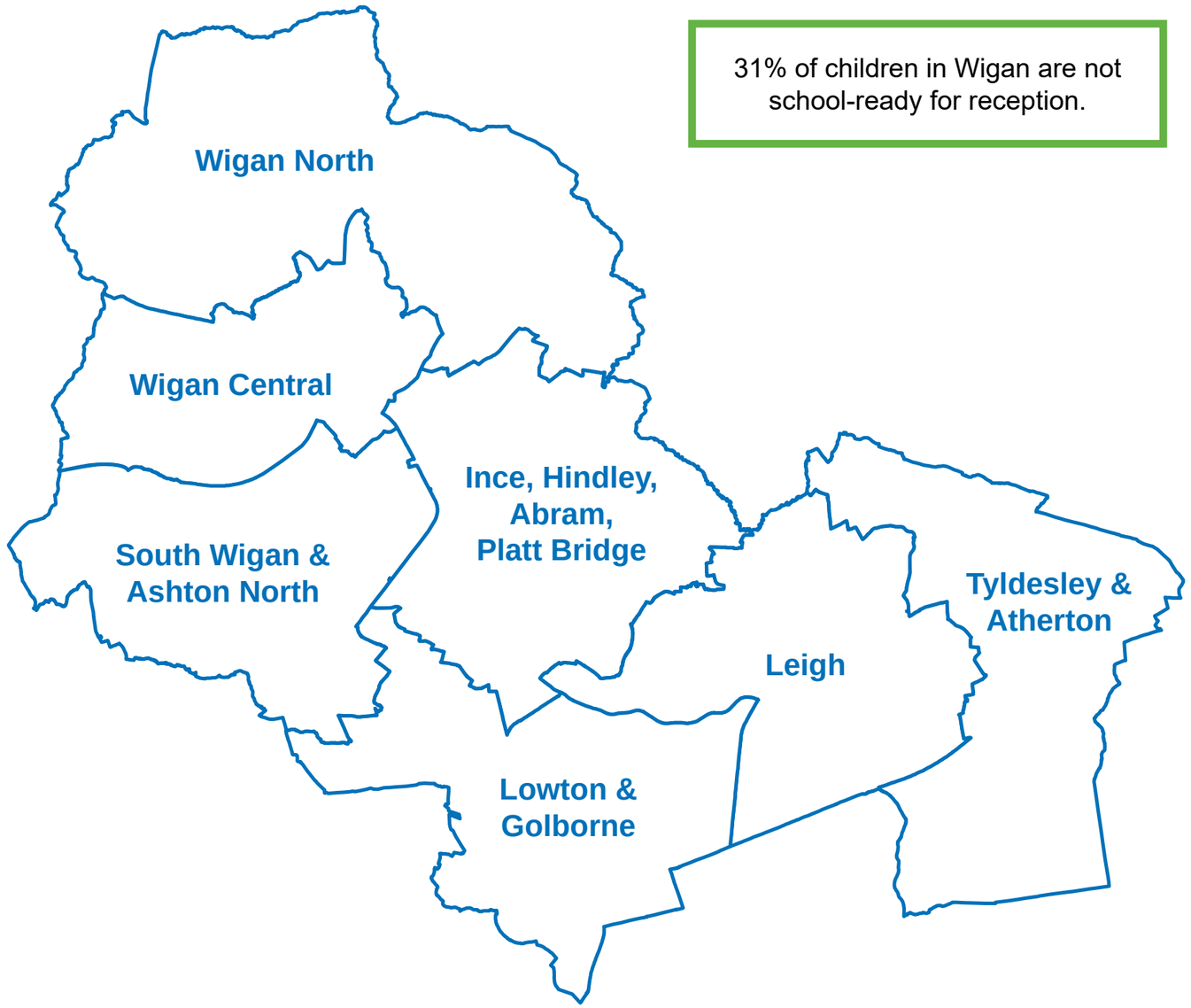
- Increasing the opportunities for local people to train and develop careers within WWL, developing a future pipeline of local talent through our role as a key in uencer within the Wigan Borough.
- Strengthening our links with Higher Education to support the development of tomorrow's workforce. This will include building on our existing relationship with Edge Hill University with the aim of being designated as a University Hospitals Trust.
- Building on the advances we have made in international recruitment.

# Our Population

Wigan has the highest percentage of population over 65 years in Greater Manchester with life expectancy for both men and women lower than the England average. With people living longer, the number of people over 65 is forecast to increase by 30,000 over the next 20 years.

31% of children in Wigan are not school-ready for reception.

29% of our residents live in the 20% most deprived areas in the country - nearly 100,000 people in the Wigan borough.
A
in our GP practices is socio-economic – linked not just to health but to debt, domestic abuse, loneliness, access to work, and cold homes.




23% of our residents are diagnosed with a long-term condition impacting on quality of life, supported by 34,000 carers (c.10% of our population). The population of Wigan Borough has higher recorded prevalence than the national average for diabetes; coronary heart disease; COPD and hypertension.

Wigan Borough also has greater rates of mental health diagnoses than the national average, which are often closely related to physical health conditions. For example, 38,933 patients (around 15% of the adult population) had a diagnosis of depression in 2019/20.

Over two-thirds of our population is overweight, with 13% of the population clinically diagnosed as obese, leading to other health complications.

65% of residents are of working age. Of those, 40% are at high risk of unplanned hospital admission, often with complex dependency on public services.

# Our Partners

**WWL is a founding member of the Healthier Wigan Partnership (HWP) – a joining together of the main health and care providers across primary, community, mental health, social care and secondary and specialist care. This partnership ensures the delivery of joined up and sustainable health and care services that meet the needs of local residents and improves the population's health in the longer-term.**

All partners are committed to working together to transform local services, with an initial focus on improving services based in the community.

The HWP membership currently includes:

- WWL
- Wigan Council
- NHS Wigan Borough Clinical Commissioning Group (CCG)
- Greater Manchester Mental Health NHS Foundation Trust
- GP Clinical Leads representing the seven Primary Care Networks of GP practices in the Wigan Borough

We also work in partnership with Greater Manchester Police, Local Voluntary and Community Sector organisations and the North West Ambulance Service.

HWP is focused on ensuring high quality health and care services at the point of access for residents, but also tackling the wider social and economic determinants of illness to improve the health of the population throughout their lives.

A Wigan Locality Plan wa rst published in 2015, and since then the collaborative work of the HWP has resulted in the following achievements:

1. Healthy Life expectancy has increased by 17 months for women and 13 months for men
2. Early deaths due to Cardio-Vascular Disease have reduced by 29% for men and 25% for women
3. Early deaths attributed to cancer have reduced by 16% for men and 9% for women
4. All childhood vaccination programmes achieve 95% herd immunity including MMR
5. Over 360 community initiatives have been supported by the community investment fund
6. 75% of residents supported by our outstanding reablement service require no further on-going social care support
7. Healthier Wigan Partnership Experience: Interactive 'Deal' training on having an asset-based approach has been delivered

   social care
8. Best in the North West at getting people home from hospital quickly
9. Formally adopted the GM Carers Charter in 2018
10. Youth Justice System
11. 73.6% of estimated people with dementia are getting help from services
12. 14,000 children are doing the Daily Mile every day whilst at school.

At the core of partners' commitment to seamless and joined up services for residents is the alignment of public services within the seven established Primary Care Networks of the Wigan Borough, forming communities of well-integrated and informed teams. This will support our joined-up aim to provide the right care, at the right time and in the right place for our local population.



# Our Region

**The NHS in England comprises several regionalised health and care structures, which are currently in the process of evolving into Integrated Care Systems, as described in the NHS Long Term Plan. WWL is part of the Greater Manchester Health and Social Care Partnership (GMHSCP), which covers a population of 2.8 million people in the North West of England.**

### GMHSCP objectives

- Transform the health and social care system
- Align health and social care systems to wider public services such as education, skills, work and housing
- Create a nancially balanced and sustainable system
- Make sure services are clinically safe throughout

### This means...

- Fewer people will die early from diseases like cardio-vascular disease, cancer and respiratory disease
- More children will reach a good level of social, cognitive and emotional development
- Fewer babies will have a low birth weight and have better outcomes
- More people staying well and living at home as long as possible
- Taking better care of those who are ill

Prior to the onset of the COVID-19 pandemic, WWL was actively engaged in key GMHSCP , equity, and standards across secondary care services across Greater Manchester. Whilst this work

working in partnership across GM can be seen by our joined-up response to the pandemic which created a single system; facilitating distribution of resources to where they are most required and seeing mutual aid provided between Trusts.

This approach will continue, and indeed deepen, for at least the initial years of Our Strategy 2030 to support all partners in the region to recover after what has been an unprecedented set of challenges for the NHS.

Beyond this period of recovery, collaboration with our partners across GM will be important to improve the resilience of services across the region and ensure our residents continue to have equitable access to high quality specialist services.

Although WWL is designated within the GMHSCP system of providers, the Trust also borders the Cheshire and Merseyside, and Lancashire and South Cumbria sustainability and transformation partnership (STP) / ICS regions. Therefore, WWL also provides services for patients in these neighbouring areas.

# The National Picture

**The national context of healthcare and the demographics of the country are always evolving. With a growing and ageing population, an inevitable increase in demands on services follows.**

This is coupled with an increase in people's expectations of health and social care services, how they are accessed, the quality they can expect from them and how the public receive and interact with them.

Some examples of the national picture include:

- Life Expectancy – This continues to grow, and whilst the rate has slowed in recent years, a greater proportion of those years are spent in poorer health.
- Ageing Population – People are increasingly susceptible to a wide range of age-related, long-term conditions, such as the estimate that 4.4 million people will be living with type 2 diabetes by 2025, and the increased prevalence of dementia.
- Health Care Costs - The spiralling costs associated with managing ever-increasing complex needs, the development of better technology and more expensive drugs and treatments, is far out-pacing any increase in system funding.
- Public Expectation – This continues to increase, as do expectations of personalised responses to services people access. The health and care system needs to diversify its o er and create mor exibility and variety in how patients access health care.
- Digital Capability - People are becoming increasingly digitally capable and reliant on smartphones or portable digital devices being thei rst point of access to a wide range of services. Service users reasonably expect better access to their own health records, arrangement of access to services and more options for self-care.
- Health and Wellbeing - There is an observed widespread gap in health and wellbeing between the most and least deprived areas in the country, which results in the most deprived living 20 more years in poor health compared to their counterparts in the least deprived areas. The strong evidence that poor physical health is often combined with mental health illness compounds the negative impact on quality of life for people in poorer areas of the country.

**The NHS Long Term Plan was published in 2019 and frames the overall direction of travel for the NHS in response to challenges faced by the national health and care system. The document outlines the following priority areas for development:**

- Investing in the evolution of service models to enable patients to access the right services more quickly by:
  - Developing Primary Care Networks

    in community settings and improve the resilience of GP services through network arrangements.
  - Rolling out Urgent Treatment Centre / Same-Day Emergency Care models to provide alternatives to A&E and reduce overnight stays for patients.
- Reducing the number of patient journeys by moving a third of outpatient appointments to non-face-to-face
- Increasing the focus on illness prevention and reducing health inequalities – particularly in relation to type 2 diabetes and its causes (smoking; obesity; alcohol consumption); and lowering air pollution.
- Improving care quality and outcomes, mainly through the elimination of

  examples of improving early diagnosis of cancer; better access to mental health services and reduction of waiting times.
- Addressing the disparity between growing demand for NHS services and the shortfall of workforce in post to meet this demand .
- The mainstreaming of digital healthcare solutions to improve patients' access to their own information, sharing of information and data driven planning and care.

More recently, the Government has published its proposals for new health and care legislation: Integration and innovation: working together to improve health and social care for all. Whilst the legislation has not yet passed parliament it signals that: NHS Foundation Trusts will continue to be independent organisations; Integrated Care Systems will become statutory bodies, resulting in more formal partnership working arrangements between WWL and GM; partnerships at local level, in our case across Wigan, are the primary focus in driving integration and improving the health of the population. The draft legislation does not provide a 'one siz ts all' solution and we will work with our local partners to maximise the opportunities this will bring to build on our successful partnerships with HWP and GM.

# The Impact of COVID-19

**Most of the local and national documents described in Our Strategy 2030 provide some of the background and drivers for its development and were published around the same time.**

World events in the time since, have had a profound impact on the environment and pressures within which the health and social care sector is operating. It is not possible to con rm with certainty the medium and longer-term impact of COVID-19 on health and social care services, in terms of the health needs of our population and ongoing infection protection control requirements. There are many clear challenges, and indeed opportunities that we must consider as we set our future direction.

## The Challenges We've Faced

- **Relentless pressure** - The amazing

  relentless pressures from the pandemic have impacted our WWL Family. High stress and sickness rates have occurred – a picture nationwide, with frontline placed under an unprecedented level of pressure to respond to COVID-19 admissions for a prolonged period of time. This has increased

- **Growing Waiting Lists** - It was observed prior to the COVID-19 pandemic that nationally the NHS wasn't uniformly meeting access standards and waiting lists were growing. Growth in waiting lists has accelerated as result of the impact of the pandemic – and reducing this backlog will present the single biggest challenge for the NHS, as the country transitions from coronavirus containment to recovery and restoration.

- **Financial Deficits** - This situation has become much more severe as a result of responding to the pandemic. WWL

  organisation, but like others we now face new

  the pandemic and stepping up and changing services to respond to it. This is in the context of GM as a system forecasting a large

  and beyond.

- **Long term health impact** - The symptoms we've described amongst our workforce are likely to be a microcosm of the general health of the population throughout the pandemic. We don't yet understand the frequency and health impacts of 'long-COVID'. In addition, the restrictions implemented to mitigate the spread of the virus will have caused: inevitable deterioration in the physical and mental health of patients on waiting lists; as well as negative impacts on physical and mental health as people spend extended periods under restricted freedoms. There will also have been missed diagnoses and avoidable deaths; and socio-economic

  those who were already most vulnerable and widen existing health inequalities.

- **Changing Workforce culture** - A rapid change in workforce behaviours and expectations as many people have been asked to adapt to working at home. It is unclear how far this will permanently alter working patterns – and may impact at a population level where people choose to access health and care services.

- **Brexit** - During the same period, the United Kingdom has formally left the European Union and an agreement was reached around the UK's new legal arrangements with the EU, which commenced in January 2021. It is anticipated that this will have an impact on workforce recruitment and retention.



The necessity to adapt quickly to respond to COVID-19 has resulted in WWL accelerating delivery of some elements of the Plan and our ambitions. In amongst the devastating impact of the pandemic, COVID-19 has given us much to build upon and take forward.

## The Action We've Taken

- **Digital Consultations** - We have adapted through the rapid roll-out of digital consultations – particularly for follow-up outpatient appointments. Moving a third of such appointments to non face-to-face formats was a mandated target of the Plan, but this became an urgent need as access to hospital sites became restricted during the COVID-19 outbreak. We successfully transitioned to a new model of virtual consultations for both hospital and community services and are committed to maintaining and building on the benefits of this new way of delivering services for the benefit and convenience of our patients post-pandemic.

- **Remote Monitoring** - We worked alongside colleagues in primary care and NWAS to improve opportunities for patients to use remote monitoring equipment, such as the roll-out of the Oximetry @ Home initiative for patients with COVID-19. This has enabled patients to be remotely monitored, preventing unnecessary admissions and leading to earlier discharges.

- **International Recruitment** - We advanced our plans for international recruitment of nurses to address immediate workforce pressures, giving opportunity to increase future resilience through an increased nursing establishment.

- **Alternatives to A&E** - We developed alternatives to A&E to see patients treated in more appropriate places, easing pressures at the front door of the hospital. This has increased the number of patients who follow a 'same day emergency care' pathway and therefore don't spend an overnight stay at the hospital.

- **Strengthened Partnerships** - We strengthened partnerships within the Wigan Borough and moved towards more collaborative system-based approaches in GM. Partnership working between our community services and Primary Care also supported the development of 'step-down' capacity at Leigh Infirmary.

# Our Strategy 2030 – Why Now?

**After a year of being all consumed by the pressures of the pandemic the need to look forward with optimism is clear and, indeed, vital.**

The launch of Our Strategy 2030 will provide colleagues, stakeholders, partners and patients with the much-needed clarity on how WWL will recover from the current situation an ourish in the years to come. It will allow everyone to see where we want to be and the roadmap for getting there. It will give us all the optimism for the future that we all now need.

WWL's preceding Trust Strategy was launched in 2014. Since this time there have been signi ant changes to the environment we operate in, changes in national policy and direction, and new challenges and opportunities to respond to. This brought about a need to refresh our collective vision, ambitions and key deliverables for the forthcoming decade.

A thorough engagement process was undertaken to develop Our Strategy 2030, with this occurring in the months immediately prior to the COVID-19 pandemic outbreak.

Although we have noted here the huge impact that the pandemic has had on the NHS, the broad strategic intentions at a national policy level remain relevant, as do the local challenges we face and the many opportunities we want to take. It follows then that the same logic applies to what our stakeholders have told us is required to take health and care services forward for people in the Wigan Borough and beyond – albeit some adjustments will be required to re-align priorities according to changes in their respective need.

What we describe in Our Strategy 2030 will provide the roadmap for ensuring we achieve our vision, reaffirming our values and behaviours in doing so, alongside the themes and ambitions to guide everything that we do.

From this, we can develop our implementation plans and focus on delivering Our Strategy 2030 through annual corporate objectives, divisional planning activities and through our enabling strategies and transformation plans.



# How Our Strategy 2030 Was Created

**Our Strategy 2030 is based on the needs of serving our residents and patients, colleagues and partners. It therefore needs to be shaped and designed by those people, to ensure it understands how our patients, staff and partners view our future and contribution to the health and wellbeing of our local residents.**

During 2019/20, we undertook a thorough engagement process which enabled us to work with a broad range of stakeholders on the objectives and priorities for WWL, including:

- Colleagues from across the organisation – representing the various Trust sites, professions, directorates and teams
- Representatives from the Healthier Wigan Partnership
- WWL's Board of Governors
- Wigan Youth Council
- Patients, Trust Members and communities.

The engagement discussions were a mixture of public meetings, stakeholder forums, and smaller group / individual discussions so that a broad range of ideas could be suggested, challenged, re ned, developed, and agreed.

We worked within the local, regional and national contexts described earlier in this document, which themselves were dynamic and required us to remain aware of relevant developments. Within this we considered what key stakeholders regarded as the irreducible service o er for WWL. This de ned the core purpose of WWL and served as a starting point for Our Strategy 2030 vision.

As discussions progressed, common themes began to emerge. We asked stakeholders to start considering six conceptual scenarios as the foundations of our potential strategic priorities.

The dialogue around the scenarios generated rich data for us to re ect on and advance our thinking about where we wanted to be as an organisation by the end of the current decade, and options for getting there. We were able to form and test a more detailed set of aims, grouped into three key strategic priorities. From this the strong theme of WWL delivering its ambitions through Improve, Integrate and Innovate emerged.

Engagement cannot and will not conclude with the publication of Our Strategy 2030. To ensure that the ambitions and deliverables described here become a reality, we will continue engaging with sta , partners and patients to help prioritise elements of the strategy and lead their implementation through the development of annual delivery plans, corporate objectives and transformation priorities.

# Our Vision for the 2020s

**Our vision for the future is for WWL to be a provider of excellent health and care services for our patients and the local community.**

WWL has been recognised by regulators as a ‘Good’ organisation which has made a series of improvements in recent years.

However, we see ‘good’ as our baseline and want that to become ‘excellent’ as we move through the 2020s towards 2030 – and to achieve that our people will be supported and empowered to deliver high quality, patient-centred care.

Through developing our approach to continuous improvement, embedding evidenced-based methodologies and nurturing a culture of improvement, we will provide the foundations to support this journey.

The demographic that we serve is ageing and there are real socio-economic challenges in the locality. We need to evolve the way health and care is viewed and support people to live healthier lives from birth through to their later years.

Our role in achieving this is multi-faceted, through our provision of services along the full continuum of care, encompassing public health and early intervention, chronic disease management, acute care, highly specialist services, and end of life care.

We’ve made notable progress in recent years but we need not just to keep up with the latest developments, but to take a leading role in them to achieve our aims.

We will develop a culture that supports innovation, creating an environment where our colleagues are comfortable in their place of work and enabling them to suggest and trial changes.

The bringing together of community services alongside acute in WWL has been a huge leap forward for the locality in furthering the commitment in ensuring continuity and collaboration between health and care services.

The Healthier Wigan Partnership will create more coordinated local access to services for our community, who will no longer feel as if they are being passed from one organisation to another – resulting in fewer visits to hospital and better outcomes for people.

This will be supported by the investment and use of technology. Our population will inevitably become more reliant on technology – and people will increasingly expect to use it to manage and access their health.

We also see technology being used to advance how clinical sta rain.

The next decade will see us make leaps with regard to better information sharing so that appropriate information is shared between health and care professionals; enabling patients to manage their long-term conditions better and report remotely on changes in symptoms; and put them in control of arranging access to health services at places and time most convenient to them.

With fewer patients attending our sites for outpatient appointments and other transformations to clinical service delivery, the form and function of our estate will also change – and advances in technology will play their part here too.

Arti ial intelligence will become more reliable and improve diagnostics; robotic technology will play a greater role and result in better procedure outcomes for patients; whilst 3-D printing will likely become a fundamental part of our orthopaedics o er.

WWL is proud to be a well-recognised organisation locally and will use that status as a positive in uence in the Wigan Borough. This will manifest itself in employment opportunities, use of socially responsible suppliers, and reductions in our carbon footprint.

Th nancial challenges we now face are signi ant. It will take a prolonged period of time for the UK as a whole to recover from the economic impact of the pandemic – and we are no exception to this reality. It is imperative that the decisions WWL makes deliver value for money and achieve sustainability for the years ahead.

# Our Strategic Framework

**At WWL, it's not just what we do, but the way we do it that is important to us. Underpinning delivery of our strategic ambitions over the next decade are the five behaviours which we all seek to embody as WWL people: Forward Thinking; Working Together; Accountable; Respectful and Demonstrate Compassion.**

**The four Ps – Patients, People, Performance and Partnerships encapsulate the areas on which we want to focus our development and improvement. Our strategic ambitions within each pillar are:**

## 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

## Performance

T

care

## Partnership

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

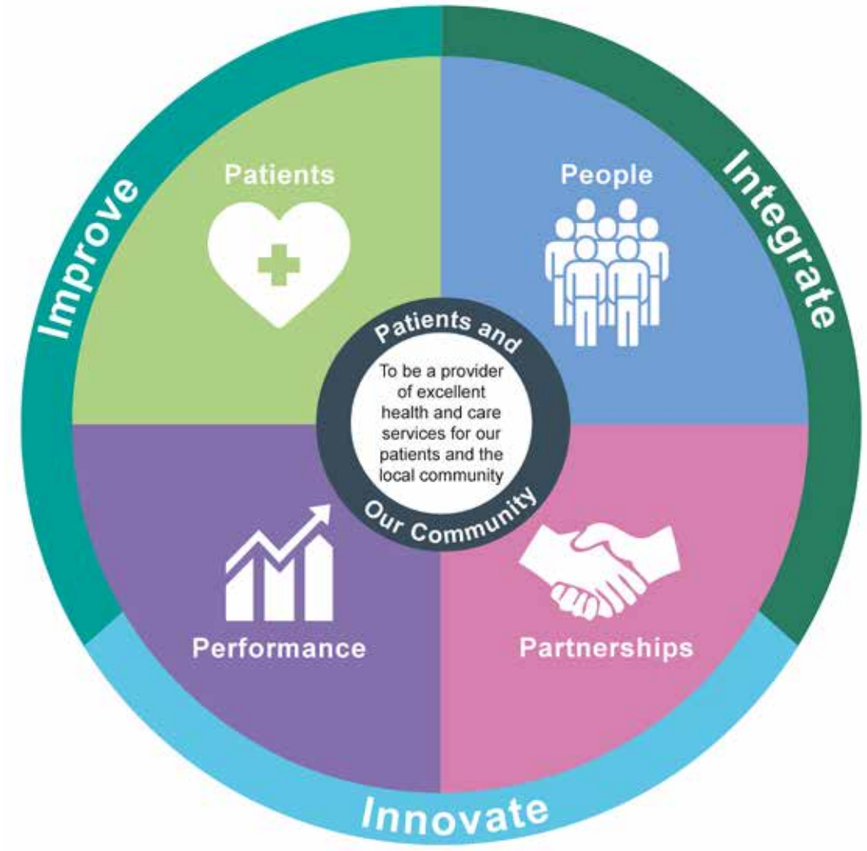
These four Ps will form the focus of our annual corporate objectives which will be reviewed annually and include measurable goals to keep us on track to deliver our ambitions.

Key to delivering these ambitions are the strategic priorities that have been

key stakeholders: **Improve**, **Integrate** and **Innovate**.

These set out "how we are going to deliver" over the next decade and will be used to guide the decisions that we make.

Through doing this we will ensure that we achieve our vision **to be a provider of excellent health and care services for our patients and the local community.**




# We Will…Improve

**By embedding an ethos of continuous improvement, we will pursue and secure ongoing improvements in the quality of care we provide, and in the experience that our patients and community have of our care.**

We will involve our community and ensure that their voice is central to our improvement journey. This will be critical in helping us understand the improvements that we need to make and give us the ability to empower people to make positive choices about their health and care. This will include supporting patients to take responsibility for their own health needs and  access the most appropriate service when required.

Our continuous improvement approach will also support us to deliver widespread transformation of the services we provide and how we deliver

from a contemporary
provider. We will look to build on the things we have learned during the COVID-19 pandemic.

outpatient appointments enabled by technology and new models of care.

We will work with our partners across the Wigan Borough to actively improve the health of our local population, supporting people to remain healthy and happy throughout life, and to holistically address health problems as they occur. Our role in this is two-fold.

Firstly, as an integrated provider of community and acute health services we will seek to provide education, support, and intervention as early as possible, preventing avoidable escalation of care needs. Secondly, by working alongside our partners in the Healthier Wigan Partnership we, as one of the largest employers in the area, recognise the opportunity to

Wigan Borough for local people.

We will develop our capability to use information to drive improvements in outcomes for our residents and patients. Through using information to support a better understanding of the health and care needs of our population, we will tailor the care and support we provide our communities, and design more joined up and sustainable health and care services.

We recognise and embrace our role as a leader in improving the environment for our communities. W
action to reduce our overall carbon footprint through a number of means, including: reducing

become electric; an increase in vehicle charging

will be designed as close to carbon neutral as possible.

## What will our patients, community, partners and people experience?

- Compassionate care, focussed on the needs of the individual, with excellent outcomes
- Our patients and their families will receive support to make informed choices to improve their health and about their care
- High quality, local services, which are accessible for Wigan Borough residents
- Increased options for accessing health services, such as: virtual consultations; services closer to patients' homes, services wrapped around other health and social care provisions; and extended opening hours according to demand
- unnecessary duplication (e.g. through

  possible) and being served by a local trust
- A multi-professional workforce, supported by technology, which meets the demands on our services
- Our people will feel empowered and equipped with the skills to make improvements within their area of work
- An inclusive, compassionate and respectful working environment; supporting the wellbeing of our people
- control over their working lives.

## Our delivery priorities will include

- Embedding a culture of continuous improvement, across the Trust and HWP, supported by recognised methodologies and development of organisational capacity and capability
- Reducing unwarranted clinical variation and

  benchmark.
- Reducing mortality, eliminating avoidable harms and improving safety and outcomes to be among the best healthcare systems
- Empowering patients to make positive choices about their health and care from school age through adulthood, developing portals for patients to access information about their condition and therefore promote self-care
- Adopting a set of standards which must be met as a minimum for every patient encounter. This will reduce mistakes and episodes of substandard care; and avoid missed diagnosis opportunities
- of being an integrated community and acute provider, doing so with primary and social care colleagues, to prevent avoidable escalations in care
- Developing our capability, within WWL and across our partners, to use information to

  and care needs of our communities.
- Focusing the Trust'
  and on its areas of specialism; ensuring capacity planning (workforce, estate, equipment) meets future demand
- delivering best value for our residents
- Developing a modern workforce model, utilising new roles, providing career development pathways, and providing employment opportunities for our local population.


# We Will…Integrate

**Gaps between health and social care have plagued the consistency and continuity of care that patients experience for too long – this was consistently reinforced through our patient engagement work. In response, we will create smoother patient journeys through further integration, building on the establishment of the Healthier Wigan Partnership (HWP) and the coming together of community services alongside our hospital services at WWL.**

We will place our patients at the centre of service redesign, recognising their expertise in their experience of care. We will learn from the experience of our patients to redesign our pathways to meet their needs and expectations. In practice, this will mean seamless single pathways instead of a series of interactions with

of the system.

We will continue working with our partners to align wider public services with health and social care, including GP practices, schools, the police and voluntary and community sector organisations within local communities (Primary Care Networks). Through creating these place-based, integrated public services, we will

of each of these communities, recognising the social determinants of healthcare issues. Crucially, we will work with all providers of health and care services needed to be able to access the same information about a patient within the Wigan Borough.

We will develop our role as an “Anchor

economics of the Wigan Borough for local people, through our employment practices and procurement choices. We will act collaboratively with our partners to utilise local companies which demonstrate progressive employment

experience and career opportunities (e.g. joint apprenticeships) to school leavers and people in education; and help to re-engage local unemployed people back into work. Our local population is our future workforce and we will engage with local schools and colleges to make them aware of the broad range of career opportunities available within the wider NHS and help potential candidates to access these employment pathways.

Through developing our role as the hub for orthopaedics activity across the region and beyond, we will build on our internationally renowned orthopaedics services based at Wrightington, supporting an increase in the

the class leading outcomes that we consistently deliver. We will do this collaboratively, working with our provider partners in Greater Manchester, and those in our neighbouring areas and across the country, to ensure equality of access and outcomes.

## What will our patients, community, partners and people experience?

- Wigan-based suppliers will be used where possible with preference given to suppliers with progressive employment practices
- Our residents will have more opportunities to work in healthcare, with clear training and development paths
- of our local communities
- Seamless delivery of public services using shared assets including buildings and supported by appropriate sharing of information
- Single continuous pathways rather than a series of separate episodes of care, with expert advice provided within a local setting
- Reduction in the need to travel to a main hospital site, supporting a reduction in our overall carbon footprint
- skilled workforce, and our people will have

  roles
- Improvements in outcomes and experience through partnerships with our neighbouring Trusts
- Recovery of elective services post-pandemic using resources across GM to reduce the number of patients waiting for surgery as quickly as possible
- Patients across GM and beyond will have access to world-class specialist orthopaedic services, receiving the best in clinical outcomes

## Our delivery priorities will include

- Implementing the WWL elements of the ‘Deal 2030’ and collaborating with the Healthier Wigan Partnership to increase our leverage

  social value in the Wigan Borough
- Integrating within a place-based care model developed around the Primary Care Networks
- integrated community and acute provider; learning from the best culture and practices across our services
- Developing the use of Expert Patient Programmes
- Working collaboratively with the wider system in GM and neighbouring regions (Cheshire and Merseyside and Lancashire and South Cumbria) to implement new models of care, where they improve outcomes and add value to services for our population
- Continue working with GM stakeholders and peer providers to deliver system-level response to the COVID-19 pandemic and its recovery
  resources and ensuring equity of access to elective services post-recovery
- Working with our neighbouring Trusts to deliver improvements in outcomes for our patients
- Working with GM providers to develop and
  rightington being
  the orthopaedics hub across the region, and beyond, to improve access and outcomes for patients requiring orthopaedic treatment and interventions

# We Will…Innovate

**Innovation and technology are two of the key enablers to achieving our vision and delivering improvements in healthcare at a fast pace. To ensure we deliver excellent care, it is vital that we put innovation at the heart of Our Strategy 2030, to make sure we develop new and novel ways of delivering our services, also looking outside to adopt thinking from other areas.**

At WWL we want to be known as an organisation which empowers its teams to make changes and therefore attracts aspirational employees who know they will have the opportunity to drive improvements for patients and develop their own careers in the process. The evidence is clear that

and treatments, better outcomes and faster recovery. Further development of our research and academic activities and reputation is therefore key, and we will seek to be accredited as a 'University Teaching Hospital' building on the recent designation as a 'Teaching Hospital'.

Feedback from our engagement was clear; . It is not limited to technology, nor is it limited to things that are "brand new". Innovation is about empowering our WWL family to suggest, and act on, new ideas into their area of work. That can sometimes involve a calculated level of risk, but where our teams see an opportunity that they want to pursue, they will be encouraged and supported to do this.

We accept that not all innovative ideas will produce the desired outcome – this is acceptable as long as we take the opportunity to learn where things don't work out. Our commitment to continuous improvement will also support us in this.

Initially, we will move towards being an 'early adopter', quickly implementing good ideas and innovations observed elsewhere. Examples of this include completing the transition from paper to electronic patient records and establishing

to self-manage their health and organise healthcare according to their preferences. This will see remote forms of consultations rolled out during the COVID-19 pandemic become business as usual; patients will begin arranging their own appointment slots for clinics, and there will be increased use of wearable devices.

Further innovation will see opportunities to

robotic surgery into practice which will help advance quality and outcomes through the

foresee all that will be considered as innovative a few years down the line, we want to support our people to be at the forefront of shaping the future of health and care.

## What will our patients, community, partners and people experience?

- Our people will be part of an organisation that is committed to research and development, actively shaping the future of healthcare
- Our community and patients will have access to new treatments and therefore have improved outcomes
- Our clinicians will have access to the right information, on the right device, at the right time
- Our patients will be able to arrange their own appointments, view their records and add/ amend information directly
- Our patients will be able to communicate with health professionals and have consultations via mobile devices.
- Patients and communities will experience fewer journeys to hospital as we adopt wearable technologies and devices enabling remote monitoring
- Our people will feel empowered to innovate within their role and license to practice
- Our patients will have opportunities to participate in clinical trials and to the latest developments in digital medicine, giving them access to the latest treatments and rapid diagnosis

## Our delivery priorities will include

- Achieving 'University Teaching Hospitals' status, supported by increasing the research and developing relationships with Edge Hill University and other institutions
- Development of facilities for research and education and clinical trials that support the latest in digital training, including enhanced simulation
- Phasing out any residual use of paper patient notes and recording all activity on the Hospital Information System (HIS)
- Creating single care records for patients in the Wigan Borough, which are accessible to all health and care professionals
- Developing the IT infrastructure supporting current and future development plans of our Trust systems
- Developing a culture of 'psychological safety' supporting our people to feel empowered to act on or suggest their ideas for change
- robotic technologies where the evidence-base supports improvements for our patients (e.g. surgical services and analysis of diagnostic scans)
- 3-D printing to improve clinical outcomes and

# Our Strategy 2030 – Delivery

The success of Our Strategy 2030 will be in its delivery.

Our Strategy 2030 is supported by key enabling strategies which set out in more detail our

digital capability, and ensuring that our estate is

Each year we will set annual corporate objectives which focus on delivery of the strategy, whilst remaining agile to changes in policy and the operating environment. Crucially, this will allow us to measure our progress towards strategy delivery and inform our service and divisional plans which set out the detailed aims and objectives for each year. This will ensure that we have a 'golden thread' which runs from our strategic vision to divisions, teams, and individuals, leveraging the collective

Our Strategy 2030 and corporate objectives will also inform the shape of our transformation plan; identifying the complex, large-scale

governance to achieve. The Trust Board will track progress towards delivery of the strategy on a regular basis.

Our Strategy 2030 is ambitious but achievable. We recognise the uncertainty in the current environment coming out of the COVID-19 pandemic, including a lack of clarity about the Trusts. Some of our ambitions will require investment to achieve them fully, whilst others can be delivered within

what we already have. This may mean that we are not be able to do everything we want to do at the time we want to do it. This will not stop us developing the plans we need to, so that we are well placed to invest wisely and maximise our potential to do so.

# Next Steps

## Risks to Implementation

Our Board Assurance Framework provides a robust foundation to support our understanding and management of the risks that may impact the delivery of Our Strategy and the annual corporate objectives. This considers those risks that are most likely to materialise and those that are likely to have the greatest adverse impact on delivering the strategy.

The environment in which we are operating in can change quickly, as demonstrated in the last 12 months, as can the challenges and risks that we face. A proactive approach to risk

pre-requisite to the successful delivery of Our Strategy 2030. We will continue to work with

committees, to ensure that we are responding to these changes, identifying risks as they manage them.

## Future Engagement

Our Strategy 2030 sets the 'roadmap' for our future over the next 10 years, identifying our key strategic priorities and providing the guide by which we will make our strategic decisions. It has been shaped by our residents, patients, WWL family and our partners, and it will ensure that we focus on the longer-term vision and sustainability of WWL. It sets out the key ways in which we will create our future; through Improving, Integrating, and Innovating.

It will evolve as we continue to engage with all stakeholders over the lifetime of the strategy and as we respond to changes in the policy and operating environment. We will also need

partners, and patients to help prioritise elements of the strategy and lead their implementation through the development of our delivery plans, to ensure that we deliver on our vision to be a provider of excellent healthcare services for our patients and the local community.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

| | |
|---|---|
| **Title of report:** | Disciplinary process and policy review |
| **Presented to:** | Board of Directors |
| **On:** | 31 March 2021 |
| **Presented by:** | Director of Workforce |
| **Prepared by:** | Strategic HR Lead |
| **Contact details:** | T: 3832 E: vikki.s.mcmanus@wwl.nhs.uk |

**Executive summary**

This report identifies the national recommendations around NHS organisations having fair, systematic and consistent disciplinary processes which promote treating our staff with kindness and dignity acknowledging that mistakes will happen and informal routes to resolve should be adopted where appropriate.

In accordance with this an updated version of the Trust's Disciplinary Policy is appended (alongside a description of our future intensions for further versions) alongside an update of progress to date on the national recommendations, next steps and our local recommendation for a training programme to support managers in facilitating disciplinary steps in a robust and fair manner.

**Link to strategy**

Fair experience for all; NHS People Plan; WWL People Plan

**Risks associated with this report and proposed mitigations**

N/A

**Financial implications**

Requirement for regular investigator and panel member training and rolling programme of updates via refresher training.

**Legal implications**

The WWL Way

Robust and fair conduct processes assist in the avoidance of legal advice and employment tribunal cases which are both costly for the Trust in money and resource.

**People implications**

Robust and fair conduct processes demonstrate our commitment to our staff around our belief in a learning culture where it is recognised that mistakes happen and informal outcomes should be the prime route to resolve so that our staff feel safe and secure in the roles they perform.

**Wider implications**

A reputation as a fair employer can only contribute to being an employer of choice and contribute to positive recruitment and retention outcomes.

**Recommendation(s)**

The Board of Directors are asked to receive and note the update.

## Report

All Trust's received a letter on 1 December 2020 from Prerana Issar, NHS Chief People Officer regarding '*sharing good practice in order to improve our people practices'*. This letter was a follow up to previous communications to Trusts from Dido Harding, Chair of NHS Improvement in May 2019 which outlined the key questions and guidance, organisations should consider as part of their local investigation and disciplinary procedures. Following the tragic death of Nurse Amin Abdullah who worked for Imperial College Healthcare, who was subject to the Trust's investigation and disciplinary procedure – an independent review was undertaken into Imperial's policy and process and from the outcome of the review the recommendations were made to all Trusts to consider.

The letter from Prerana states –

*I urge you to honestly reflect on your organisation's disciplinary procedures, review the recommendations we issued in May 2019 and the attached example of good practice, and consider what has worked well and what could be further improved.*

*Where action is required, I urge NHS organisations to commit to tangible and timely action to review on a yearly basis and by the end of this financial year, all disciplinary procedures against the recommendations and that these are formally discussed/minuted at a Public Board or equivalent. We will continue work with the CQC to embed the learning from these reviews to form part of the formal oversight framework. I would also like to suggest your policy is made available on your organisation's public website by the end of the financial year.*

In light of the recommendations we took steps to review our current process and a paper setting out WWL's approach to Just Culture was tabled in September 2019. The following actions were taken forward which embraced the recommendations –

- Employee relations triage – now a fortnightly Executive Led Disciplinary Scrutiny Panel attended by senior clinical colleagues and staff side.
- Employee relations case support – a robust support framework is in design. The principles have been in place since 2020. Further development is underway considering an approach which includes a holistic approach based on personal need inclusive of OH, S4W etc.
- Employee relations reporting – this commenced in early 2020 but was suspended due to the pandemic. This has now been reignited and reports on activity will come to each People Committee
- Employee Relations case review – these commenced quarterly ahead of the pandemic and are now planned into 2021/22 – a review of a selection of cases focusing on a division at a time.
- Fast track processes – this was designed and implemented during 2020
- Grievance arbitration – a new Dignity @ Work Policy and SOP are in draft form and currently progressing through ratification. The new procedure includes steps such as a facilitated meeting or a trained mediation meeting as part of the resolution pathway ahead of formal routes.
- Case de-briefing and learning – from 2021 each conduct case will have an evaluation discussion between HR and staff side to capture any learning points at the closure of the matter.

- Investigation bank – due to financial restraints this has not proceeded however will remain under review.

Additional elements in relation to management development; communication and engagement; the behaviour framework and leadership behaviours commenced in 2020 and will continue as appropriate into 2021/22.

Completion of some of the actions were delayed due to the pandemic however during this period developments were taken forward to support managers and staff during this time. The Fast Track process within the procedure was agreed in partnership and the principles applied so that staff have an option to apply for a resolution to a formal conduct matters via an accelerated route. This has been beneficial to all stakeholders so that the matter is dealt with in a robust manner but via a quick methodology so resolved quicker.

Additionally a WWL 'Just Culture' Framework for escalation of workforce incidents (Decision Tree) was created and adopted during the pandemic which contributes to a consistent and comprehensive methodology for managers to use when considering if informal or formal routes for conduct resolution are most appropriate.

**Disciplinary Policy Development** – see Appendix.

We envisage our policy development should go through several versions changes. Currently we need to maintain the overall policy style within the organisation, therefore the latest review (version 1) of the policy has maintained this but we would like to progress to a version (2) that removes many of the formal titles and becomes more informal, responding to the key questions our employees ask and written in a way that is more natural to read and understand. Finally we believe that a HR Policy Handbook (version 3) would be more beneficial to staff and managers – so the general spirit and themes, alongside all responsibilities are maintained in an overarching chapter – with the rest of the handbook defining the key points/steps under each HR policy/procedure heading. Streamlining the content and making it more user friendly.

Version 1 – key points of update

- Reviewed and re-written in parts to provide clear guidance to promote informal resolution where possible and appropriate; providing further clarity on responsibilities; promoting fairness and consistency with consideration given to the full context of any allegations including mitigation and contributing elements such as human factors; staffing levels etc. The policy has been updated with signposting to the 'decision tree'

- Where formal matters are agreed to progress, clear oversight should be in place to ensure options for informal resolution routes continue and when matters progress to hearings there is consistency and fairness applied alongside independence and objectivity, that includes ensuring the panel are reflective of the skills; competencies and demographics of the case and affected employees.

- Training – to ensure objectivity and independence is maintained at every stage and identified or perceived conflicts of interest are acknowledged and appropriately mitigated. Managers should be able to demonstrate the aptitude and competencies (in areas such as

awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations)

- Health and Wellbeing – focus is given within the policy to confirm the responsibility and role of both line managers and case managers in ensuring they safeguard the welfare of staff and maintain their duty of care towards staff who are subject to conduct matters. A personal support and communication framework should be put in place and regularly reviewed. The policy defines this is supported and facilitated by the HR and Steps 4 Wellness representatives.

- A new exclusion risk assessment has been defined for those matters where exclusion, restriction, or redeployment of an employee from their substantive role/duties is required to ensure protection to the employee and investigation – this will be held on the intranet alongside the policy so it can be reviewed and updated as needed in partnership with staff side colleagues without formal approval restraints and delays.

## Next steps

- The draft has been under consideration with all key stakeholder and links have been made with Steps 4 Wellness team to fully define what will be within the **support and communication framework.**

- Once fully ratified the policy will need to be fully **communicated across the Trust**. This may form part of a programme of communications linked additionally to actions from the FTSU audit launch inclusive of updates to the policy and FTSU ambassador programme alongside any communications and promotion linked to Psychological Safety developments and Just Culture.

- **Publication** on the Trust's website.

- The **design and delivery of an appropriate training programme** is being explored with the Hempsons/ACAS and any potential routes for a joined-up approach with GM Trusts to drive consistency and cost effectiveness.

- We continue to respond to relevant feedback from staff who have been subject to conduct processes and whilst negative feedback causes us all concern that we have failed to support staff effectively it does further encourage review of our processes, to learn and continuously improve. Based on recent feedback we are exploring the adoption of an **investigation policy/procedure,** that will enhance any training for managers and further drive a consistent, fair, and robust process across the organisation.

## Recommendations

Adopt and invest in principle in a training programme for all managers who investigate as part of employee relations processes; and sit on panels where decisions on sanctions applied to staff are taken. Training would include both initial training and a rolling programme of refresher training every 3 years. We understand that no estimated costs are provided at this time and therefore approval for any investment would need to be go through an appropriate approval route.

## Appendices

## TW10-097 Disciplinary Policy 2021 – follows this paper.

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

| | |
|---|---|
| **POLICY NAME:** | **Disciplinary Policy** |
| **POLICY ID NUMBER:** | **TW10-097** |
| **VERSION NUMBER:** | **10** |
| **APPROVING COMMITTEE:** | **Partnership** |
| **DATE THIS VERSION APPROVED:** | |
| **RATIFYING COMMITTEE** | **PARC** |
| **DATE THIS VERSION RATIFIED:** | |
| **AUTHOR (S)** (JOB TITLE) | **Strategic HR Lead** |
| **DIVISION/DIRECTORATE:** | **Corporate / Workforce** |
| **LINKS TO ANY OTHER POLICIES/PROCEDURES:** | **Policy for maintaining high professional standards**<br>**Code of Conduct**<br>**Grievance Procedure**<br>**Safeguarding Policies**<br>**Fraud, Corruption and Bribery Policy & Response Plan**<br>**Attendance Management Policy**<br>**Conflicts of Interest Policy**<br>**Standard Financial Instructions (SFI)** |
| **CONSULTED WITH:** | **Policy Development Group / Staff Side** |

| | | |
|---|---|---|
| **DATES PREVIOUS VERSION(s) APPROVED** | Version<br>9 | Date<br>November 2019 |
| **NEXT REVIEW DATE:** | | |
| **MANAGER RESPONSIBLE FOR REVIEW (Must be Authors Line Manager)** | **Deputy Director of HR** | |

The WWL Way

CONTENTS PAGE

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

## 1 INTRODUCTION

1.1 Wrightington Wigan and Leigh Teaching NHS Trust requires high standards of conduct from everyone and is committed to helping people improve and learn from mistakes. This policy and procedure is designed to ensure a fair, systematic and consistent approach is taken when an employee's behaviour or action is in breach of workplace rules or falls short of the expected standards.

1.2 Inevitably, as a large employer responsible for upholding standards for our patients, there are times when we need to follow formal procedures, but in these circumstances it is essential that we treat people with dignity and kindness in line with our values, regardless of the circumstances.

1.3 We are also committed to combatting any bias or discrimination in our employment and management practices. As part of our commitment to developing a just and learning culture cases are thoroughly assessed to ensure there is sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action. We should always be asking ourselves whether our actions are proportionate and justifiable and whether managing situations informally achieves a more productive outcome.

## 2 POLICY STATEMENT

2.1 This policy and procedure reflects the recommendations from the NHS Improvement group convened in response to the Verita Report (outcome from the review into the death of Nurse Amin Abdullah in 2016) and communicated to NHS Trusts in 2019 by Baroness Dido Harding, Chair of NHS Improvement.

2.2 The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by helping staff feel confident to speak up when things go wrong, rather than fearing blame. An objective and prompt examination of the issues and circumstances should be carried out to establish whether there are truly grounds for a formal investigation and/or for formal action. Would training for the employee, support, guidance or informal management be more appropriate and productive?

2.3 This policy has been developed in consultation with the Trust's recognised trade unions and is in accordance with the ACAS Code of Practice on disciplinary and grievance procedures.

2.4 This policy applies to everyone employed by the Trust on a permanent or temporary basis. Issues relating to professional misconduct of Medical and Dental staff should be managed under the Trust's Maintaining High Professional Standards Policy.

## 3 KEY PRINCIPLES

3.1 The Trust expects all employees to behave appropriately and professionally. Everyone has the right to be treated fairly, with dignity and respect in the application of the disciplinary process.

3.2 Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should

be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.

3.3 A member of staff who is subject to the disciplinary process can be represented at all formal stages of the process by a recognised trade union/professional body representative. Alternatively, they can be accompanied by a work colleague, who is not involved in the disciplinary investigation process. In the event of the colleague being legally qualified, they will not act in this capacity during the disciplinary process. Further alternative and/or additional support/representation will be considered in exceptional circumstances and should be discussed at the earliest interval. Refer to section 22 for further details.

3.4 Consideration should be given to those staff who have any additional requirements and require reasonable adjustments in order to participate under this process.

3.5 Audio or visual recording of any meeting held under this process is not permitted. Any person caught covertly recording any meetings under this process may be subject to disciplinary action.

3.6 Virtual meetings will be considered by the chairs of the meetings and relevant trade union representatives and if deemed appropriate, given relevant current circumstances, will be a viable meeting method at all stages, inclusive of hearings.

3.7 Those subject to this policy and team members affected by its application will be offered a personalised support and communication arrangement at each stage. Please refer to the support framework associated to this policy. This can be found in the Trust intranet policy library or via the HR team.

3.8 All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise)

3.9 The Trust aims to ensure all managers who investigate concerns or chair/sit on hearing panels must have appropriate and up to date training on workforce investigations/managing/chairing disciplinary cases. Such training should involve appropriate refreshers within three years of the initial training.

## 4 RESPONSIBILITIES

### 4.1 Trust Board

4.1.1 Responsible for the initiation of this policy under its commitment and to promote a culture of fairness, openness and learning in the Trust by helping staff feel confident to speak up when things go wrong, rather than fearing blame.

4.1.2 To receive reports and have assurance that conduct matters are handled within the organisation by competent managers who operate in a consistent, fair and respectful manner towards all employees involved in conduct procedures.

4.1.3 Ensure all managers who undertake actions within the disciplinary process are able to access training and maintain their competency.

### 4.2 Responsibility of Executive Led Disciplinary Scrutiny Panel

4.2.1 Review all potential formal disciplinary cases prior to commencement and where appropriate, utilise a series of questions and the ‘just culture’ decision tree to decide whether there is an appropriate basis to invoke formal management.

4.2.2 Act in accordance with the published triage process and terms of reference.

4.2.3 Consider all human factors that may have been a contributory factor, whether the issue is one of capability rather than conduct and whether there are early indications of system failings.

4.2.4 Review all non-medical exclusions risk assessments at each panel to ensure the exclusion remains essential.

4.2.5 Seek assurance that a personalised support and communication arrangement has been agreed between the relevant manager and the employee for all cases that progress formally.

4.3 **Responsibility of Managers**

4.3.1 Ensure staff are made aware of the disciplinary policy and associated rules (Appendix 2).

4.3.2 Managers should try to resolve minor matters of concern informally. If informal approaches do not bring about improvement or if misconduct is sufficiently serious, formal stages of this procedure should be followed.

4.3.3 Managers will ensure that all action taken under this policy and procedure is reasonable and proportionate. At an early stage, employees will be told why disciplinary action is being considered and they will be given the opportunity to respond to allegations before decisions about formal sanctions are taken.

4.3.4 Undertake training/mentoring in the application of this policy.

4.3.5 Inform Human Resources (HR) when allegations are received.

4.3.6 Any suspected fraud, corruption or bribery should be reported to the Trust's nominated Fraud Specialist Manager.

4.3.7 Managers must ensure they maintain their duty of care towards any employee (inclusive of any alleged victim and/or perpetrator) who is subject to a conduct process by ensuring a personalised support and communication arrangement is in place.

4.3.8 Ensure any concerns to be considered under a formal route are referred to the Executive Scrutiny Panel for approval ahead of any formal process commencing.

4.4 **Responsibility of HR**

4.4.1 Ensure the policy is compliant with current legislation.

4.4.2 Ensure appropriate training/mentoring is provided to managers regarding the application of this policy.

4.4.3 Liaise with appropriate stakeholders to determine appropriate process to be applied such as informal resolution or investigation required.

4.4.4 Facilitate support with stakeholders at any meeting where exclusion is considered.

4.4.5 Ensure managers have initiated a personalised support and communication arrangement.

4.4.6 Co-ordinate hearings as required.

4.4.7 Manage the list of appropriately skilled panel members, case managers and investigators in conjunction with staff side.

4.4.8 Support management representatives in the disciplinary process.

4.4.9 Ensure that accurate but non verbatim written records are maintained and provided to relevant stakeholders as soon as possible.

4.4.10 Refer any incident of suspected fraud to the Fraud Specialist Manager or the Chief Finance Officer prior to the commencement of any investigation. The Fraud Specialist Manager will agree with the Chief Finance Officer and the HR Department the method of approach to the investigation of any allegation.

4.4.11 Ensure any concerns to be considered under a formal route are referred to the Executive Scrutiny Panel for approval ahead of the commencement of a formal process.

4.4.12 Within 4 weeks of the conclusion of any formal conduct/disciplinary matter the relevant HR representatives from the investigation and any panels, alongside staff side colleagues should review the case and evaluate any learning to drive continuous improvements of the disciplinary process.

4.4.13 Ensure relevant mechanisms are in place to provide assurance to the Board that the statement and principles of this policy are upheld.

4.5 **Responsibility of Employees**

4.5.1 Behave appropriately and in accordance with the Trust's values.

4.5.2 Ensure that they are aware of the disciplinary policy, the associated rules and its implications (See Appendix 2).

4.5.3 Engage appropriately with each stage of the process.

4.6 **Responsibility of Case Manager**

4.6.1 Undertake appropriate training to ensure complete independence and objectivity can be delivered throughout their oversight of the matter.

4.6.2 Undertake the role in accordance with the principles of this policy.

4.6.3 Use a comprehensive and consistent decision-making methodology, such as the workplace incident 'decision tree' to ensure fair application of the process.

4.6.4 Consider, offer and enact the fast track procedure if appropriate, following discussion with the HR representative.

4.6.5 Develop and issue terms of reference for investigations.

4.6.6 Manage the pace of the investigation within agreed time scales.

4.6.7 Review the progress of the investigation at regular intervals, being openminded to consider if the investigator confirms there is evidence to support the formal process continuing. Consider would training for the employee, support, guidance or informal management be more appropriate and productive?

4.6.8 Where evidence is not identified, take action at the earliest interval to close the case and communicate this outcome to all parties.

4.6.9 Receive the investigation report and refer any further investigation requirements to the investigating officer.

4.6.10 Once the investigation report is received a case manager may determine an informal route is a more appropriate resolution.

4.6.11 Ensure a personalised support and communication arrangement is in place and reviewed at regular intervals for any employee subject to the case they are managing.

4.6.12 Fraudulent/Corrupt Activities. Managers who have been informed of a potential fraud must promptly report it to the Chief Finance Officer and the Trust's Counter Fraud Officer before taking any action, including suspension, which could potentially alert the member of staff. Further guidance is contained in the Trust's Counter Fraud and Corruption Policy, which must be carefully followed.

4.6.13 It is recommended that a different senior manager will act as any panel chair to ensure independence is evident however the case manager may act as panel chair for any case that proceeds to a formal hearing providing they have had no direct involvement within the investigation aside from issuing the terms of reference and updates on any investigation progress only, therefore objectivity and independence is maintained and there is no identified conflict of interest. Consideration for the membership of the panel should be reflective of paragraph 12.2.

4.7 **Responsibility of Investigating Officer**

4.7.1 Undertake appropriate training to ensure complete independence and objectivity can be delivered throughout their investigation.

4.7.2 Complete a fact-finding investigation in accordance with terms of reference (Appendix 6).

4.7.3 Where evidence is not identified, take action at the earliest interval to highlight this to the case manager so consideration to close the case and communicate this outcome to all parties.

4.7.4 Compile a balanced and robust report on completion of the investigation.

4.7.5 Determine if there appears to be a case to answer that should be heard at a disciplinary hearing.

4.7.6 Present the management case at disciplinary hearings.

4.7.7 Refer any incident of suspected fraud to HR.

4.7.8 All incidences of suspected fraud must be referred to the Fraud Specialist Manager or the Chief Finance Officer before any investigation takes place. Normally notification will be the responsibility of a senior member of the HR Department. The Fraud Specialist Manager will agree with the Chief Finance Officer and a senior member of the HR Department the method of approach to the investigation of the allegation.

## 5 CONFIDENTIALITY

5.1 Disciplinary cases will be treated sensitively and confidentially. Information will only be shared with those who have a legitimate right to be informed in accordance with Data Protection Act 2018 and the Common Law Duty of Confidentiality. Breaches of confidentiality by any party may result in disciplinary action.

## 6 WORKPLACE/JUST CULTURE DECISION TREE

6.1 In accordance with the principles of this policy, in response to any workplace concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps. The Trust's 'decision tree' is the agreed framework for considering any concerns and should be utilised by any manager/case manager and the outcome discussed with the relevant HR representative.

6.2 Managers should consider carefully all mitigation such as staffing levels, health issues or other human or workplace factors as part of using the decision tree and ahead of determining a formal route is the most appropriate action.

6.3 If the outcome from the decision tree methodology is that a formal route is the most appropriate step, the HR representative will refer the matter to the Executive Scrutiny Panel for consideration and approval.

## 7 SUPPORT FOR THOSE AFFECTED BY FORMAL PROCEDURES

7.1 It is the responsibility of all managers and HR representatives that manage, facilitate and support a conduct/disciplinary matter to consider - What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct support will be provided to them? Furthermore, how will you ensure the dignity of the individual(s) is respected at all times and in all communications, and that your duty of care is not compromised in any way, at any stage?

7.2 Managers must ensure that a personalised support and communication arrangement is in place and reviewed at regular intervals for any employee subject to the case they are managing. To support the discussion and arrangements managers should refer to the accompanying guidance and template available on the Trust's policy library or via the HR team.

7.3 Depending on the discussion with the relevant individual, a Health and Wellbeing Staff Liaison Officer may be appointed to directly support and assist the individual in accessing internal health and wellbeing support mechanisms.

7.4 Managers of any member of staff who is subject to being excluded or redeployed from their substantive role whilst an investigation proceeds must ensure that support and communication arrangements are immediately agreed with the employee before they leave the department or are redeployed, unless an alternative time to discuss is requested by the employee or their representative.

## 8 FAST-TRACK DISCIPLINARY

8.1 In cases of alleged misconduct where dismissal is not an option and where an employee does not wish to contest the allegations, they can opt to have their case dealt with by way of the fast-track process. This formal route should be a quicker and far less stressful process for all those involved.

8.2 The Trust's Fast-Track Disciplinary process is defined within the associated protocol, available via the HR Department.

8.3 The protocol can be applied to all conduct matters, where the available facts of the case and any known mitigation are determined by a manager and their HR advisor as leading to a resolution or disciplinary sanction that is likely to be more than an informal route but less than a dismissal. This protocol does not preclude managers resolving matters via informal routes if at all possible.

8.4 There is no obligation for managers or employees to offer or apply for this route in conduct matters; however, consideration should be given to the facts of the conduct matter, the potential outcome and any benefit identified to reducing the time and any detrimental impact on all those involved in the case.

8.5 Any managed contemplating offering this route for employee consideration should seek the advice of their HR advisor.

8.6 Any employee considering this route in resolution of a conduct matter and the associated allegations against them should seek advice via their union representative, a workplace colleague or a member of the HR team.

## 9 EXCLUSION/RESTRICTIONS/REDEPLOYMENT

9.1 Exclusion is not a disciplinary sanction, it is a holding measure on full pay whilst an investigation is completed and is implemented to safeguard the employee, patients and the Trust. The excluding manager and those supporting an exclusion or redeployment should ensure any employee subject to exclusion is fully supported at this time and not treat them as 'guilty' in any way as this is not the aim of this action. Managers should consider the exclusion or redeployment as a temporary step and prepare as though the employee will return to their substantive role and act accordingly.

9.2 The matter of exclusion should be discussed between the relevant manager and HR contact, with the exclusion risk assessment document (available on the Trust intranet or via HR) being completed and consideration being given to interim alternatives such as restriction or alternative duties. Except where immediate safety or security issues prevail, any decision to exclude should be a last resort that is proportionate, time-bound and only applied where there is full justification for doing so.

9.3 An employee subject to this discussion will be entitled to representation in accordance with section 22. however given the often immediate or urgent requirement for any meeting to take place, if representation is not available this will not prevent the meeting going ahead.

9.4 If possible, the decision to exclude should be supported by the Executive Scrutiny Panel ahead of the exclusion taking place however due to the nature of exclusion, it is unlikely to be the case that this decision on whether or not to proceed can wait for the panel to meet. Therefore, efforts should be made by the HR contact to discuss with either the Strategic HR Lead, Deputy Director of HR or Director of Workforce in these situations as an alternative. In any event, the views of as many panel members as possible will be sought by the Director of Workforce / Deputy Director of HR/ Strategic HR Lead, recognising the immediacy of the situation.

9.5 The panel will review the documented exclusion risk assessment and any further information that has become available at the next panel meeting, in order that any corrective action can be taken quickly, where required. The panel will review the status of all exclusions at each meeting to ensure their continuation remains proportionate and necessary.

9.6 Ideally the excluding manager should meet with the employee to advise of their decision to exclude them from work, move them to another area or restrict their duties whilst the investigation is completed. In all instances, their decision will be confirmed in writing within 2 working days.

9.7 If the employee is excluded from work, they should not attend any Trust premises unless requested by the case manager/investigating officer. The employee may attend medical appointments at Trust premises but must not speak to any witnesses involved in the investigation. Meetings with trade union/professional body representative on Trust premises are permitted.

9.8 Excluded employees should be advised of their entitlement to contact the Freedom to Speak Up Guardian at any time on SpeakUp@wwl.nhs.uk or 01942 822662 to discuss any concerns they might have in relation to patient safety or care.

9.9 Employees who are excluded from the Trust must not work for another employer during their normal working hours.

9.10 The excluding manager must ensure that support and arrangements for the employee in accordance with section 7 is agreed with the employee.

9.11 Immediate support and assistance should be given to any excluded or redeployed member of staff to ensure they are able to obtain any personal property from their substantive working area, they may wish to take with them whilst excluded/redeployed. Managers and support staff should consider if the staff member needs to be accompanied whilst obtaining their belongings and leaving their department. The overriding aim should be one of support and assistance with the dignity and respect of the individual in mind; and only where there may be a risk to any employee or investigation should any employee be accompanied unless the employee themselves wishes to be accompanied. Employees should not feel ostracised or prejudged by the exclusion/redeployment process.

9.12 Excluding managers should consider **with** the employee any communications that may be appropriate and should be provided to colleagues to explain their absence or redeployment from the department during the relevant period.

9.13 Excluding managers should not request the return of Trust Identification or remove any other Trust access unless they are able to identify a clear risk to the investigation and/or any staff or patients with the employee maintaining this during the relevant period.

## 10 ILL HEALTH DURING EXCLUSION

10.1 If an employee is excluded due to a conduct matter and has advised the Trust they are too unwell to participate at any stage in the conduct process, the employee will be referred to Occupational Health in the first instance, so the relevant manager/HR support is able to seek advice and determine if any support or reasonable adjustments can be made to enable the conduct process to be concluded.

10.2 Advice will be sought by Occupational Health and consideration will be given to reasonable adjustments such as an employee participating within any stage of the process in writing or if representations are able to be made on the employees behalf.

10.3 If reasonable adjustments or support is not identified and extended sickness absence occurs which prevents the continuation or conclusion of the conduct process, consideration will be given to pausing the conduct process.

10.4 Should the conduct process be paused, the Trust's Attendance Management process will be commenced by the employees' line manager, or other appropriate manager depending on the circumstances. This process will include the exploration of supportive measures with the employee to determine if and when they are able to participate within the conduct process again.

10.5 In this instance the employee will no longer be considered as excluded but absent due to sickness and they will be recorded on the ESR system accordingly. Once the period of sickness absence has ended, consideration will be given to the status of the exclusion, which is likely to be reinstated.

10.6 Employees will need to provide the Trust with a relevant 'Fitness to Work' Statement to support the period of sickness absence in accordance with the Trust's Attendance Management Policy.

10.7 Should the employee be dismissed for reason of ill health incapability, consideration will be given to the conduct matter and process and a satisfactory conclusion will be defined by management with HR advice and support, which may include but not be limited to a disciplinary hearing.

10.8 Any subsequent employment reference requested by a potential employer to the Trust for an employee dismissed due to ill health incapability, but with a live conduct matter at the date of the dismissal will include factual information based on how the conduct matter was concluded by the Trust.

## 11 MANAGEMENT OF MISCONDUCT

11.1 The Trust recognises that cases of minor misconduct are best dealt with informally and quickly. A quiet word is often all that is needed. Cases of minor misconduct should initially be dealt with through a recorded file note, which will remain live for 6 months but may be retained within the personal file for information purposes. Any recorded information should be shared with the employee and a copy issued.

11.2 If conduct does not improve, or an act of serious misconduct occurs, a formal disciplinary investigation may be commissioned by the case manager following approval from the Executive Scrutiny Panel.

11.3 Any recommendation for a formal disciplinary investigation will be forwarded to the Trust's Executive Led Disciplinary Scrutiny Panel to ensure that fairness and consistency of reason is applied to commencing a formal investigation and assurance that an informal resolution would not be appropriate.

11.4 Managers should remain openminded and consider if an informal resolution is a viable route at all stages, including during any formal process. A formal process should be stopped at the earliest point if an informal route or no case to answer would be more appropriate as a resolution to the matter.

11.5 Managers, with the advice and support from HR, can consider if any conduct matter is eligible to be resolved via the Trust's Fast-Track Disciplinary process. If managers believe the facts of the case may be resolved by this method, they will inform an employee of their entitlement to apply. If the application is approved there will be no further requirement for a formal investigation to be undertaken whilst the case proceeds to resolution via the fast-track route. Should the fast-track route not conclude to resolution there may be a requirement for the matter to revert to the formal investigation under this policy.

11.6 For matters that proceed to a formal investigation, where possible, the investigating officer should complete their investigation within 8 weeks. If this is not possible, this should be referred to the case manager who will arrange to contact the employee with an update. This will include a review of the exclusion or restricted practice, if applicable.

11.7 Where evidence is not identified, investigators and case managers must take action at the earliest interval to close the case and communicate this outcome to all parties, which includes advising the Executive Scrutiny Panel there is no case to answer.

11.8 Where the evidence suggests there may be an appropriate informal resolution route, this should be highlighted to the case manager at the earliest interval for consideration and any relevant action. Where an informal outcome has been agreed this outcome should be confirmed with the Executive Scrutiny Panel.

11.9 On completion of the investigation, the investigating officer should complete an investigation report and provide this to the case manager within 4 weeks.

11.10 The case manager will write to the employee to confirm if they are to be referred to a disciplinary hearing.

## 12 DISCIPLINARY HEARINGS

12.1 If the decision is made that a formal disciplinary hearing is necessary, it will be chaired by a manager who has was not involved within the investigation. A representative from the HR Department will support the chair of the panel and a professional advisor may also be in attendance.

12.2 The consistency of the panel will include a minimum of 2 panel members (inclusive of the HR representative) and should be representative of both the profession and demographics relevant to the case and employee. Where a professional conduct matter is under consideration then a professional advisor will be on the panel in advisory, but non-decision-making capacity.

12.3 When a decision is taken to proceed to a disciplinary hearing, all relevant information gathered during the investigation process will be provided to the member of staff.

12.4 The employee will be invited in writing to attend the hearing, providing at least 5 working days' notice. The letter will also include:

12.4.1 Allegations which are to be considered;
12.4.2 Disciplinary rules which are alleged to have been broken;
12.4.3 Whether the allegations are classified as gross or general misconduct and possible outcome/sanction;
12.4.4 Date, time & venue of the hearing;
12.4.5 Panel members, including the HR representative and professional advisor (if applicable);
12.4.6 The employee's right to representation;
12.4.7 The employee's right to call witnesses;
12.4.8 The employee's right to provide a written statement of case.

12.5 Where a clinical recommendation via Occupational Health or a GP has been made, or a recommendation by a Health and Wellbeing Staff Liaison Officer has been received which confirms that any party (such as a witness) within the hearing may be subject to psychological damage by attending a panel in person, arrangements can be made for video conferencing to take place and input into the proceedings via this methodology.

## 13 LEVELS OF AUTHORITY

13.1 Gross misconduct cases – Executive Director, Deputy Director, Divisional Director of Nursing or Head of Department.

13.2 General misconduct cases – Those listed in 13.1 plus Matrons, Ward Managers, Directorate Managers or equivalent.

## 14 SANCTIONS

14.1 The panel will take all of the evidence presented at the disciplinary hearing into consideration when making their decision. In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.

14.2 The possible decisions are:
- 14.2.1 No case to answer
- 14.2.2 Recorded file note
- 14.2.3 Informal measures
- 14.2.4 First written warning
- 14.2.5 Final written warning
- 14.2.6 Dismissal.

14.3 In addition, consideration will be given to transfer and/or demotion.

14.4 Additional action as a result of being issued with a disciplinary warning: In accordance with the Trust's Pay Progression Policy and procedure - If a first or final written warning is issued, the member of staff will not be awarded an annual pay increase on the pay step date whilst the warning remains 'live'. The Chair of a hearing will request the line manager action this via the ESR system. The manager should initiate a pay step review meeting before the expiry of the warning and if all other requirements have been met, the member of staff will progress to the next pay step effective from the date after the warning expires.

14.5 In the first six months of employment with the Trust, any act of misconduct may result in dismissal.

14.6 Formal written warnings should last for 12 months unless exceptional circumstances apply.

14.7 Cases of gross misconduct which result in dismissal will be implemented with immediate effect without notice.

14.8 The outcome of any disciplinary hearing or appeal hearing will be confirmed in writing within 14 days of the hearing.

## 15 APPEALS

15.1 All appeals must be lodged on the appeal form (Appendix 3) and submitted to the Deputy Director of HR within 14 calendar days of the disciplinary outcome being confirmed.

15.2 The acceptable grounds of appeal are:

- 15.2.1 Procedure was not adhered to;
- 15.2.2 An inappropriate sanction was applied;
- 15.2.3 Additional information / evidence has become available.

15.3 Appeals will normally be chaired by a manager of higher seniority than the initial disciplinary hearing. The panel should not have had any prior involvement in the case. The panel will

receive advice and support from a member of the HR Department. The consistency of the panel will include a minimum of 2 panel members (inclusive of the HR representative) and should be representative of both the profession and demographics relevant to the case and employee. Where a professional conduct matter is under consideration then a professional advisor will be on the panel, in an advisory but non-decision-making capacity.

15.4 Appeals against dismissal will be heard by a minimum of 2 senior managers with the authority to consider cases of gross misconduct. At least 1 of the panel members will be a Director of the Trust.

15.5 If the grounds of appeal are that additional evidence has become available, the chair of the panel may consider running the appeal as a complete re-hearing. In such instance there would be no further right of appeal.

## 16 HEARING FORMATS

### 16.1 Disciplinary hearing

Disciplinary hearings are held in the following format:-

16.1.1 The management side will present their case;
16.1.2 The employee (and/or their trade union representative) can ask questions of the management side;
16.1.3 The panel can ask questions of the management side;
16.1.4 Questions are asked of witnesses called by the management side;
16.1.5 The employee (and/or their trade union representative) present their case;
16.1.6 The management can ask questions regarding the employee's case;
16.1.7 The panel can ask questions regarding the employee's case;
16.1.8 Questions are asked of any witnesses the employee has called;
16.1.9 Summary presented by the management side;
16.1.10 Summary presented by the member of staff (and/or their trade union representative);
16.1.11 The hearing is adjourned whilst the panel considers their decision;
16.1.12 The hearing is reconvened, and the chair confirms their decision;
16.1.13 The outcome is confirmed in writing.

### 16.2 Appeal hearing

Appeal hearings are held in the following format:

16.2.1 The employee (and / or their trade union representative) will present their case;
16.2.2 The management can ask questions regarding the employee's case;
16.2.3 The panel can ask questions regarding the employee's case;
16.2.4 Questions are asked of any witnesses the employee has called;
16.2.5 The management side will present their case;
16.2.6 The employee (and/or their trade union representative) can ask questions of the management side;
16.2.7 The panel can ask questions of the management side;
16.2.8 Questions are asked of witnesses called by the management side;
16.2.9 Summary presented by the member of staff (and / or their trade union representative);
16.2.10 Summary presented by the management side;
16.2.11 The hearing is adjourned whilst the panel considers their decision;
16.2.12 The hearing is reconvened and the chair confirms their decision;
16.2.13 The outcome is confirmed in writing.

## 17 RE-SCHEDULING HEARINGS

17.1 If the employee, or their representative, is unable to attend a hearing and a good reason for failing to attend is provided, the hearing may be adjourned to another date which will be mutually agreed. All efforts should be made for this to be rearranged within no more than 4 weeks.

17.2 If the employee is unable to attend the re-arranged hearing, it may take place in the employee's absence unless an acceptable explanation is provided. The employee will also be provided with the opportunity to make a written submission. In cases where the delay is caused through ill health the advice of the occupational health and well-being department will be sought.

## 18 SAFEGUARDING AND CHILD PROTECTION ISSUES

18.1 Allegations of safeguarding in relation to children or vulnerable adults against employees should be dealt with in accordance with the Trust's Safeguarding Policies. A Safeguarding representative should be allocated to support the case to provide professional advice around this.

18.2 Any allegations against an employee or volunteer should be reported to the relevant safeguarding lead/Medical Director who will determine whether referral to the LADO is necessary in relation to the national guidelines. Any referral to the LADO must be completed within 24 hours of the incident being reported.

## 19 POLICE INVOLVEMENT

19.1 If an employee is interviewed by the police for a suspected criminal matter, including motoring offences, they must complete the declaration form (Appendix 4). Any subsequent arrest, caution or conviction must be declared on this form. The relevant HR Business Partner will confirm in writing what action, if any, is necessary following receipt of the completed form.

19.2 If an employee is convicted of a criminal offence during the course of their employment, inside or outside of working hours, the Trust may need to investigate and take disciplinary action.

19.3 The Trust will take into consideration the nature of the offence, its effect on employment and any other relevant factors.

19.4 It may be necessary for the Trust to liaise with the relevant police force. It may not be necessary for the Trust to wait for the outcome of legal proceedings, and if the member of staff refuses to co-operate, the Trust may take action based on the information available.

19.5 If a member of staff is detained in custody prior to conviction, they will be regarded as absent from duty and no payment made.

19.6 All employees are contractually obliged to inform the Trust if they receive a criminal conviction during employment with the Trust. If the Trust is made aware that an employee has failed to notify the Trust, the Trust may consider notifying the Fraud Specialist Manager who may investigate and take further action.

## 20 CORRUPTION AND BRIBERY

20.1 In accordance with the Trust's Fraud, Corruption and Bribery Policy & Response Plan, any suspicious activity, within the scope of this policy, will be referred to and subsequently investigated by the Trust's Fraud Specialist Manager. The results of any such investigation could lead to internal disciplinary and/or civil/criminal prosecution proceedings being instigated against the appropriate person/persons involved.

20.2 The Fraud Act 2006 states that a person is guilty of fraud if he/she is in breach of the sections listed below:

20.2.1 Fraud by false representation;
20.2.2 Fraud by failing to disclose information; and
20.2.3 Fraud by abuse of position.

20.3 The Bribery Act 2010 repeals existing legislation. It is a criminal offence to give, promise or offer a bribe, and to request, agree to receive or accept a bribe, either at home or abroad, from UK or Non-UK businesses or individuals.

20.4 It also places specific responsibility on organisations to have in place sufficient and adequate procedures to prevent bribery taking place. Under the act, bribery is defined as "inducement for an action which is illegal unethical or a breach of the Trust's SFI's". (Standard Financial Instructions) Inducements can take the form of gifts, loans, fees, rewards or other privileges. Bribery is broadly defined as the offering or acceptance of inducements, gifts or favours, payments or benefit in kind which may influence the improper action of any person. Bribery does not always result in a loss. The corrupt person may not benefit directly from their deeds; however, they may be unreasonably using their position to give advantage to another.

20.5 It is a long established principle that public sector bodies, including the NHS, must be impartial and honest in the conduct of their business and their employees should remain beyond suspicion. It is also an offence under the Bribery Act 2010 for an employee to accept any inducement or reward for doing, or refraining from doing, anything in her/his official capacity. A breach of the provisions of these Acts renders employees liable to prosecution and may also lead to loss of their employment and pension rights in the NHS.

20.6 All staff should be aware that disciplinary action may be taken in cases where a member of staff fails to declare a relevant interest, or is found to have abused his or her official position or knowledge, for the purposes of self-benefit, or that of family and/or friends. Disciplinary action may lead to dismissal.

20.7 It is a mandatory requirement for all staff Band 8 and above to complete and submit the Declaration of Interests form to confirm the accuracy of information they have previously provided and provide details of any changes to that information. The form is available on the Trust intranet via the Finance page or from the Company Secretary/Director of Corporate Affairs or the Head of Financial Services and Payroll, alternatively email financial.services@wwl.nhs.uk

20.8 Examples where a declaration is required include:

20.8.1 Directorships, including Non-Executive directorships, held in private companies or PLCs (with the exception of those of dormant companies);
20.8.2 Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;
20.8.3 Shareholdings in organisations likely or possibly seeking to do business with the NHS;
20.8.4 A position of authority in a charity or voluntary organisation in the field of health and social care;
20.8.5 Any connection with a voluntary or other organisation contracting for NHS services;
20.8.6 The interests of spouses and cohabiting partners should also be declared.

20.9 This list is not exhaustive and constitutes key examples; if there is any doubt with regard to declaration of interests these should be discussed with the Company Secretary/Director of Corporate Affairs, Head of Financial Services and Payroll and/or the LCFS.

20.10 Where no interest exists a nil return must be submitted.

20.11 The Trust has an accredited Fraud Specialist Manager who is responsible for investigating all suspected cases of fraud, corruption and bribery. If you wish to contact the Trust's Fraud Specialist Manager, please contact the Fraud Specialist Manager by phone on ext. 6204 (01257 256204), 07827 835979 (mobile) or e-mail; collette.ryan@nhs.net or collette.ryan@wwl.nhs.uk.

20.12 Alternatively staff can report their suspicions by using the NHS Counter Fraud Authority (NHS CFA) Service National Fraud Hotline on 0800 028 40 60 or online at www.cfa.nhs.uk/reportfraud (this number/link can be used to report such matters anonymously if required).

20.13 Staff need to be aware that a breach of these Acts renders them liable to prosecution and may also lead to loss of their employment and superannuation rights in the NHS.

## 21 REFERRAL TO EXTERNAL BODIES/ORGANISATIONS

21.1 In cases where there is concern that an employee may be a danger to patients, the Trust may consider that it has an obligation to inform other organisations, including the private sector, of any restriction on practice or exclusion and provide a summary of the reasons for it. Details of other employers (NHS and non-NHS) may be readily available via the relevant declaration form but, where it is not, the employee should supply them. Failure to do so may result in further disciplinary action or, where applicable, referral to any relevant regulatory body, as the paramount interest is the safety of patients.

21.2 Where a NHS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer.

21.3 Where allegations have been made which relate to a professional matter or to professional misconduct, it may be appropriate to inform the regulating professional body. Before doing so, the line manager/excluding manager should seek advice from the appropriate professional head to ascertain if notification is appropriate.

21.4 The Safeguarding Vulnerable Groups Act 2006 (SVGA) places a legal duty on employers and personnel suppliers to refer any person who has:

21.4.1 Harmed or poses a risk of harm to a child or vulnerable adult;
21.4.2 Satisfied the harm test; or
21.4.3 Received a caution or conviction for a relevant offence

21.5 In this regard a referral will be made to the Disclosure and Barring Service (DBS) should any individual who is, or was, employed within the Trust in a regulated activity and, as an outcome of a disciplinary process, been found to comply with any of the aforementioned criteria.

## 22 RIGHT TO BE ACCOMPANIED

22.1 An employee, who has allegations or concerns raised against them may be accompanied by a trade union / staff side representative or workplace colleague (not otherwise involved or likely to be involved in the process) to any formal meeting or hearing under this procedure. For the avoidance of doubt, this does not include if an employee is invited to attend an investigation meeting as a witness to a concern or allegation against another

employee. In the event of the colleague being legally qualified, they will not act in this capacity during the disciplinary process. An exception to this however would be in cases of suspected fraud or theft where the employee is required to be interviewed under caution by the Trust Counter Fraud Officer, legal representation would be allowed in this example.

22.2 If the employee's choice of representative is inappropriate management may request the employee to choose someone else, for example:

22.2.1 It is identified that there may be a conflict of interest or may prejudice the meeting; or

22.2.2 If the representative is unavailable or cannot be released from work at the time a meeting is scheduled and will not be available for more than five working days afterwards.

22.3 Alternative and/or additional support/representation will be considered in exceptional circumstances and should be discussed at the earliest interval.

22.4 The employee and their representative should make every effort to attend any formal meeting/hearing(s) arranged.

22.5 One postponement may be permitted for representation purposes.

22.6 It is the employee's responsibility to arrange their own representation.

## 23 LEAVING EMPLOYMENT DURING ACTIVE DISCIPLINARY PROCESS

23.1 Where an individual leaves their employment following any concerns having been raised and where a resolution or conclusion has not been determined, the Human Resources department will consider the most appropriate, fair and consistent method of concluding the case and support a manager to take forwards. This may include continuing with any investigation and/or hearing as appropriate.

23.2 The employee subject to the concerns will be invited to continue to participate and/or respond whilst they remain employed and after they have ceased their employment until the matter has been resolved.

23.3 Any request from any subsequent employer for a reference will be provided with factual information in relation to the matter and any conclusion.

23.4 Consideration will be given in accordance with paragraph 21 in relation to any appropriate referral to an external body/organisation.

## 24 GRIEVANCES

The grievance procedure does not apply to issues relating to disciplinary cases. Any concerns regarding the disciplinary process should be raised during the investigation and/or during hearings.

## 25 FREEDOM TO SPEAK UP (RAISING CONCERNS)

25.1 The Trust will not tolerate harassment/victimisation nor any attempt to apply an unwarranted sanction or any other detriment to a person who has reported a genuine concern.

25.2 Investigations into the alleged conduct of employees who have previously spoken up should also seek to identify whether such allegations are motivated by a desire to cause detriment to that individual.

25.3 If evidence is found to confirm that allegations were made maliciously, appropriate action will be taken.

## 26 HUMAN RIGHTS ACT

Implications of the Human Rights Act have been taken into account in the formulation of this document and they have, where appropriate, been fully reflected in its wording.

## 27 INCLUSION AND DIVERSITY

The document has been assessed against the Equality Impact Assessment Form from the Trust's Equality Impact Assessment Guidance and, as far as we are aware, there is no impact on any protected characteristics.

## 28 MONITORING AND REVIEW

28.1 This policy will be reviewed periodically in partnership with staff side and monitored by the Trust's People Committee.

28.2 The application and outcomes of this policy and employment relations cases associated with this policy are reviewed periodically and reported within the Workforce Governance framework and as part of regular Employee Relations Review Panels.

## 29 ACCESSIBILITY STATEMENT

This document can be made available in a range of alternative formats e.g. large print, Braille and audio cd.
For more details, please contact the HR Department on 01942 77 3766 or email equalityanddiversity@wwl.nhs.uk

**Appendix 1**

## REFERENCES

Employment Rights Act 1996
Employment Relations Act 1999
Employment Act 2002 & 2008
Employment Act 2002 (Dispute Resolution) Regulations 2004
Fraud Act 2006
Bribery Act 2010
ACAS Code of Practice – Disciplinary and Grievance Procedures
Policy for maintaining high professional standards
Grievance Procedure
Safeguarding Policies
Fraud Corruption and Bribery Policy & Response Plan
Managing safeguarding allegations against staff (National Guidelines)
The Code of Conduct for NHS Staff
The Human Rights Act 1998
The Equality Act 2010
Public Interest Disclosure Act 1998.
Public Concern at Work Guidance
Standing Financial Instructions (SFI's)
NHS Anti-Fraud Manual (NHS CFA) 2019
Standards of Business Conduct for NHS Staff HSG (93) 5
www.nhsemployers.org/EmploymentPolicyAndPractice/UKEmploymentPractice/Pages/Core-Standards-For-NHS-Managers.aspx

**Appendix 2**

**Misconduct Breaches / Rules**

The Trust considers the following to be examples of the type of offences which constitute general and gross misconduct. Managers will have the discretion to determine the seriousness of the conduct and identify if the offence falls under 'general' rather than 'gross' misconduct where appropriate. The list is not exhaustive.

| No | General Misconduct | Gross Misconduct |
|---|---|---|
| **1** | | Ill treatment, wilful neglect and / or sexual offences against patients. |
| **2** | | Theft or Embezzlement of Fraud, Corruption and Bribery including any breach of Trust Standing Financial Instructions |
| **3** | | Fraud or falsification of records (e.g. application forms, CVs, sickness forms, overtime, qualifications, employment references and expenses claims) |
| **4** | | Failure to give notice of any financial interest of which they are aware, in a contract which has been or is proposed to be, entered into by the Trust. |
| **5** | | Fraudulent misuse of the Trust's property or name (e.g. phones, cars or computers) |
| **6** | | Physical or indecent assault during the course of employment and / or on Trust premises. |
| **7** | | Serious verbal abuse of a patient, member of the public during the course of employment or on the Trust premises |
| **8** | | Behaviour inclusive of words or acts that seriously breach the Trust values and Behaviour Framework, including any form of discrimination, victimisation or harassment on the grounds of sex, race, sexual orientation, disability, age belief or religion. |
| **9** | Disclosure of privileged and confidential information to any unauthorised persons outside the provisions the Trust's Freedom to Speak Up Policy. | Deliberate disclosure of privileged and confidential information to any unauthorised persons outside the provisions of the Trust's Freedom to Speak Up Policy. |
| **10** | Failure to comply with the legal requirement and / or Trust regulations concerning medicines. | Negligent or deliberate failure to comply with the legal requirement and / or Trust regulations concerning medicines. |
| **11** | Practising without a professional registration in a profession where there is a requirement to obtain and maintain professional registration. | Deliberately practising without a professional registration in a profession where there is a requirement to obtain and maintain professional registration. |
| **12** | | Serious and/or deliberate breach or failure to adhere to standard operating procedures and codes of conduct applicable to specific departments, professions or grades of staff, or any explicit term of his/her contract. |
| **13** | Failure to observe Health & Safety and Fire Regulations or instructions. | Any act or omission constituting serious danger to the Health & Safety of any person during the course of employment or on the Trust premises. |
| **14** | | Theft or attempted theft on the Trust premises or during employment by the Trust including Trust assets |

| No | General Misconduct | Gross Misconduct |
|---|---|---|
| 15 | Misrepresentation at the time of appointment or at any time during employment (e.g. previous employment; qualifications held). | Falsification of any official documentation, qualifications or information used in support of an application for any post. |
| 16 | | Consumption of alcohol and / or misuse of drugs and / or other substances to an extent which seriously affects the satisfactory performance of the employee's duties and / or jeopardises the safety and welfare of a patient(s), member(s) of the public or member(s) of staff. |
| 17 | Negligence in job performance. | Any act or omission constituting serious and/or deliberate negligence in an employee's performance of their duties. |
| 18 | | Criminal offences outside of the working relationship which substantially affect the performance of duties, or the relationship between the employee and the Trust. |
| 19 | | Failure to disclose to the Trust any criminal action inclusive of arrest, cautions, convictions and bind overs. |
| 20 | | Maliciously making or assisting someone else to make an unfounded complaint. |
| 21 | Unjustified refusal of a lawful and reasonable instruction without reasonable grounds, or to wear any uniform or protective clothing provided by the Trust. | Serious act(s) of insubordination or unjustified refusal of a lawful and reasonable instruction which could result in immediate serious consequences. |
| 22 | | Breach of the Trust's IT Policies/ unauthorised access of IT systems and /or inappropriate use of the internet or email system. |
| 23 | | Inappropriate words or acts (including social networking) which brings the Trust's / employee's reputation into disrepute. |
| 24 | | Deliberate misappropriation or attempted misappropriation of Trust funds or resources; fraudulent manipulations of accounts financial statements, timesheets, expense claims or other official records; or breach of the Trust Standing Financial Instructions. |
| 25 | | Unauthorised absence from work. |
| | | Undertaking any other employment while unable to attend for duty for reason of ill-health while in receipt of sick pay, that may amount to fraud (PERS 12) including employees who are excluded who work for another employer during their normal working hours |
| 26 | | Culpable damage caused by an employee during the course of their employment or on the Trust premises. |
| 27 | | Acceptance of gifts or hospitality in contravention of 'Standards of business conduct for NHS staff'. The Department of Health Circular HSG (93) 5, The Code of Conduct for NHS Staff |
| 28 | | Failure to inform the Trust of any pecuniary interest of which the employee is aware in a contract which has been or is proposed to be entered into by the Trust in accordance with 'Standards of business conduct for NHS staff'. |

| No | General Misconduct | Gross Misconduct |
|---|---|---|
| **29** | Failure to comply with the Trust's no-smoking policy. | |
| **30** | | Personal misconduct which seriously affects his / her performance of duties and / or relationship between the member of staff and the Trust. |
| **31** | | Unauthorised use of the Trust's resources or of information obtained during the course of his / her employment, or for personal reasons not connected with his / her duties. |
| **32** | Undertaking any other employment which adversely affects the performance of his / her duties. | |
| **33** | Failure, without reasonable grounds, to comply with the requirements of Trust Policies and Procedures. | |
| **34** | | Any breach of an explicit term of his / her contract of employment. |
| **35** | | Failure to comply with fit and proper persons test (Directors and those within interim Directors posts only) |
| **36** | | Failure to comply with duty of candour |

**Appendix 3**

| **Disciplinary Appeal Form** | |
|---|---|
| **Name** | |
| **Department** | |
| **Job Title** | |
| **Pay Band** | |
| **Date of disciplinary hearing** | |
| **Disciplinary sanction** | |
| | |
| **Grounds of appeal** | |
| ☐ | An inappropriate sanction was implemented |
| ☐ | Process was not followed |
| ☐ | New evidence is to be considered |
| **Reasons for appeal** | |
| | |
| **Signature** | |
| **Date** | |

**Completed forms should be sent to Deputy Director of HR, Suite 7, Buckingham Row**

**Appendix 4**

| Notification of involvement of the Police / Criminal Conviction / Caution | |
|---|---|
| **Employee Name** | |
| **Ward / Department** | |
| **Date of incident** | |
| **Date of police interview** | |
| **Date of arrest** | |
| **Date of Bail** | |
| **Conditions of Bail** | |
| **Date of caution / charge** | |
| **Date of conviction** | |
| **Details of incident and outcome** | |
| | |
| **Name of Manager** | |
| **Signature of Manager** | |
| **Date Information Received** | |
| **HR Business Partner** | |
| **HR use only - Follow up action required** | |
| | |

**Completed forms should be returned to the HR Department, Suite 7, Buckingham Row**

**Appendix 5**

| Investigation Terms of Reference | |
|---|---|
| Employee Name | |
| Employee Job Title | |
| Employee Department | |
| Case Manager | |
| Case Investigator | |
| HR Support | |
| Date investigation commissioned | |
| Initial source of information | |
| Concerns to be investigated | • |
| Witnesses to be interviewed | • |
| Additional documentation to be reviewed | • |
| Supplementary Information | |
| External review required | |
| Professional clinical advice required | |
| Target completion date | |
| Exclusion or restricted practice | |
| Terms of Reference Author | |
| Date Agreed | |

# Equality Impact Assessment Form

## STAGE 1 - INITIAL ASSESSMENT

| For each of the protected characteristics listed answer the questions below using<br><br>**Y** to indicate Yes and<br><br>**N** to indicate No | **Sex** (male / female / transgender) | **Age** (18 years+) | **Race / Ethnicity** | **Disability** (hearing / visual / physical / learning disability / mental health) | **Religion / Belief** | **Sexual Orientation** (Gay/Lesbian/ | **Gender Re-Assignment** | **Marriage / Civil Partnership** | **Pregnancy & Maternity** | **Carers** | **Other Group** | **List Negative / Positive Impacts Below** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Does the policy have the potential to affect individuals or communities differently in a negative way?** | n | n | n | n | n | n | n | n | n | n | n | |
| **Is there potential for the policy to promote equality of opportunity for all / promote good relations with different groups – Have a positive impact on individuals and communities.** | y | y | y | y | y | y | y | y | y | y | y | |
| **In relation to each protected characteristic, are there any areas where you are unsure about the impact and more information is needed?** | n | n | n | n | n | n | n | n | n | n | n | **If Yes**: Please state how you are going to gather this information. |

| **Job Title** | **Strategic HR Lead** | | | **Date** | March 2021 |
|---|---|---|---|---|---|

**IF 'YES an NEGATIVE IMPACT' IS IDENTIFIED - A Full Equality Impact Assessment STAGE 2 Form must be completed. This can be accessed via http://intranet/Departments/Equality_Diversity/Equality_Impact_Assessment_Guidance.asp**

**Please note: As a member of Trust staff carrying out a review of an existing or proposal for a new service, policy or function you are required to complete an Equality Impact Assessment. By stating that you have NOT identified a negative impact, you are agreeing that the organisation has NOT discriminated against any of the protected characteristics. Please ensure that you have the evidence to support this decision as the Trust will be liable for any breaches in Equality Legislation.**

**Appendix 4**

Wrightington, Wigan and Leigh NHS Foundation Trust

## POLICY MONITORING AND REVIEW ARRANGEMENTS

| Para | Audit / Monitoring requirement | Method of Audit / Monitoring | Responsible person | Frequency of Audit | Monitoring committee | Type of Evidence | Location where evidence is held |
|---|---|---|---|---|---|---|---|
| | Rolling monthly review of compliance of in date documents | Project Officer to advise author 6 months in advance of review date and advise CQEC of overall Trust compliance | Project Officer | Monthly rolling programme | CQEC | Monthly compliance report | Team Drive: Director of Nursing/Corporate QEC |
| 26 | Equality Assessment | Equality Duty report | HR Business Partner | Annual | People Committee | Report against protected characteristics | Employee relations case files & ESR |
| 27 | Application and outcomes of this policy | Employee Relations Case Review | Director of Workforce/DD of HR | 6 monthly/Quarterly | Employee Relations Review Panel | Case files and associated documents | Employee relations case files |
| 27 | Application and outcomes of this policy | Summary report | Director of Workforce/DD of HR | Quarterly | People Committee | HR Case tracker information and Case files | Employee relations case files |

| | |
|---|---|
| **Title of report:** | Q3 Mortality Report |
| **Presented to:** | Quality & Safety Committee |
| **On:** | 14 April 2021 |
| **Presented by:** | Sanjay Arya; Medical Director |
| **Prepared by:** | Alison Unsworth, Clinical Audit and Effectiveness Manager |
| **Contact details:** | Sanjay.arya@wwl.nhs.uk |

**Executive summary**

The purpose of this report is to provide the Quality and Safety Committee 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 Q3 for 2020/21.

**Link to strategy**

- Patients
- Performance

**Risks associated with this report and proposed mitigations**

The Trust's rising SHMI position (as indicated above).

**Financial implications**

None known

**Legal implications**

None known

**People implications**

None known

**Wider implications**

None known

**Recommendation(s)**

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

# Mortality Review
# 2020 - 2021 Quarter 3

## 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 | | | 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.

The impact of the global COVID pandemic is demonstrated within the figures for Q1 2020/2021 compared to previous years.

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 Q3, 560/596 (94%) of all deaths were reviewed.

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

### 3.1 Potentially Preventable Deaths

1 patient was escalated by the Corporate Mortality Review Team as potentially preventable (patient with coning following lumbar puncture), however after further review this was classed as a non-preventable death.

### 3.2 Themes/Learning

Themes identified during the corporate morality review process were:

- Hospital Acquired COVID at high rates
- Re-appearance of COVID after summer
- Low level of non-COVID deaths
- Late presentation of severe diseases, including:
    - heart failure
    - various cancers
    - CVA
- Deaths related to social deprivation
- Patient who died from coning after lumbar puncture
- Whilst some COVID deaths are due to COVID, others are associated with COVID
- Poorly treated DKA after giving dexamethasone and resulting hyperglycaemia
- Patients with severe hypoxia at presentation
- Post-operative deaths related to COVID
- Anti-coagulation associated intracranial bleeding
- Discharges to Care Homes with COVID
- Poor management of Parkinson's Medications
- Late diagnosis of Parkinson's
- Remdesivir still being used despite evidence of lack of benefit.

## 4.0 External Reporting

### 4.1 Unexpected Deaths Reported to STEIS in Q3 2020-2021

- Patient admitted with AKI 3 and prescribed aggressive fluid replacement. During the patient's admission he did not receive the prescribed fluid resuscitation. When the patient deteriorated there was a delay in escalation of the patient to the medical team for review.

- Delay in escalation and treatment of a patient with AKI and sepsis

- Delay in escalation of a deteriorating patient

- Delay in diagnosis and treatment of a patient with diabetic ketoacidosis

### 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 Q3 2020 – 2021 the Trust reported **5** hospital death and **0** 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 Q3 2020-21, 1 still birth and 1 neonatal death.

- Stillbirth at term: Clinical decision was made to induce labour at 40 weeks 2 days gestation to optimise the possibility of Vaginal Delivery as keen not to have a repeat c/section. Sadly attended at 40 weeks and 1 day with no fetal movements and fetal death in Utero was diagnosed. Mother high risk due to pre-existing medical conditions and previous c/section. There were no obvious indications of the cause of death at the time of birth. The parents have consented to a post-mortem and the reports are awaited from the Royal Manchester Childrens Hospital.

- Neonatal death: Diagnosed with severe congenital abnormalities at 12 weeks. (Anencephaly which is incompatible with life) Parents decided to continue with pregnancy until it naturally ended. Support was provided to the family by a neonatal consultant, consultant obstetrician and the bereavement midwife during the antenatal period. With the Bereavement midwife providing continuity at the time of birth and the postnatal period. Support from Derien House Children's Hospice was also offered but declined by the parents.

Both cases have been reported and reviewed appropriately and their cases are currently being processed using the Perinatal Mortality Reporting Tool. And full MDT review.

## 5.0 Community Deaths

There have been 7 community deaths reported via Datix in Q3 2020/2021.

## 6.0 Prevention of Future Deaths Notices

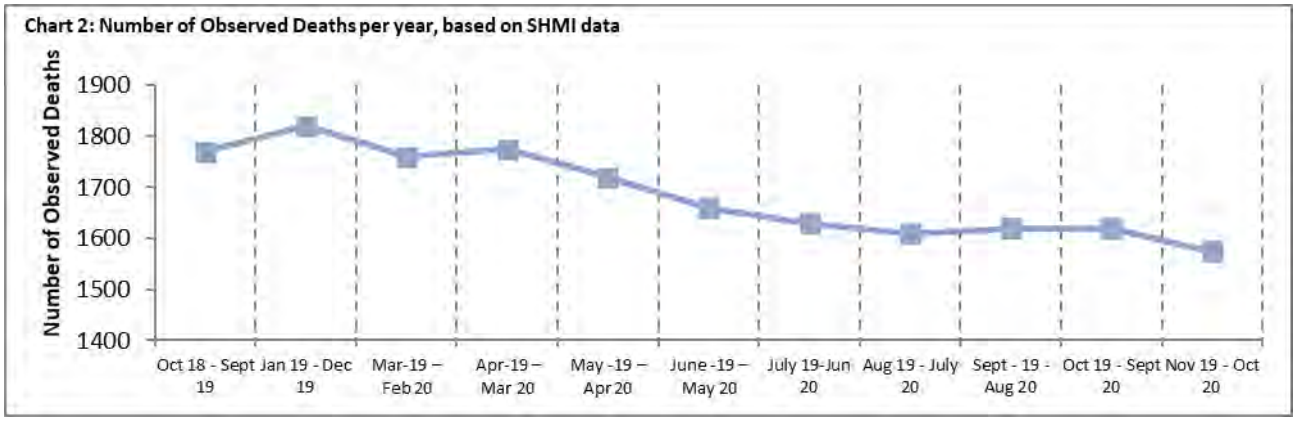
There have been no Prevention of Future Deaths Notices (Regulation 28) issued by HM Coroner.

## 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)

The Trust's SHMI has been static for the last 3 updates. SHMI is now published monthly and the figure given for a rolling 12 months.

The current SHMI value is 1.15 for the period November 2019 – October 2020 (published 11th March 2021). It should be noted that SHMI has excluded any COVID data from their analysis from the July 2020 publication (data set shaded blue in chart 1).

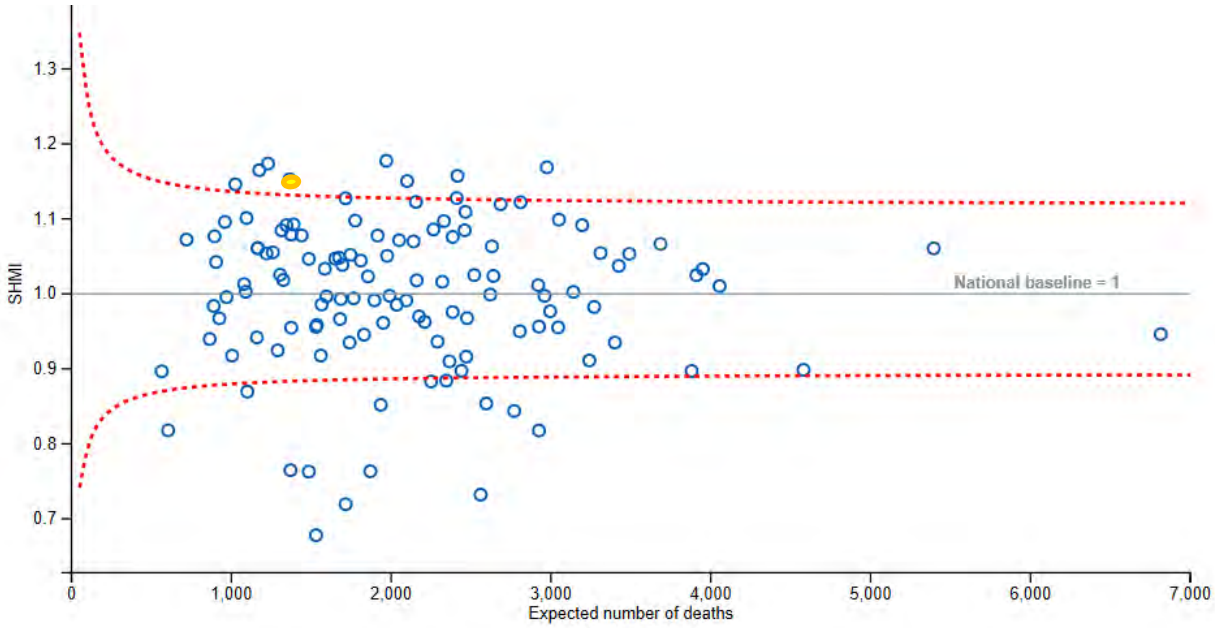
| Chart 1 | Oct 18 - Sept 19 | Jan 19 - Dec 19 | Mar-19 - Feb 20 | Apr-19 - Mar 20 | May -19 - Apr 20 | June -19 - May 20 | July 19-Jun 20 | Aug 19 - July 20 | Sept - 19 - Aug 20 | Oct 19 - Sept 20 | Nov 19 - Oct 20 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| SHMI | 1.16 | 1.2 | 1.17 | 1.18 | 1.17 | 1.16 | 1.14 | 1.14 | 1.15 | 1.15 | 1.15 |
| Observed Deaths | 1770 | 1820 | 1760 | 1775 | 1720 | 1660 | 1630 | 1610 | 1620 | 1620 | 1575 |
| Expected Deaths | 1520 | 1515 | 1495 | 1505 | 1460 | 1430 | 1420 | 1400 | 1405 | 1405 | 1365 |
| Discharged | 46470 | 46605 | 46245 | 45385 | 43905 | 42915 | 42430 | 41785 | 38190 | 41025 | 39565 |




There are currently three diagnostic groups on SHMI with more deaths than expected. These are septicaemia (except in labour), shock; Pneumonia (excluding TB/STD) and urinary tract infections. A separate paper is being provided to the Quality and Safety Committee setting out the Trust's Mortality Improvement plan addressing what work is being undertaken in these respective areas.

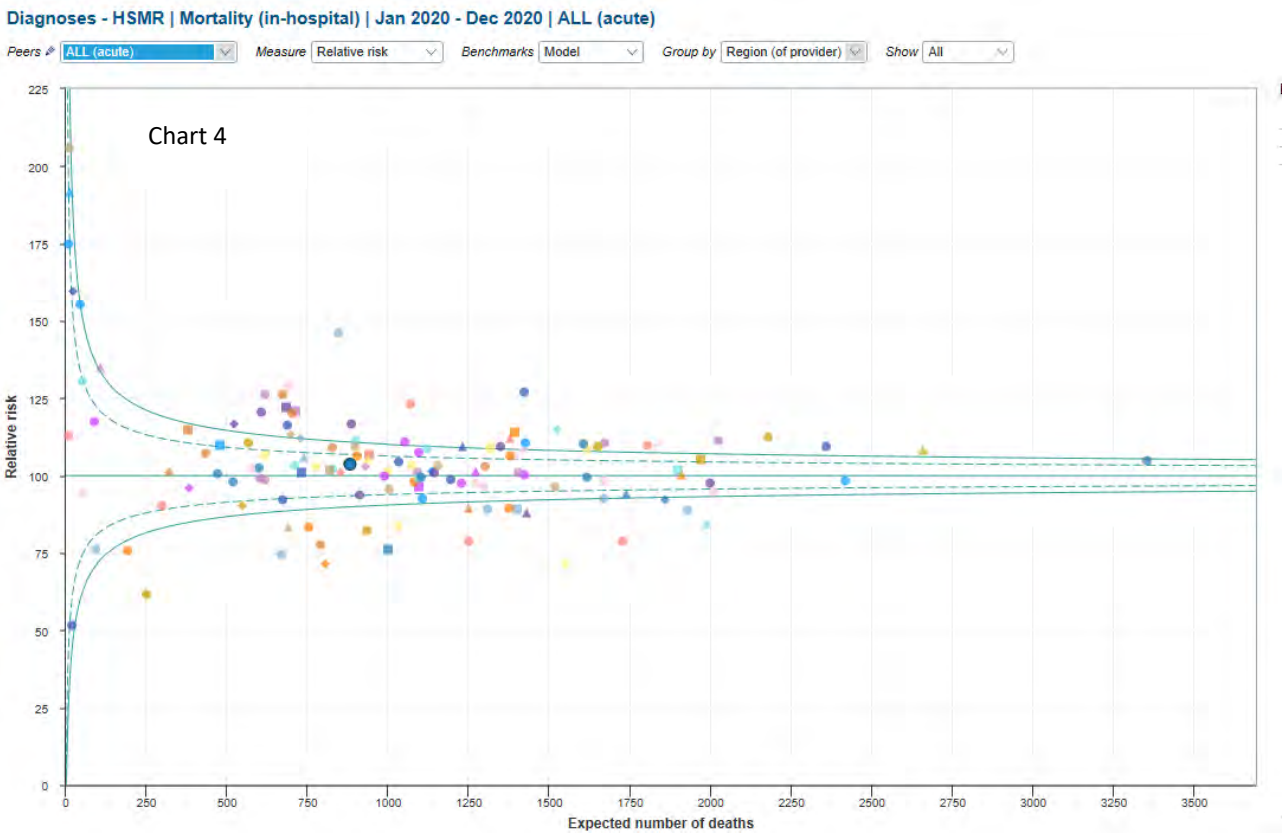
The chart below (chart 3) shows the position of WWL (marked in yellow) compared nationally. There are five Trusts in a worse position than WWL. However, WWL are still outside expected control limits.

**Chart 3: SHMI National position**




**HSMR**

The Trust's HSMR rolling 12 months data (January 2020 to December 2020) is 103.9. This is a slight increase in the previously reported figure (November 19 to October 20) 102.6. 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) | Jan 2020 - Dec 2020 | ALL (acute)
Peers ALL (acute)
Measure Relative risk
Benchmarks Model
Group by Region (of provider)
Show All
Chart 4
Relative risk
Expected number of deaths
225
200
175
150
125
100
75
50
25
0
0
250
500
750
1000
1250
1500
1750
2000
2250
2500
2750
3000
3250
3500

| | |
|---|---|
| **Title of report:** | Safe Staffing Report |
| **Presented to:** | Trust Board |
| **On:** | March 2021 |
| **Presented by:** | Chief Nurse |
| **Prepared by:** | Assistant  Chief Nurse |
| **Contact details:** | T: 01942 778570 fiona.bryant@wwl.nhs.uk |

**Executive summary**

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

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

This report covers the time period December 2020 to February 2021.  Inpatient areas have the staffing ratios at 1:8 and fill rates reported within the report are against the Trust agreed staffing requirements. The agreed nurse to patient ratio is 1:8 pre Covid staffing levels, this is the agreed minimum of nurses required, however as staffing levels allow or the patient acuity the nurse to patient ratio would be amended

worthy of note that due to the onset of the Covid-19 pandemic in March 2020 changes to clinical areas and a significant workforce response to enable the adaption of surge plans have been enacted, therefore it has not been possible to complete a traditional establishment review during this time

The Board are asked to note;

- The registered nurse vacancy does show an improved picture however it still remains a pressure most significantly at B5 level. The greatest risk with respect to B5 vacancy factor still remains within the division of Medicine.  However recruitment remains proactive

- In January 2020 the Board agreed additional investment to increase staffing ratios and in April 2020 inpatient ward establishments were increased in accordance with the phased investment plan agreed by the Board, delivering a ratio of 55:45 for inpatient areas. This was supported by the recruitment and retention plan. This investment resulted in an increase in the percentage of registered nurse vacancies.

- There has been a sustained reduction in District Nursing vacancies, staffing reviews are being undertaken with a new HON and recruitment will remain proactive.

- Pre-pandemic there had been plans to review overall vacancies, employment offers and divisional plans for alternative workforce models; the pandemic has afforded the divisions an opportunity to undertake this. There has been the introduction of the Care maker role, introducing AHPs into the ward and critical care establishments to support alternative ways of workings of and to mitigate the reduction in registered nurse availability within the clinical ward areas.

- The recent restrictions on international nurse recruitment has improved during this period and the organisation over the past quarter has seen the arrival of additional international nurses and the programme continues around the active recruitment of these nurses in to our current remaining vacancies. There trajectory is for a further 32 international nurses to join WWL by the end of the financial year.

- Many services have remained stepped down during this period which has allowed for staff redeployment to areas with increased activity and pressure such as Critical care areas, CPAP and covid positive areas. However the impact of nursing staff vacancies and sickness absence levels are reflected in fill rates in. Fill rates are only one indicator of quality; skills and competencies and staff feedback need to be also considered. The Division of Medicine and Surgery are working in a more collaborative way to address daily staffing pressure and E Roster is being managed in a more proactive way. There continues to be a high use of temporary staffing to back fill vacancies and sickness absence. With both NHSP and where required agency staff to cover staffing short falls. It is important to note that at this current time the organisation has remained in a covid surge position which has impacted this on availability of staff. Being in a covid surge position also impacts upon staffs psychological well-being especially with the need to step up and step down services involving repatriation and potential redeployment. With changes to the Government shielding advice an additional number of staff have require a further period of shielding this has impacted on staff availability. However this is due to change by the beginning of April.

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

- Birth Rate plus has been undertaken within Maternity linked specifically to support new models of working, this has allowed the division to review its existing availability of Registered Midwives and look to redeploy them in to areas of short fall. The vacancies and the division continue to proactively recruit to support the GM approach for placing midwifery students in to roles on completion of training. The 90-10 midwife to support staff ratio is being proactively managed, supporting the release of time to care. The 90-10 split has been undertaken within the existing budget, however with the Continuity of Carer programme a further calculation tool has been used, which may indicate a need to increase midwifery staffing

- Community have had an improving trend in pressures ulcers in Q2 20/21. The bedded areas of the Trust have sustained its position, and work continues with the pressure area improvement plan. During this quarter there has been the appointment of a Tissue Viability Nurse, who is reviewing the improvement and working closely with the divisions to sustain improvements and ensure the improvement plan is fully embedded in to the organisation

**Link to strategy**

Delivery of safe care

**Risks associated with this report and proposed mitigations**

- Registered nurse recruitment is being proactively managed. The trust is working with HR and external agencies around trust branding and making sure WWL is seen as an employer of choice across the region. There remain a high number of vacancies particularly at B5 level within the division of Medicine; this continues to result in a high use of temporary staff. The plan to reduce B5 vacancies by the end of the financial year has been refreshed to reflect current B5 turnover rates. We are proactively recruiting our 3rd year student nurses, along with a commitment to the international nurse recruitment program through GTEC, along with recruitment through NHSP. We have committed to the recommencement of virtual recruitment events which are planned. Over the last two quarters there has been a commitment to Band 5 to Band 6 development with the successful development to date of 23 of our existing Band 5 nurses in to Band 6 roles, a further 25 are on the development programme, with a 3rd cohort planned for the next quarter. This has taken from the existing band 5 staffing cohort

  In December 2020, 18 international nurses joined WWL initially undertaking an orientation and shadowing shifts. 7 of the international nurses have critical care experience; the additional nurses will be shared across the Divisions. From the 1st March we had 18 International Nurses Join us and a further 23 will have joined by 31st March 2021. Ongoing reviews of staffing continue to ensure there is an appropriate balance of substantive and temporary staffing to provide safe care, and there is increased focus on local induction of temporary staff.

- Community have had an improving trend in pressures ulcers, this improvement has not been as sustained for the bedded areas of the Trust, but the organisation has appointed a Tissue Viability Nurse and has a clear improvement plan with the expectation of seeing marked improvements in the next quarter.

**Financial implications**

- Temporary staffing costs related to the vacancy level and increased absence linked to sickness absence

**Legal implications**

- Potential for litigation associated with the development of hospital acquired pressure ulcers.

**People implications**

- Potential impact on staff wellbeing associated with the current pandemic and the reduced numbers of staff being available, due to vacancy, increased sickness and shielding

- Impact on staff due to redeployment to alternative work area due to need to maintain patient safety during Covid pandemic.

- Nursing KPI's assist in addressing any professional, clinical or cultural issues with respect to accountability, delegation of duties and professional responsibilities of registered staff.

**Wider implications**

- Increased scrutiny from Commissioners and Regulators

**Recommendation(s)**

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

**Safe Staffing Report – November 2020-February 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.

The below remain the main influences on the fill rates

- Sickness rate and Vacancy rate being 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. It has been agreed for safe care data submission to be aligned to the two shift start times as compliance has been variable, this will continue to be monitored for compliance

- Nurse Sensitive Indicators (KPI'S) demonstrate the outcome for patients by measuring harm.
    - Cases of Clostridium Difficile (CDT);
    - Pressure Ulcers Category 1&2 / Category 3&4;
    - *Falls resulting in physical harm / not resulting in physical harm;
    - *Medication administration errors resulting in harm / not resulting in harm.

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

- The impact of Nurse staffing on Patients' Experience can be demonstrated by two specific questions from the monthly Real Time Patient Experience Survey. The NICE guidance on safe staffing in hospitals suggests using a number of questions in the form of a patient experience survey. For some of the NICE questions the trust has an equivalent question, or proxy question within the monthly Real Time Patient Experience survey or Always Events Survey, with the two questions matching most closely featuring in this report. However during this quarter due to the pandemic patient experience and feedback has not been as robust as previously, but plans are to reintroduce this where possible as this is invaluable feedback to assist us to make service delivery improvements

**3.0 CURRENT POSITION – November 2020 to February 2021**

The current reporting period reflects the staffing position during the on-going Covid 19 Pandemic

Fill rates within inpatient areas for support staff appear to have improved in most areas, there does still remain a couple of specific areas where the fill rates for none qualified is much lower than planned. The organisation has been proactive in appointing in to the Care maker role, which is a pipeline in to supporting the HCSW vacancy. Over the past quarter we have recruited 30 Care makers, the HCA vacancy has reduced from 75 to 52 at this time. But this will reduce further as some care makers are transitioning in to these roles. Along with this the organisation has committed to be involved with external recruitment companies to again support a proactive approach to continuing to fill the support worker vacancy. This has a potential positive impact for the community and the local work force and would be viewed as positive by our clinical staff. By the end of the financial year we will be in a position where we have recruited to all our HCA vacancies, however this will continue to be a focus with a more planned approach to HCA recruitment.

Over the last quarter the fill rates for qualified staff has been overall slightly improved, but with some variation. This reflects some of the areas that were required to escalate due to increased activity across especially across medicine (unscheduled care). Registered and unregistered staff are redeployed to other clinical areas where there is increased activity to ensure patient care is delivered appropriately. During this quarter the senior nursing team have worked closely with E Roster team to ensure number of beds in the ward area and the staffing is aligned to the correct area as in the previous quarter due to changes within the clinical area, this had not been completed, so therefore the fill rates reflect correctly on the fill rates.

During this reporting period E-roster staffing levels were placed back to the pre Covid agreed ratio of 1:8 registered nurses within bedded areas of the Trust.

In April 2020 inpatient ward establishments were increased in accordance with the investment agreed by Board in 2019. This has resulted in an increase in the percentage of registered nurse vacancies which is reflected within the appendices of this report. However there has been an improvement in narrowing the vacancy gap in both registered and none registered staff groups

At the end of February 2021 this shows a massive improvement in our vacancy from where we were in October 2020. In October 2020 the nursing vacancy for both qualified and unqualified was at 347 WTE deficits across the organisation. Of these, 70 WTE have been appointed to and 31 WTE are due to be filled via the pipeline of either student nurses or international nurses, which

have been allocated to specific wards or departments. February 2021 the current nursing vacancy both qualified and unqualified is 106 WTE. However local intelligence with on-going pipe recruitment shows around 40 WTE qualified vacancies.

Specifically looking at band 2, there remains a vacancy of 34.36 WTE vacancies across all divisions. This figure excludes care makers. There are currently 22 WTE Care makers employed from the first surge. Many of the Care Makers have now been offered a substantive role as HCSW; this is currently being worked through with staff side and HR, to support a seamless transition. Additional Care Makers have also been recruited who will help reduce the HCSW vacancy and take us to a position of slightly over total HCA establishment going in to the new financial year. Although this is a financial pressure for the organisation, it is a prudent move due to attrition at this grade which enables us to reduce the likelihood of a short fall as staff leave or move on to other roles. This is important to also consider due to the Band 2 to Band 3 work that is currently under review

To continue to address recruitment in a proactive way there are planned recruitment days scheduled of both qualified and unqualified staff. Internally we have agreed to run a Band 2 to 3 workforce development, this is to retain our existing band 2, make opportunities available to upskill them to extend their role skilling them to take greater responsibility and greater job satisfaction, seeing WWL as a Trust that clearly supports staff development. Making such roles an integral part of our none-registered workforce supports a releasing time to care approach to service delivery.

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

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

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

The staffing within the community has improved greatly, there is still a vacancy of 25.5 WTE qualified nurse vacancy and 8.84 WTE DN vacancies but team structures and recruitment are being reviewed by the new DDON and DDOP

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

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

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

Rainbow ward had previously been red for nurse staffing, however for the reporting period this has improved and is demonstrated in the fill rates for qualified and unqualified staff. This can be attributed to staff returning from other areas due to the covid pandemic. Currently the area does not have any vacancy either. Despite this the area does carry a 9% sickness rate which for a specialised area does at times place a pressure on the area. It should be noted that the bed base on Rainbow Ward 19 beds in total throughout this period of time and a ratio of 1:6 (RN to patient) was maintained throughout December to March 2021

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

There has been only 2 red flag for nursing, one was related to a shortfall in staffing on Standish Ward, and the second was related to a delay in recognition of a patient in A&E in December 2020. Maternity had 2 red flags for the same period, one was a delay in LSCS and the second was delay at a home birth, neither of the maternity red flags were related to a lack of appropriate staffing. The fill rates across unscheduled care are still of concern and appear to be the area with increased challenges around its fill rates. The area continues to carry vacancy and increased staff sickness which will impact on the ability to cover the off duty, the ward managers for the area has covered some of the short fall, but this impacts upon her time to effectively offer support and manage the team in a challenging area. However no red flags were raised in these areas. None of the red flags raised were related to patient harms at this time (Appendix 2 Table 4). For January the number of red flags had increased, specifically in ICU, these were related to unavailability of staff, vital signs not assessed or recorded and an omission in providing patient medications. None of these have related to direct patient harm. Also during this period Lowton ward had one red flag that was related to staffing shortfall. This is a total of 5 red flags and 3 of the 5 were related to staffing issues. ICU is a challenge to cover with additional staffing as there is a very specific skill set required for this area, however ODP staff where appropriate can support with specific tasks only.

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

The community services division has continued to track safe staffing through a number of mechanisms including utilising our workforce data and triangulating this with incidents and their risk register.

Pressure ulcer management continues to be an area of scrutiny and to enable the trust to have oversight of the whole function they have integrated the community team into the corporate patient safety team as of beginning of March.

Sickness absence is on a downward trend and all vacancies (78) are all out to advert – 51 have offers and 4 have a start date with the remaining at early stage of recruitment.

The division are reviewing all their small and often specialist services to ensure the workforce is sustainable in the future. This will involve further integration across divisions which will be reported through the divisional management structure and also the monthly executive performance meetings.

The community assessment unit was opened on the 8th February; it is currently running 12 out of the 21 beds to allow the team to upskill and to fill some key vacancies. All beds will be open by the end of March, subject to safe staffing being in place. The unit will be subject to the same safe staffing processes as the wider trust.

The division are currently planning for recovery and are working with other divisions to ensure any redeployed colleagues return with an appropriate rest time and an opportunity to integrate at their own pace back into their substantive role

Community have had an improving trend in pressures ulcers in Q4 19/20 and Q1 20/21. The bedded areas of the Trust saw an improvement in Q4 19/20. There have been no reported pressure ulcers for the month of October. However sustained improvement has not been achieved so ongoing focus and work is required to embed the pressure ulcer improvement plan across all areas. The introduction of a tissue viability nurse is allowing a refreshed focus on pressure ulcers and she is working closely with the inpatient areas to make sustained improvements

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

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

Quality linked to nurse indicators is high on the agenda for nursing with a definite refocus on the perfect ward and ward accreditation process, this will under pin a culture of sustained improvement in patient care and will be a way to support individual areas to take ownership for quality indicators, specifically linked to care delivery

Between November 2020 and January 2021 there were 10 CDT's reported, bringing the Trust total to 36 against an annual trajectory of 20; all are subject to internal review but have not yet been

reviewed by the CCG. There are, however, probably 2 lapses in care identified; one related to inappropriate use of antibiotics and one related to a delay in sampling.

During this time there have also been 2 MRSA bacteraemia's; one was due to a delayed diagnosis of a pre-existing MRSA infection, the other possibly related to a urinary catheter infection. Full reports have been completed and submitted to the CCG for review.

There were significant numbers of patients in hospital with COVID and 16 outbreaks declared over the 3 month period. Each outbreak was investigated and reported to NHS England as per national guidance. Action plans have been drawn up for all key learning points and circulated via a number of different channels. A COVID Hospital Onset Reduction Plan is in place to address the numbers being seen and put in to place the actions required from the IPC Board Assurance Framework and the Key Actions document issued by NHS England.

Due to the COVID pandemic the deep clean programme has remained suspended; additional resource has been put into the wards and ICU at RAEI to provide additional cleaning.

There was 1 fall reported where moderate or severe harm occurred within the reporting period. This was on the AS, however from review of this case it

**4.0 ACTIONS BEING TAKEN**

- The B5 vacancy reduction plan is being reviewed and refreshed to reflect current labour turnover rates. The retention of our band 5 workforce is also being reviewed with the band 5 to 6 uplift programme; has so far been successful with 23 successful registrants moving from Band 5 to 6 and a further 25 currently on cohort two and cohort 3 out to advert

- A partnership working continues with NHS Professionals (NHSP) to support with staffing shortfalls

- HON for medicine and Surgery working in a collaborative way around staff short fall escalation supporting a hospital wide approach to staff being redeployed to improve skill mix and staffing numbers

- On-going monitoring of the progress to reduce B5 vacancies within the Trust

Arrival of the new Chief Nurse during the end of this quarter who will review KPI'S to address basic care standards and culture within the nursing, midwifery and AHP workforce. The pressure ulcer improvement plan is being overseen by the Deputy Chief Nurse with the newly appointed Tissue Viability Nurse

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

**5.0 RECOMMENDATIONS**

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

## Appendices

Appendix 1 Safe Staffing Exception Reports
November 2020

**SAFE ST AFFING EXCEPT ION REPORT – November 2020**

**Division of Medicine – Scheduled Care**

| | Average Fill Rates (%) & CHPPD | | | | | | Staff Availability | | | Staff Experience | Nurse Sensitive Indicators | | | | Patient Experience % (Number surveyed) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RN / RM | | | CSW | | | | | | | | | | | | |
| Ward | Day shift (%) | Night shift (%) | CHPPD | Day shift (%) | Night shift (%) | CHPPD | Sickness (%) | Vacancies (%) | Vacancies (%) - Registered Nursing Band 5-8 | Datix Incidents - related to staffing/Red Flags | CDT | Falls (Harm / No Harm) | PU (Grade 1&2 / Grade 3 &4) | Drug Admin Errors (Harm / No Harm) | Do you think the hospital staff did everything they could do to control your pain? | Have you been given the care you felt you required when you needed it most? |
| Acute Stroke Unit | 92.2% | 138.8% | 3.9 | 145.0% | 133.2% | 7.2 | 27.73% | 4.40% | 14.35% | | | 0/1 | | | | |
| Astley | 103.1% | 153.8% | 3.4 | 131.6% | 170.8% | 6.3 | 13.08% | 4.56% | 11.15% | | | 0/3 | | | | |
| Bryn North | | | | | | | 0.00% | Unable to report vacancies as there is no budget recorded for this department | | | | 0/1 | | 0/1 | | |
| Bryn South | 68.4% | 86.9% | 3.1 | 119.8% | 123.7% | 6.3 | 0.00% | Unable to report vacancies as there is no budget recorded for this department | | | | 0/1 | | 0/1 | | |
| Coronary Care Unit | 119.1% | 99.0% | 7.9 | 2600.2% | | 3.0 | 4.78% | 35.22% | 35.36% | | | 0/2 | | | | |
| Highfield | | | | | | | | | | | | | | | | |
| Ince | 104.3% | 112.0% | 3.5 | 113.5% | 173.8% | 5.4 | 8.25% | 28.87% | 44.46% | | | 0/4 | | | | |
| Pemberton | 68.1% | 91.8% | 4.0 | 121.8% | 124.0% | 5.1 | 18.19% | 7.98% | 7.27% | | 1 | 0/2 | | | | |
| Shevington | 94.9% | 107.9% | 3.4 | 114.2% | 151.5% | 5.7 | 13.90% | 14.29% | 28.47% | | | 1/4 | | | | |
| Standish | 133.8% | 111.2% | 3.5 | 121.4% | 188.3% | 5.9 | 11.94% | 10.72% | 28.38% | | 1 | 1/2 | | 5/1 | | |
| Winstanley | 256.3% | 152.8% | 32.1 | 97.4% | 144.7% | 24.1 | 18.88% | 8.54% | 22.81% | | 1 | | | 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 | 102.0% | 109.3% | 24.1 | 98.1% | | 2.7 | 8.24% | 0.00% | 0.00% | | | | | 0/1 | | |
| Langtree | 79.9% | 90.3% | 2.7 | 152.4% | 228.3% | 4.1 | 24.87% | 8.58% | 17.89% | | | 0/1 | | 1/2 | | |
| Orrell | 75.5% | 82.5% | 2.6 | 118.1% | 131.4% | 5.3 | 7.10% | 6.53% | 13.40% | | | 1/8 | | | | |
| Swinley | 98.6% | 109.5% | 3.8 | 145.2% | 205.6% | 4.6 | 7.73% | 7.88% | 14.80% | | | 0/5 | | | | |
| Maternity Unit | 100.4% | 95.6% | 16.6 | 94.6% | 93.3% | 4.5 | 7.14% | 0.00% | 0.00% | | | | | | | |
| Neonatal Unit | 90.8% | 94.3% | 14.3 | 100.0% | | 2.1 | 9.05% | 2.51% | 0.00% | | | | | | | |
| Rainbow | 109.2% | 97.0% | 10.4 | 127.1% | 91.9% | 3.8 | 11.90% | 0.00% | 0.00% | | | 0/1 | | 0/1 | | |

**Division of Specialist Services**

| | Average Fill Rates (%) & CHPPD | | | | | | Staff Availability | | | Staff Experience | Nurse Sensitive Indicators | | | | Patient Experience % (Number surveyed) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RN / RM | | | CSW | | | | | | | | | | | | |
| Ward | Day shift (%) | Night shift (%) | CHPPD | Day shift (%) | Night shift (%) | CHPPD | Sickness (%) | Vacancies (%) | Vacancies (%) - Registered Nursing Band 5-8 | Datix Incidents - related to staffing/Red Flags | CDT | Falls (Harm / No Harm) | PU (Grade 1&2 / Grade 3 &4) | Drug Admin Errors (Harm / No Harm) | Do you think the hospital staff did everything they could do to control your pain? | Have you been given the care you felt you required when you needed it most? |
| Aspull | 85.3% | 94.6% | 2.9 | 123.0% | 169.2% | 5.83 | 9.75% | 22.33% | 35.01% | | 1 | 0/6 | | 0/1 | | |
| Ward A | 20.9% | 13.3% | 8.7 | 8.8% | 14.2% | 5.43 | 3.35% | 23.24% | 22.65% | | | | | | | |
| Ward B | 102.1% | 153.5% | 4.6 | 99.1% | 120.1% | 4.58 | 17.20% | 26.30% | 28.85% | | | | | | | |
| JCW | | | | | | | 12.87% | 18.47% | 24.44% | | | | | | | |

**Division of Medicine – Unscheduled Care**

| Ward | Average Fill Rates (%) & CHPPD: RN / RM Day shift (%) | RN / RM Night shift (%) | RN / RM CHPPD | CSW Day shift (%) | CSW Night shift (%) | CSW CHPPD | Staff Availability: Sickness (%) | Vacancies (%) | Vacancies (%) - Registered Nursing Band 5-8 | Staff Experience: Datix Incidents - related to staffing/Red Flags | Nurse Sensitive Indicators: CDT | Falls (Harm / No Harm) | PU (Grade 1&2 / Grade 3 & 4) | Drug Admin Errors (Harm / No Harm) | Patient Experience % (Number surveyed): Do you think the hospital staff did everything they could do to control your pain? | Have you been given the care you felt you required when you needed it most? |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A&E Emg Care | 94.8% | 118.5% | | 132.4% | 212.5% | | 6.84% | 23.60% | 31.44% | | | 0/3 | | 0/2 | | |
| A&E Paeds | 119.9% | 101.7% | | | | | 3.44% | 2.48% | 2.48% | | | | | | | |
| A&E NP's | 53.4% | 0.0% | | 24.2% | | | | | | | | | | | | |
| CDW | 70.7% | 98.0% | | 106.5% | 103.4% | | 1.63% | 14.83% | 25.33% | | | | | | | |
| Lowton | 59.7% | 92.1% | | 105.3% | 131.6% | | 10.06% | 5.82% | 22.69% | | | 0/6 | | 1/3 | | |
| Medical Assessment Unit | 78.7% | 113.4% | | 89.3% | 109.1% | | 17.06% | 13.09% | 28.50% | | | 0/8 | | 0/3 | | |

**Division of Surgery**

| Ward | Average Fill Rates (%) & CHPPD: RN / RM Day shift (%) | RN / RM Night shift (%) | RN / RM CHPPD | CSW Day shift (%) | CSW Night shift (%) | CSW CHPPD | Staff Availability: Sickness (%) | Vacancies (%) | Vacancies (%) - Registered Nursing Band 5-8 | Staff Experience: Datix Incidents - related to staffing/Red Flags | Nurse Sensitive Indicators: CDT | Falls (Harm / No Harm) | PU (Grade 1&2 / Grade 3 & 4) | Drug Admin Errors (Harm / No Harm) | Patient Experience % (Number surveyed): Do you think the hospital staff did everything they could do to control your pain? | Have you been given the care you felt you required when you needed it most? |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ICU/HDU | 110.4% | 103.8% | 26.9 | 104.6% | 0.0% | 4.7 | 3.23% | 0.00% | 0.00% | | | | 4/1 | | | |
| Langtree | 79.0% | 106.1% | 2.9 | 156.4% | 229.1% | 4.3 | 13.82% | 7.63% | 17.89% | | | 0/3 | | 0/4 | | |
| Orrell | 83.7% | 82.0% | 3.4 | 106.4% | 107.8% | 5.7 | 8.67% | 3.98% | 2.46% | | 1 | 0/6 | | | | |
| Swinley | 97.2% | 94.0% | 3.3 | 133.8% | 209.6% | 4.4 | 8.03% | 4.10% | 11.84% | | | 0/5 | | | | |
| Maternity Unit | 102.8% | 91.8% | 12.7 | 108.2% | 93.1% | 3.7 | 8.73% | 0.00% | 0.00% | | | | | 0/2 | | |
| Neonatal Unit | 104.4% | 109.2% | 9.2 | 110.6% | 0.0% | 1.4 | 4.17% | 0.00% | 0.00% | | | | | 0/1 | | |
| Rainbow | 95.0% | 94.3% | 9.9 | 123.0% | 93.5% | 3.8 | 9.09% | 0.00% | 0.00% | | | 0/1 | | 0/2 | | |

**Division of Specialist Services**

| Ward | Average Fill Rates (%) & CHPPD: RN / RM Day shift (%) | RN / RM Night shift (%) | RN / RM CHPPD | CSW Day shift (%) | CSW Night shift (%) | CSW CHPPD | Staff Availability: Sickness (%) | Vacancies (%) | Vacancies (%) - Registered Nursing Band 5-8 | Staff Experience: Datix Incidents - related to staffing/Red Flags | Nurse Sensitive Indicators: CDT | Falls (Harm / No Harm) | PU (Grade 1&2 / Grade 3 & 4) | Drug Admin Errors (Harm / No Harm) | Patient Experience % (Number surveyed): Do you think the hospital staff did everything they could do to control your pain? | Have you been given the care you felt you required when you needed it most? |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Aspull | 93.4% | 90.6% | 3.2 | 116.7% | 165.0% | 6.05 | 11.73% | 18.79% | 34.40% | | | 0/4 | | 0/3 | | |
| Ward A | 93.6% | 81.1% | 4.1 | 73.7% | 96.5% | 3.99 | 2.00% | 23.15% | 22.65% | | | 0/1 | | | | |
| Ward B | 95.2% | 107.3% | 3.8 | 100.5% | 107.8% | 4.30 | 14.50% | 22.52% | 21.85% | | | 0/7 | | 0/1 | | |
| JCW | | | | | | | 14.60% | 18.47% | 24.44% | | | | | | | |

**Other – Community Covid**

| Ward | Average Fill Rates (%) & CHPPD: RN / RM Day shift (%) | RN / RM Night shift (%) | RN / RM CHPPD | CSW Day shift (%) | CSW Night shift (%) | CSW CHPPD | Staff Availability: Sickness (%) | Vacancies (%) | Vacancies (%) - Registered Nursing Band 5-8 | Staff Experience: Datix Incidents - related to staffing/Red Flags | Nurse Sensitive Indicators: CDT | Falls (Harm / No Harm) | PU (Grade 1&2 / Grade 3 & 4) | Drug Admin Errors (Harm / No Harm) | Patient Experience % (Number surveyed): Do you think the hospital staff did everything they could do to control your pain? | Have you been given the care you felt you required when you needed it most? |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Leigh Covid Recovery Unit | | | | | | | 6.4% | Unable to report vacancies as there is no budget recorded for this department | | | | | | | | |

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

February 2021

**Appendix 2**

**Table 2** Nurse Vacancies February 2021 Trust Wide

**Table 1. Summary of Nursing Vacancies by Division**

| Qualified or Unqualified | Division | Appointed To | Out To Advert | Vacancy | Pipeline: Student Nurse Allocated | Pipeline: International Nurses Allocated | Total All Vacancies | Total Vacancies Not Appointed To |
|---|---|---|---|---|---|---|---|---|
| **Qualified** | Medicine | 29.68 | 21.21 | 14.07 | 7.96 | 13.00 | 85.92 | 35.28 |
| | Specialist Services | 5.81 | 22.45 | 16.41 | 0.00 | 8.92 | 53.60 | 38.87 |
| | Surgery | 18.09 | 16.92 | 11.89 | 3.00 | 2.00 | 51.90 | 28.81 |
| | Community | 20.67 | 9.81 | 13.89 | 2.00 | 2.00 | 48.37 | 23.70 |
| | Corporate | 3.10 | 4.20 | 1.25 | 0.00 | 0.00 | 8.55 | 5.45 |
| **Qualified Total** | | **77.36** | **74.59** | **57.51** | **12.96** | **25.92** | **248.34** | **132.10** |
| **Unqualified** | Specialist Services | 3.20 | 9.37 | 14.38 | 0.00 | 0.00 | 26.95 | 23.75 |
| | Community | 3.75 | 3.28 | 6.80 | 0.00 | 0.00 | 13.83 | 10.08 |
| | Surgery | 3.03 | 3.62 | (3.70) | 0.00 | 0.00 | 2.95 | (0.08) |
| | Corporate | 0.00 | 0.00 | 1.00 | 0.00 | 0.00 | 1.00 | 1.00 |
| | Medicine | 12.89 | 3.87 | (26.85) | 0.00 | 0.00 | (10.08) | (22.97) |
| **Unqualified Total** | | **22.87** | **20.15** | **(8.38)** | **0.00** | **0.00** | **34.65** | **11.77** |
| **Grand Total** | | **100.23** | **94.74** | **49.13** | **12.96** | **25.92** | **282.99** | **143.88** |

**Table 2. Summary of Nursing Vacancies by Band**

| Qualified or Unqualified | Band | Appointed To | Out To Advert | Vacancy | Pipeline: Student Nurse Allocated | Pipeline: International Nurses Allocated | Total All Vacancies | Total Vacancies Not Appointed To |
|---|---|---|---|---|---|---|---|---|
| **Qualified** | Nurse Band 5 | 48.54 | 27.91 | 31.97 | 12.96 | 25.92 | 147.29 | 59.88 |
| | Nurse Band 6 | 12.29 | 23.76 | 11.86 | 0.00 | 0.00 | 47.91 | 35.62 |
| | Nurse Band 7 | 7.49 | 12.31 | 9.01 | 0.00 | 0.00 | 28.81 | 21.32 |
| | Nurse Band 8 | 1.00 | 0.00 | 0.00 | 0.00 | 0.00 | 1.00 | 0.00 |
| | Nurse Band 8A | 5.04 | 6.01 | 4.15 | 0.00 | 0.00 | 15.20 | 10.16 |
| | Nurse Band 8B | 2.00 | 0.00 | 0.00 | 0.00 | 0.00 | 2.00 | 0.00 |
| | Health Visitor Band 6 | 1.00 | 0.00 | 0.00 | 0.00 | 0.00 | 1.00 | 0.00 |
| | School Nurse Band 5 | 0.00 | 3.80 | 0.52 | 0.00 | 0.00 | 4.32 | 4.32 |
| | School Nurse Band 6 | 0.00 | 0.80 | 0.00 | 0.00 | 0.00 | 0.80 | 0.80 |
| **Qualified Total** | | **77.36** | **74.59** | **57.51** | **12.96** | **25.92** | **248.34** | **132.10** |
| **Unqualified** | Nurse Band 2 | 14.99 | 10.92 | (20.34) | 0.00 | 0.00 | 5.57 | (9.41) |
| | Nurse Band 3 | 1.60 | 0.00 | 1.42 | 0.00 | 0.00 | 3.02 | 1.42 |
| | Nurse Band 4 | 2.54 | 5.95 | 0.75 | 0.00 | 0.00 | 9.23 | 6.69 |
| | Healthcare Assistant Band 2 | 1.20 | 0.00 | 0.54 | 0.00 | 0.00 | 1.74 | 0.54 |
| | Healthcare Assistant Band 3 | 0.00 | 0.00 | 5.61 | 0.00 | 0.00 | 5.61 | 5.61 |
| | Healthcare Assistant Band 4 | 2.55 | 3.28 | 2.47 | 0.00 | 0.00 | 8.29 | 5.75 |
| | Student Health Visitor | 0.00 | 0.00 | 1.00 | 0.00 | 0.00 | 1.00 | 1.00 |
| | Nursery Nurse | 0.00 | 0.00 | 0.17 | 0.00 | 0.00 | 0.17 | 0.17 |
| **Unqualified Total** | | **22.87** | **20.15** | **(8.38)** | **0.00** | **0.00** | **34.65** | **11.77** |
| **Grand Total** | | **100.23** | **94.74** | **49.13** | **12.96** | **25.92** | **282.99** | **143.88** |

**Table 5. Summary of HCA Vacancies by Division at band 2 and 3**

| Division | Appointed To | Out To Advert | Vacancy | Pipeline: Student Nurse Allocated | Pipeline: International Nurses Allocated | Total All Vacancies | Total Vacancies Not Appointed To |
|---|---|---|---|---|---|---|---|
| Specialist Services | 3.20 | 7.73 | 12.74 | 0.00 | 0.00 | 23.67 | 20.47 |
| Community | 1.20 | 0.00 | 4.63 | 0.00 | 0.00 | 5.83 | 4.63 |
| Surgery | 2.49 | 2.62 | (3.70) | 0.00 | 0.00 | 1.41 | (1.08) |
| Corporate | 0.00 | 0.00 | 1.00 | 0.00 | 0.00 | 1.00 | 1.00 |
| Medicine | 10.89 | 0.57 | (27.42) | 0.00 | 0.00 | (15.96) | (26.85) |
| **Grand Total** | **17.79** | **10.92** | **(12.76)** | **0.00** | **0.00** | **15.95** | **(1.84)** |

**Table 3. Summary of AHP Vacancies by Division**

| Qualified or Unqualified | Division | Appointed To | Out To Advert | Vacancy | Total All Vacancies | Total Vacancies Not Appointed To |
|---|---|---|---|---|---|---|
| **Qualified** | Specialist Services | 1.00 | 17.24 | 11.03 | 29.27 | 28.27 |
| | Community | 1.00 | 0.00 | 11.21 | 12.21 | 11.21 |
| | Medicine | 5.00 | 3.28 | 2.04 | 10.32 | 5.32 |
| | Surgery | 0.00 | 0.00 | 0.52 | 0.52 | 0.52 |
| **Qualified Total** | | **7.00** | **20.52** | **24.79** | **52.31** | **45.31** |
| **Unqualified** | Community | 1.60 | 0.00 | 9.01 | 10.61 | 9.01 |
| | Specialist Services | 0.00 | 4.96 | 3.15 | 8.11 | 8.11 |
| | Medicine | 0.00 | 0.00 | 1.00 | 1.00 | 1.00 |
| **Unqualified Total** | | **1.60** | **4.96** | **13.17** | **19.73** | **18.13** |
| **Grand Total** | | **8.60** | **25.48** | **37.96** | **72.04** | **63.44** |

**Table 4. Summary of AHP Vacancies by Band**

| Qualified or Unqualified | Band | Appointed To | Out To Advert | Vacancy | Total All Vacancies | Total Vacancies Not Appointed To |
|---|---|---|---|---|---|---|
| **Qualified** | Occupational Therapist Band 5 | 1.00 | 1.00 | 5.30 | 7.30 | 6.30 |
| | Occupational Therapist Band 6 | 3.00 | 2.00 | 0.00 | 5.00 | 2.00 |
| | Occupational Therapist Band 7 | 0.00 | 0.00 | 0.36 | 0.36 | 0.36 |
| | Other PTB Band 5 | 0.00 | 0.57 | 0.00 | 0.57 | 0.57 |
| | Physiotherapist Band 5 | 0.00 | 0.00 | 3.66 | 3.66 | 3.66 |
| | Physiotherapist Band 6 | 1.00 | 6.00 | 3.92 | 10.92 | 9.92 |
| | Physiotherapist Band 7 | 0.00 | 1.00 | 0.60 | 1.60 | 1.60 |
| | Pysiotherapist Band 8A | 0.00 | 0.00 | 2.59 | 2.59 | 2.59 |
| | Radiographer Band 5 | 0.00 | 3.00 | 0.00 | 3.00 | 3.00 |
| | Radiographer Band 6 | 0.00 | 5.67 | 1.40 | 7.07 | 7.07 |
| | Radiographer Band 7 | 0.00 | 0.00 | 0.81 | 0.81 | 0.81 |
| | Radiographer Band 4 | 0.00 | 0.00 | 1.24 | 1.24 | 1.24 |
| | Speech Therapist Band 6 (AfC) | 1.00 | 0.80 | 0.20 | 2.00 | 1.00 |
| | Speech Therapist Band 7 (AfC) | 0.00 | 0.48 | 1.52 | 2.00 | 2.00 |
| | Speech Therapist Band 5 (AfC) | 1.00 | 0.00 | 2.00 | 3.00 | 2.00 |
| | Dietician Band 6 | 0.00 | 0.00 | 0.75 | 0.75 | 0.75 |
| | Chiropodist Band 5 | 0.00 | 0.00 | 0.40 | 0.40 | 0.40 |
| | Occupational Therapist Band 8A | 0.00 | 0.00 | 0.04 | 0.04 | 0.04 |
| **Qualified Total** | | **7.00** | **20.52** | **24.79** | **52.31** | **45.31** |
| **Unqualified** | AHP Assistant Band 2 | 0.00 | 0.52 | 2.90 | 3.42 | 3.42 |
| | AHP Assistant Band 3 | 1.60 | 2.00 | 5.43 | 9.03 | 7.43 |
| | Other PTB Band 2 | 0.00 | 0.00 | 0.14 | 0.14 | 0.14 |
| | Radiographer Band 3 | 0.00 | 0.44 | 0.49 | 0.93 | 0.93 |
| | AHP Assistant Band 4 | 0.00 | 1.00 | 4.20 | 5.20 | 5.20 |
| | Other PTB Band 7 | 0.00 | 1.00 | 0.00 | 1.00 | 1.00 |
| **Unqualified Total** | | **1.60** | **4.96** | **13.17** | **19.73** | **18.13** |
| **Grand Total** | | **8.60** | **25.48** | **37.96** | **72.04** | **63.44** |

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

**Table 1** *Red Metrics in Inpatient Areas October 2020*

| | 2020 12 | 2021 02 | Total |
|---|---|---|---|
| **Intensive Care Unit (ICU)** | | **4** | **4** |
| A shortfall of more than 8 hours or 25% of registered nurse time available | | 2 | 2 |
| Patient vital signs not assessed or recorded as outlined in the care plan | | 1 | 1 |
| Unplanned omission in providing patient medications | | 1 | 1 |
| **Lowton Ward** | | **1** | **1** |
| A shortfall of more than 8 hours or 25% of registered nurse time available | | 1 | 1 |
| **Standish Ward** | **1** | 0 | **1** |
| A shortfall of more than 8 hours or 25% of registered nurse time | 1 | | 1 |
| Totals: | 1 | 5 | 6 |

| Red Flag Category | Number of of Incidents August 2020 | Number of Incidents September 2020 | No of Incidents October 2020 |
|---|---|---|---|
| Shortfall of more than 8 hours or 25% of registered nurses in a shift | 12 | 13 | 20 |
| Delay of 30 minutes or more for the administration of pain relief | 0 | 0 | 0 |
| Delay or omission of intentional rounding | 0 | 0 | 0 |

| Red Flag Category | Number of of Incidents August 2020 | Number of Incidents September 2020 | No of Incidents October 2020 |
|---|---|---|---|
| Less than 2 registered nurses on shift | 0 | 0 | 1 |
| Vital signs not assessed or recorded as planned | 0 | 0 | 0 |
| Unplanned omission of medication | 0 | 0 | 0 |
| **Total** | **12** | **13** | **21** |

**Table 4** *Nursing Red Flags August and October 2020*

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

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

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

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

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

| | |
|---|---|
| **Title of report:** | 2021/22 Corporate Objectives |
| **Presented to:** | Trust Board |
| **On:** | 31st March 2021 |
| **Presented by:** | Silas Nicholls, Chief Executive |
| **Prepared by:** | Karlyn Forrest, Director of Strategic Transformation |
| **Contact details:** | E: karlyn.forrest@wwl.nhs.uk |

**Executive summary**

The report outlines the proposed corporate objectives for FY 2021/22.

The corporate objectives set out what the Trust plans to achieve during the financial year 2021/22, what the organisation will prioritise and focus on during the year to progress the longer-term ambitions within the strategy. The board assurance framework will be the mechanism for the Board to monitor the delivery of the agreed objectives, also setting out the risks to achieving these and providing a clear analysis of progress.

The objectives are presented under the four Ps, therefore ensuring effective oversight of the delivery of the corporate objectives through the committee structure, with an allocated director for each.

Due to the unprecedented situation of entering the new financial year without planning guidance, there are three objectives which will be revisited and refined during Q1 to ensure that clear outcomes and measurables are confirmed. These are indicated against each objective.

**Link to strategy**

The corporate objectives outline the priorities for 2021/22 to progress the longer-term ambitions within the strategy.

**Risks associated with this report and proposed mitigations**

None

**Financial implications**

None

**Legal implications**

None

**People implications**

None

**Wider implications**

None

**Recommendation(s)**

The Board is recommended to approve the corporate objectives for 2021/22.

| | | |
|---|---|---|
|  | **Patients: To be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience.** | |
| Ref | Objective | Lead Executive |
| CO1 | We will reduce preventable death demonstrated by bringing the Trust's Summary Hospital Level Mortality Indicator (SHMI) within the expected range by the 31st March 2022. | Sanjay Arya |
| CO2 | We will improve the safety and quality of our clinical services by achieving the following by the 31st March 2022:<br>• 25% reduction in mortality related to Sepsis<br>• 25% reduction in mortality related to Acute Kidney Injury | Sanjay Arya |
| CO3 | We will improve the safety and delivery of Harm Free Care by achieving the following by the 31st March 2022:<br>• 50% reduction in Hospital Acquired Category 3 and 4 pressures ulcers<br>• 20% reduction in serious incidents related to deteriorating patients | Rabina Tindale |
| 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 the 31st March 2022. | Rabina Tindale |
| CO5 | We will improve our safety culture by introducing Human Factors Awareness Training, ensuring delivery to 50% of our ward managers by the 31st March 2022. | Rabina Tindale |

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

| Ref | Objective | Lead Executive |
|---|---|---|
| CO6 | We will support the physical health and mental well-being of our WWL family by ensuring we have a comprehensive range of well-being activities and services that are accessible to our colleagues. By the 31st March 2022, we will have achieved:<br>• Well-being score of 3.75 in Your Voice Survey<br>• Positive evaluation of Steps 4 Wellness services | Alison Balson |
| CO7 | We will improve nursing, AHP and midwifery recruitment and retention so that by the 31st March 2022 have will have achieved:<br>• A reduction in the clinical vacancy rate to under 5%<br>• 95% of our people having a prioritised personal development plan that is supported by the Trust<br>• Talent mapping and succession plans for Nursing, AHP and midwifery leadership roles<br>• A personal development score of 3.75 in Your Voice Survey<br>• A 5% reduction in leavers with less than 12 months service | Rabina Tindale |
| 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 31st March 2022, we will have achieved:<br>• Implementation of the civility and just culture programmes of work<br>• Engagement and psychological safety score of 3.75 in Your Voice Survey<br>• 30% of people leaders will have undertaken or have completed (with modular top up requirement) an accredited leadership development programme | Alison Balson |
| CO9 | We will place fairness and compassion at the centre of our people policies, always respecting the needs and diversity of our colleagues. By 31st March 2022, we will have achieved:<br>• Reduced our gender pay gap by at least 5% and improved our WRES and WDES outcomes<br>• Compassionate leadership score of 3.75 from Your Voice Survey<br>• Re-designed key WWL Employment Policies (Disciplinary, Grievance, Dignity at Work, Attendance Management, Performance Management and Raising Concerns) | Alison Balson |

| | | |
|---|---|---|
|  | **Performance: To consistently deliver efficient, effective and equitable patient care** | |
| Ref | Objective | Lead Executive |
| 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:<br>• Reduce the number of patients waiting over 52 weeks<br>• See and treat priority 2 patients within Royal College timescales<br>• Improve against national minimum standards for cancer services | Mary Fleming |
| CO11 | **We will improve the Trust's financial sustainability by a focus on productivity in all areas, demonstrated through meeting the expectations of NHSE/I for 2021/22. | Ian Boyle |
| CO12 | We will have created and communicated our Digital Strategy to drive excellence in digital healthcare for patients by the 1st October 2021, and by the end of March 2022 have modernised key elements of our IT infrastructure demonstrated through:<br>• 100% of staff being provided with the latest versions of Microsoft Office and MS Teams<br>• The deployment of a new, modern Telephony solution throughout the Trust<br>• Implementation of the first clinical pathway in HIS<br>• Increase critical system availability from a year-end FY2020/21 position of 95% to a FY2021/22 year-end position of 98% through conforming to NHS Digital's Data Security and Protection toolkit resulting in the reduction of unplanned outages. | Mary Fleming |
| CO13 | We will have refreshed the Estate Strategy by the 1st January 2022, exploring and leveraging the benefit of locality working under the One Public Estate initiative with Wigan CCG and Wigan Council, whilst supporting the Trust Service Strategy and incorporating the longer-term implications and benefits of remote working. | Ian Boyle |

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

| Ref | Objective | Lead Executive |
|---|---|---|
| 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:<br>• seen an increase in our OOA referrals to 10,000<br>• restored and recovered to pre-COVID capacity of 20 orthopaedic sessions per working day | Richard Mundon |
| CO15 | ** We will create and agree our development and delivery plan for achieving the criteria required to become a University Hospitals Trust in a maximum of 5 years' time by the end of Q1, and then deliver the 2021/22 elements of this plan by the end of March 2022. | Sanjay Arya |
| CO16 | We will continue to work side by side with our HWP partners in the development and provision of integrated and placed-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 we contribute to community wealth building in Wigan in keeping with our anchor institution role. | Richard Mundon |

**The level of reduction / improvement across the three outcomes to be achieved by March 2022 to be included in the objective once the planning guidance is received and the elective recovery modelling is complete in Q1.*

*** Corporate objective to be updated in 2021/22 when year 1 deliverables are able to be confirmed / planning guidance confirmed.*

| | |
|---|---|
| **Title of report:** | Appointment of Deputy Chief Executive |
| **Presented to:** | Board of Directors |
| **On:** | 31 March 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**

The constitution provides that one of the executive directors may be appointed as the Deputy Chief Executive and confirms that such an appointment is a matter for the whole board.

Expressions of interest were invited from all eligible directors and a recruitment process was undertaken which took account of candidates' board experience, recent 360º feedback and their vision for the role. As part of the process a formal interview was held with all candidates, with the panel comprising the Chair, Chief Executive and a Non-Executive Director.

Following the conclusion of this process, the interview panel unanimously recommends the appointment of Mary Fleming as Deputy Chief Executive with effect from 1 April 2021.

**Link to strategy**

There is no link to the organisational strategy.

**Risks associated with this report and proposed mitigations**

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

**Financial implications**

Remuneration for the post is in line with the Deputy Chief Executive pay scale set out in the Executive Remuneration Framework. This has been incorporated into budget setting and therefore there are no financial implications to bring to the board's attention.

**Legal implications**

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

**People implications**

The Deputy Chief Executive post is a permanent position and represents a change to the post holder's terms and conditions of appointment. All relevant fit and proper person checks have been conducted.

**Wider implications**

There are no wider implications to highlight.

**Recommendation(s)**

The Board of Directors is recommended to appoint Mary Fleming as Deputy Chief Executive with effect from 1 April 2021.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

| | |
|---|---|
| **Title of report:** | Review of risk appetite statement |
| **Presented to:** | Board of Directors |
| **On:** | 31 March 2021 |
| **Presented by:** | Director of Corporate Affairs |
| **Prepared by:** | Paul Howard, Director of Corporate Affairs |
| **Contact details:** | T: 01942 822027 \| E: paul.howard@wwl.nhs.uk |

**Executive summary**

In March 2020, the Board approved changes to its risk appetite statement because of the COVID-19 pandemic and directed that the statement should be presented to each board meeting to ensure its continuing appropriateness and relevance. This risk appetite statement was subsequently amended by the board at its meeting in September 2020 to reflect changes to the prevailing situation.

The executive team has recently reviewed the risk appetite statement and is proposing some further amendments which are highlighted in yellow in the attached statement for ease of reference.

The intention behind the changes is to begin to return the organisation to a more business as usual approach. For that reason, specific references to the COVID-19 pandemic within the narrative have been removed. The board is requested to note that a more specific COVID-19 risk appetite statement can be reinstated again if needed if the prevailing circumstances require it.

**Link to strategy**

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

**Risks associated with this report and proposed mitigations**

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

**Financial implications**

There are no financial implications arising out of this report.

**Legal implications**

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

**People implications**

There are no people implications in this report.

**Wider implications**

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

**Recommendation(s)**

The Board of Directors is recommended to approve the amended risk appetite statement as presented.

Given the move to a more business as usual approach, it is recommended that the review of statement reverts to being undertaken annually or whenever there is a material change in the foundation trust's circumstances.

# Risk appetite statement

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

**Introduction**

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

At Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust we recognise that complete risk control and avoidance is impossible but that risks can be minimised by making sound judgments and having a common understanding of the organisation's risk appetite and value set. Precise measurement of risk appetite is not always possible and we have therefore defined our risk appetite by way of a broad statement of approach, based on a matrix developed by the Good Governance Institute. A copy of the matrix is appended to this statement for information.

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

**Our risk appetite**

We have determined our risk appetite for FY2021/22 as follows:

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

We will review this position at least annually or whenever there is a material change in the foundation trust's circumstances.

This statement was approved by the Board of Directors at its meeting on 31 March 2021.

_____

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

## Appendix: Risk appetite matrix

*(based on a model from the Good Governance Institute)*

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

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| **Title of report:** | IPC Update and IPC BAF |
| **Presented to:** | [Trust Board] |
| **On:** | [31 March 2021] |
| **Presented by:** | [Rabina Tindale, Chief Nurse, Director IPC] |
| **Prepared by:** | [Rebecca Gerrard, Deputy Director IPC] |
| **Contact details:** | T: [07798741695 ] E: [3115 ] |

**Executive summary**

This paper provides:

- An IPC update including data on Hospital Onset COVID Infection (HOCI) and COVID Outbreaks.
- The updated IPC BAF – Appendix 1

**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**

Some of the 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.

The WWL Way

There is a risk assessment titled 'There is a risk of inpatients developing hospital onset COVID-19 infection whilst at RAEI'.
Also a risk assessment titled: 'There is a risk that WWL will not be able to comply with all the requirements in the 'Key Actions: IPC and testing' document published by NHS England/Improvement on 17/11/20'. This has been updated in light of the amended guidance.

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

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

**People implications**
Additional resource will be required in some areas e.g. cleaning to 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.

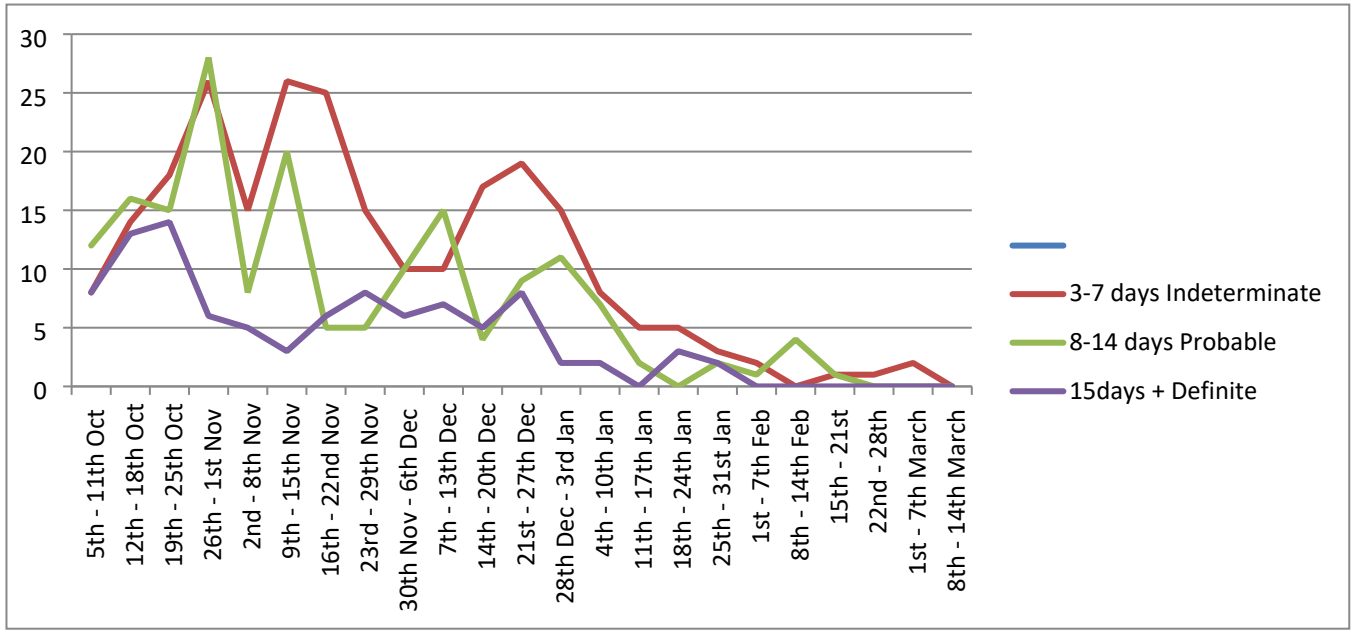
**Wider implications**
IPC is fundamental to the way all staff work and requires a Trust-wide approach.

**Recommendation(s)**
The Board are asked to acknowledge the key points in this paper and continue to support the implementation of actions required to enable compliance with the new guidance and reduce hospital onset COVID infection.

## Report

**Current situation on hospital onset COVID infections (HOCI)**

The numbers of HOCI cases per week from early October is shown below. The number of probable and definite infections has decreased significantly.




**COVID-19 Outbreaks**

Outbreaks on Standish and Swinley closed on 13th and 15th March respectively as they had seen no new HOCI cases for 28 days. There have been no new COVID outbreaks.

**New National Resources**

PHE launched an 'Implementation Toolkit' on 8th March to support excellence in IPC behaviours in relation to COVID titled 'Every action counts'. Resources include posters, leaflets, videos, checklists etc that can be downloaded and edited for use locally. The IPC team and Comms are reviewing these. Please see: https://www.england.nhs.uk/coronavirus/publication/every-action-counts/

**Appendices**
**Appendix 1: Latest version of the IPC BAF**

Changes are highlighted and include:

- 
- COVID Safety Champions are completing audits of own areas. Results to be collated.
- The PPE e-learning modules have been reviewed and updated
- The COVID-19 SOP has been updated and approved at IPC Committee in March.
- The risk assessment on CorPro masks reviewed has been reviewed, updated and approved at IPCC and REMC. CorPro masks are to be phased out.
- Cleaning: The Deep clean team still being used to carry out additional cleaning in high risk areas and outbreak wards. With current resources the focus remains on clinical areas. Monitoring is not routinely undertaken in non-clinical areas.
- Ventilation: At RAEI window opening has been maximised. Estates are completing a review at other sites in preparation for discussion at the next Ventilation Working Group meeting.
- Visiting is still subject to covid-19 restrictions but Exec agreed visitors can attend in exceptional circumstances. A decision tree has been drawn up and agreed by the Exec for special circumstances - this includes IPC requirements.
- The business case is being revised for an IT surveillance system for IPC.
- Compliance with swabbing at day 4 and 6 has improved but is still less than 80%.
- Now COVID prevalence has reduced, positive swabs are to be retested before being reported which will increase turnaround times again.
- A system has been established for carrying out additional testing on vaccinated patients and for identifying patients who may have new variants.
- Working areas for vaccinated high risk staff has been extended.
- Options for clear screens for between inpatient beds are being explored e.g. the use of clear plastic curtains that sit parallel to standard curtains but these have not yet arrived.
- A new SOP with escalation processes is being drawn up to help promote mask wearing amongst inpatients.

| 1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments & consider the susceptibility of service users & any risks posed by their environment & other service users | | | |
|---|---|---|---|
| **Key lines of enquiry** | **Evidence** | **Gaps in Assurance** | **Mitigating Actions** |
| Systems and processes are in place to ensure:<br>• infection risk is assessed at the front door and this is documented in patient notes | • All patients attending A/E are screened for COVID-19 on registration with a risk assessment completed. Symptomatic and asymptomatic patients are segregated at this point.<br>• Flow chart is in place Ward allocation of symptomatic, asymptomatic, positive and negative patients.<br>• All patients within the community are contacted to ensure a face to face visit is clinically required ensuring that staff do not mix visits for both symptomatic and asymptomatic patients.<br>• Telephone advice lines are in place where visits are not required.<br>• 18/1/21: All patients requiring admission undergo a lateral flow test now, as well as a PCR. | No gaps | N/A |
| • Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission | • Microbiology results are obtained and documented in HIS before patients are moved to designated COVID-19 negative or positive ward.<br>• If symptomatic but negative, patients are reassessed by medics. If COVID-19 still suspected patients stay on the ward and are retested which is all documented on HIS.<br>• There is a Flowchart on Screening of admissions for COVID-19 infection' and in the Standard Operating Procedure on swabbing.<br>• This is supported by frequent updates within the COVID-19 Newsletters.<br>• 22/1/20: A new flow chart has been introduced to limit the number of times patients who have been a contact of a positive case can be moved and recohorted | No gaps | N/A |

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| • compliance with the national guidance around discharge or transfer of COVID-19 positive patients | • National guidance is in use and documented on WWL intranet and in SOPs.<br>• There is a flow chart on stepping patients down based on national guidance and this is included in the COVID-19 SOP.<br>• Information, flowcharts and the rationale on swabbing practice has been provided to the council to share with the care homes. | None | N/A |
| • Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice | • Monitoring of IPC practices against key policies (including COVID-19) is included within IPC audit programme and includes environmental checklists, hand hygiene and PPE.<br>• Monitoring of IPC practice is also included within matron's mini audits. | None | N/A |
| • Monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice | • PPE audit tool revised to incorporate new guidance.<br>• PPE audits carried out monthly on wards at RAEI.<br>• Feb 21: COVID Safety Champions completing audits of own areas. Results to be collated. | None | N/A |
| • Staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase | • Trust SOP in place.<br>• Mass testing in line with national guidance/ roll out.<br>• First mass asymptomatic staff testing programme implemented within the Trust end October 2020.<br>• All staff now been offered lateral flow kits.<br>• Test & Trace risk assessment process in place.<br>• Feb 21: T&T risk assessment process now led by HR team who liaise with IPC as required. | None | NA |
| • Training in IPC standard infection control and transmission-based precautions are provided to all staff | • Mandatory training covers:<br>- IPC level 1 and 2<br>- PPE: one for clinical and one for non-clinical staff (Updated Feb 21)<br>All are undertaken via e-learning modules. | None | N/A |

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| • IPC measures in relation to COVID-19 should be included in all staff induction and mandatory training | • IPC measures in relation to COVID-19 form part of the above<br>• COVID-19 module launched Dec 20 and is mandatory for all staff.<br>• Jan 21: IPC level 1 and 2 and COVID-19 module reviewed and updated | None | NA |
| • All staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work | • Multi-modal communications strategy in place which includes poster, roller banner and newsletter campaign and regular reminders.<br>• IPC COVID SOP.<br>• All managers use the 'just culture' framework for escalation of workforce incidents. | None | NA |
| • All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance | • PHE national guidance in place across the Trust<br>• There is a PPE Store at each main site: PPE is delivered daily to wards and additional stock is available 24/7 if required.<br>• A PowerPoint Presentation on PPE (along with a quiz to test learning) is on e-learning for all staff and is mandatory.<br>• Feb 21: PPE modules reviewed and updated | None | N/A |
| • National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way | • All new guidance is acted upon in a timely manner<br>• Where necessary SOP's are updated<br>• Changes are communicated through the IPC team, newsletters and Divisional leads<br>• Feb 21: New guidance re CorPro masks and visors has been circulated.<br>• March 21: updated COVID-19 SOP approved at IPC Committee. | None | NA |
| • changes to guidance are brought to the attention of boards and any risks and mitigating actions are | • DIPC or Deputy present to the Board through the performance report or specific agenda items.<br>• Quality and Safety committee review quarterly IPC | None | N/A |

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| highlighted | reports. | | |
| • risks are reflected in risk registers and the board assurance framework where appropriate | • Risk register<br>• IPC BAF reviews<br>• Feb 21: Risk assessment on CorPro masks has been reviewed, updated and approved at IPCC and REMC in March. CorPro masks are to be phased out. | None | N/A |
| • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens | • Q&S sign off for IPC audit programme annually<br>• IPC Committee monitors progress and establishes mitigating actions to be taken | None | N/A |
| • That Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner. | • IPC check and validate data on HOCI that is downloaded from HIS before submission. CEO and DIPC are copied in so can check data.<br>• Dec 20: Outbreak data now on IT system that all relevant/designated staff can access. | None | NA |
| • ensure the Trust Board has oversight of ongoing outbreaks and action plans. | • Outbreaks that meet StEIS criteria are reported through Safety Committees.<br>• IPC report through IPC Committee up to Q&S and monthly Performance report to Board<br>• Regular IPC updates on COVID to the Board | 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:<br>• designated teams with appropriate training are | • Staff self-declaration for extremely vulnerable or high risk categories as defined by PHE England.<br>• Line manager risk assessment of the above individuals | None | N/A |

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| assigned to care for and treat patients in COVID-19 isolation or cohort areas | • All redeployed staff to undertake additional training to meet their needs<br>• Where staff have been redeployed additional training has been provided.<br>• PPE training is mandatory | | |
| • 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.<br>• All Domestics are trained in the correct use of PPE and have been masked fit tested and issued with personal CorPro half masks. | None | N/A |
| • decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance | • Domestic provision for the cleaning of isolation rooms and cohort areas follow PHE and National Guidance in place.<br>• SOP in place in conjunction with IPC<br>• Rapid Response Domestic team cover terminal cleans and work out of hours. | None | N/A |
| • increased frequency at least twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance | • A second tier clean is carried out in all isolation rooms and cohort areas to assist with the removal of bioburden as set out in national guidance<br>• Feb 21: Deep clean team being used to carry out additional cleaning in high risk areas and outbreak wards. | None | NA |
| • cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped | • SoChlor used at 1,000ppm is used for cleaning in all clinical areas.<br>• Green disinfectant wipes are used in non-clinical areas and at mask stations to clean re-usable CorPro masks. | None | N/A |

| | | | |
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| viruses | | | |
| • Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning /disinfectant solutions/products as per national guidance | • Manufacturers guidance followed and available on the intranet and included in decontamination SOP | None | N/A |
| • 'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids | • IPC review Ward Housekeeping schedules<br>• Compliance is audited via Matron and IPC Spot audits and reported to IPC Committee.<br>• Disinfectant wipes are recommended for non-clinical area PCs and phones. Wipes also available on 'cleaning stations' at ward entrances/exits for re-usable half masks.<br>• SOP's in place for all Facilities staff.<br>• Environmental cleaning audits in place and reported to the IPCC. | Amended 'Key actions' guidance calls for all high touch surfaces and items to be decontaminated multiple times every day | Additional cleaning is being carried out on CPAP ward, ICU and the wards that have COVID outbreaks. For nursing equipment the Ward Cleaning Schedules have been revised and re-issued – they are yet to be formally audited. |
| • electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards should be cleaned a minimum of twice daily | • Decontamination SOP in place.<br>• Green disinfectant wipes are used in non-clinical areas and at mask stations to clean re-usable CorPro masks.<br>• Feb 21: COVID Safety Champions completing audits of own areas. Results to be collated. | None | N/A |
| • rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily) | • Limited designated PPE doffing areas.<br>• All clinical areas undergo decontamination of the environment at least twice daily. | None | N/A |
| • linen from possible and confirmed COVID-19 patients is managed in line | • Linen system managed in line with PHE and National guidance<br>• SOP available on the Intranet | None | N/A |

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| with PHE and other national guidance and the appropriate precautions are taken | • External contractor performance against the contractual requirements | | |
| • single use items are used where possible and according to single use policy | • Single Use SOP in place<br>• Single Use is included in mandatory level 2 IPC training.<br>• Patient Safety Alerts communicated through internal Newsletters, Governance Team and changes to individual policies | None | N/A |
| • reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance | • Strategic and Operational Decontamination Groups in place<br>• Decontamination SOP both WWL wide and at departments levels in place<br>• All reusable equipment is decontaminated in line with national guidance<br>• Audit programme in place<br>• Risk assessment process in place to minimise risk | Timely meeting of the Decontamination Group | Decontamination issues are currently covered through IPCC. |
| • ensure cleaning standards and frequencies are monitored in non- clinical areas with actions in place to resolve issues in maintaining a clean environment | • Kitchens & toilets are cleaned in non-clinical areas.<br>• With current resources the focus remains on clinical areas. Monitoring is not routinely undertaken in non-clinical areas. | Lack of an audit tool to assess compliance with standards in non-clinical areas | Need to design and agree an audit tool for non-clinical areas |
| • ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air | • Mechanical ventilation available in some admission and waiting areas.<br>• Where mechanical ventilation is not available, managers have been advised to encourage the dilution of air by opening windows.<br>• Window restrictors are in place for all windows<br>• March 21: At RAEI window opening has been maximised. Estates are completing a review at other sites in preparation for discussion at the next Ventilation Working Group meeting. | None | N/A |

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| • there is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants | • SoChlor is used for the routine cleaning of the environment across all risk pathways and will continue. | None | N/A |
| **3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance** | | | |
| **Key lines of enquiry** | **Evidence** | **Gaps in Assurance** | **Mitigating Actions** |
| Systems and process are in place to ensure:<br>• arrangements around antimicrobial stewardship is maintained | • Regular remote antimicrobial ward rounds are performed by the Consultant Microbiologist.<br>• Daily Antimicrobial ward rounds undertaken within Critical Care by Consultant Microbiologist<br>• Data collected on each intervention and feedback given.<br>• Antimicrobial Pharmacist continues to review prescribing and new guidance as appropriate.<br>• Antimicrobial audit in place | None | N/A |
| • mandatory reporting requirements are adhered to and boards continue to maintain oversight | • Mandatory reporting through the Board performance report<br>• Mandatory reporting through the quarterly IPC paper to Quality and Safety Committee<br>• Monthly reporting through Divisional Quality Assurance Groups | None | N/A |
| **4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion** | | | |
| • **Key lines of enquiry** | **Evidence** | **Gaps in Assurance** | **Mitigating Actions** |
| Systems and processes are in place to ensure:<br>• implementation of national guidance on visiting | • National guidance reviewed frequently with discussion at Board and Exec Team on restrictions<br>• Changes communicated through Divisional Teams and via COVID Newsletter. | None | |

| | | | |
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| patients in a care setting | • Visitor disclaimer in use.<br>• Feb 21: Visiting is still subject to covid-19 restrictions but Exec agreed visitors can attend in exceptional circumstances. Decision tree drawn up and agreed by Exec for special circumstances - this includes IPC requirements. | | |
| • areas in which suspected or confirmed COVID-19 patients are being treated in areas clearly marked with appropriate signage and have restricted access | • Blue, yellow, green, cohort bay system in place across as GM with supporting SOP.<br>• Entry to wards is via swipe which restricts unauthorised access.<br>• Colour coded signs for all wards in place.<br>• Signs include key instructions e.g. PPE required and who can enter. Also clear signage in ECC indicating symptomatic and asymptomatic patient areas.<br>• IPC attend bed management meetings and provide advice re patient moves 24/7. | 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.<br>• External website has clear information and advice on https://www.wwl.nhs.uk/ | None | N/A |
| • infection status is communicated to the receiving organisation or department when a 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.<br>• 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.<br>• All patients swabbed every 7 days in line with GM guidance and if no recent swab again 48hours before discharge to nursing or care home | None | N/A |
| • there is clearly displayed and written information available to prompt | • Roller banners are displayed at each entrance to prompt patients, visitors and staff to comply with hands face, space. | None | N/A |

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| patients' visitors and staff to comply with hands, face and space advice. | • Alcohol hand gel/ mask stations are available at hospital and department entrances.<br>• Patient leaflets on in patient swabbing and use of face masks are available and updated March 21. | | |
| **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:<br>• screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases | • Patients are assessed on admission and admitted to the most appropriate bed<br>• All patients attending A/E are screened for COVID-19 symptoms on registration<br>• Patients are further assessed at triage and segregated appropriately<br>• Telephone screening is in place for all elective patients.<br>• SOPs are in place to support NICE Guidance<br>• App in place to show compliance with swabbing on admission, day 4 and day 6. | None | N/A |
| • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from Non COVID- 19 cases to minimise the risk of cross-infection as per national guidance | • As above | None | N/A |
| • staff are aware of agreed template for triage questions to ask | • COVID-19 risk assessment questions included within COVID SOP.<br>• HIS core assessment questions are included in the COVID-19 checklist | None | N/A |
| • triage undertaken by clinical staff who are trained and competent in the clinical case | • Staff within AED have received specific training in relation to COVID-19 clinical case definition.<br>• Pathways of care are defined within the Trust | None | N/A |

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| definition and patient is allocated appropriate pathway as soon as possible | COVID-19 SOP.<br>• 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.<br>• SOP on mask wearing. | None | NA |
| • face masks are available for patients with respiratory symptoms | • FRSMs are available in all clinical areas and at all entrances; all visitors are asked to wear masks as they enter hospital.<br>• There is an SOP on mask wearing.<br>• Patients are asked to wear a mask unless clinically impossible.<br>• There is an information leaflet for patients on masks approved at IPC Committee. | Many patients either refuse to or can't wear masks | Staff asked to ensure patients are sat/lay at least 2m apart and pull curtains if safe to do so.<br>Staff being asked to ensure masks are easily accessible.<br>Additional posters distributed to remind patients.<br>A new SOP with escalation processes is being drawn up to help promote mask wearing amongst inpatients. |
| • provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care | • FRSMs are available in all clinical areas and at all entrances; staff and visitors are requested to wear masks as they enter hospital.<br>• There is an SOP on mask wearing.<br>• Patients are asked to wear a mask unless clinically impossible.<br>• There is an information leaflet for patients on masks approved at IPC Committee.<br>• Feb 21: WWL is to pilot the use of clear plastic curtains (that sit parallel to standard curtains) in ASU (not yet arrived).<br>• Mar 21:patient leaflet updated | Many patients either refuse to or can't wear masks | Staff asked to ensure patients are sat/lay at least 2m apart and pull curtains if safe to do so.<br>Additional posters distributed to remind patients. |

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| • ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff | • Seating rearranged or areas blocked off to ensure segregation.<br>• Floor markings where required.<br>• Hot clinic areas in the community have reduced and have clear signage.<br>• Staff are not utilising patient entrances in order to reduce footfall<br>• Perspex screens were present in AED reception.<br>• Perspex screens required across the organisation reviewed and implemented. | None | N/A |
| • for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative | • COVID SOP in place.<br>• Patient incident forms completed for all HOCI >8days that includes test and trace requirements<br>• IPC carry out daily tracking to monitor patient moves.<br>• IPC attend bed manager meetings each day.<br>• Bay closure spreadsheet maintained by IPC. | No IT system to support tracking patients – currently done manually. | SOP reinforced at times of significant pressure.<br>Business case being revised for IT surveillance system for IPC. |
| • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re- tested and contacts traced promptly | • COVID SOP in place.<br>• Patient Incident forms completed for those patients with hospital onset COVID-19 >8days that includes test and trace requirements<br>• IPC carry out daily tracking to monitor patient moves.<br>• IPC attend bed manager meetings each day.<br>• Bay closure spreadsheet maintained by IPC<br>• Feb 21: Additional swabbing is carried out on outbreak wards. | As above | As above |
| • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately | • In line with departmental SOPs, should patients attend who are symptomatic a risk assessment is undertaken.<br>• All COVID departmental SOPs are sign off by IPC. | None | N/A |

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

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

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| 19 transmission | | | |
| • hand hygiene facilities including instructional posters | • Instructional posters available at all alcohol hand gel stations throughout the hospital and ward/ department entrances.<br>• Guidance is given to all elective patients within the patient information booklet | None | N/A |
| • good respiratory hygiene measures | • Facemasks are available at all hospital and ward/ department entrances.<br>• Roller banners and posters are used to promote mask use and good respiratory hygiene | None | N/A |
| • maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care | • Roller banners and posters used to promote social distancing.<br>• Trust SOPs clearly define the need to maintain 2 metres distance unless wearing PPE as part of patient care.<br>• There are signs on doors to indicate the maximum number of people who should be in the room at any one point.<br>• Floor marking are present in many outpatient areas and keep left signs in corridors | None | N/A |
| • frequent decontamination of equipment and environment in both clinical and non-clinical areas | • Decontamination of the environment within clinical areas included within the Trust COVID-19 SOP.<br>• Facilities audit compliance in clinical areas monthly that are reviewed by IPCC.<br>• Cleaning schedules on the wards. | Unable to comply with Key actions on cleaning | Additional cleaning is being carried out on CPAP ward, ICU and the wards that have COVID outbreaks.<br>For nursing equipment the Ward Cleaning Schedules have been revised and re-issued – they are yet to be audited. |
| • clear advice on use of face coverings and facemasks by patients/ individuals, visitors and by staff in non-patient | • Facemasks are available at all hospital and ward/ department entrances.<br>• Roller banners and posters are used to promote mask use and good respiratory hygiene. | None | N/A |

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| facing areas | | | |
| • staff regularly undertake hand hygiene training and observe standard infection control precautions | • Hand hygiene training is mandatory<br>• Hand hygiene audits take place monthly in all clinical areas and the results are monitored by IPCC and the Board | None | NA |
| • the use of hand air dryers should be avoided in all clinical areas. | • There are no hand dryers in any clinical areas at WWL.<br>• Where hand dryers were available for the public these have been deactivated and replaced with paper towels. | None | N/A |
| • guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas | • Hand hygiene posters are available from IPC and on intranet.<br>• Laminated posters displayed in all areas | None | N/A |
| • staff understand the requirements for uniform laundering where this is not provided for on site | • National guidance has been followed with information for staff on laundering their uniforms<br>• Staff have been updated through the COVID Newsletters | None | N/A |
| • all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE national guidance and other if they or a member of their household display any of the symptoms | • National guidance is being followed and available on the intranet.<br>• Updates are included in the COVID Newsletters.<br>• A drive through facility for staff testing at Leigh and at Wrightington and the phlebotomists can also swab staff as required at RAEI.<br>• IPC liaise closely with H&S and Occupational Health as required.<br>• Mass staff testing took place in October prior to the National scheme<br>• December 20: Staff now have lateral flow kits for twice weekly testing | None | N/A |
| • a rapid and continued response through ongoing surveillance of rates of | • An electronic laboratory reporting process (Queue) provides the IPCT with timely COVID-19 positive results. | None | N/A |

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

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| barriers as appropriate to patients/individuals and staff understand the different risk areas | • Entry to wards is via swipe which restricts unauthorised access. | | |
| • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate | • Patients are currently cohorted on admission into symptomatic or non-symptomatic areas then wards.<br>• Where a designated side room is available this would be used<br>• Once the COVID result is known they are moved to either +ve or –ve ward.<br>• There is an Operational flowchart and COVID SOP.<br>• Reminder at senior meetings, in Newsletters<br>• COVID SOP | There is a risk assessment on lack of siderooms. | Options for clear screens for between inpatient beds are being explored |
| • 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<br>• 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.<br>• IPC guidance on blue, green and yellow wards has been implemented and circulated to all wards<br>• Reinforced through Newsletter<br>• SOP covering all actions required<br>• 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.<br>• Side rooms on non-COVID wards are used for patients requiring isolation for other reasons e.g. MRSA.<br>• C.diff patients are managed on Pemberton ward.<br>• COVID positive CPAP ward has separate SOP. | None | NA |

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| | • Mandatory surveillance data is reported to IPCC and Trust Board. | | |
| **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:<br>• ensure screens taken on admission given priority and reported within 24hrs | • There is a prioritisation system in place at Oldham virology lab which prioritises clinical specimens over staff screening samples but does not differentiate admission screens. | Admission screens are not differentiated. | 18/1/20: Lateral flow done on all patients to be admitted.<br>COVID testing now done at Salford. |
| • regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available | • Dec 20: There is now an App that displays this data on a daily basis now.<br>• 5/1/21: Testing now done at Salford and turnaround times have improved. | Mar 21: Now prevalence has reduced, positive swabs are to be retested before being reported which will increase turnaround times again. | Recommendations made to reduce transit time are in the COVID Reduction plan.<br>Point of care testing is awaited. |
| • testing is undertaken by competent and trained individuals | • The Laboratories used are UKAS accredited | None | N/A |
| • patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance | • Testing is performed in line with national guidance. It is provided by Northern Care Alliance, monitoring of compliance is through contractual discussions.<br>• Trust guidance is in line with NICE recommendations on testing for suspected COVID cases and for other infections.<br>• The HIS tracking board highlights if swabs take longer than 48 hours and highlights when patients need re-swabbing.<br>• System established for antibody testing<br>• March 21: System established for carrying out additional testing on vaccinated patients and for identifying patients who may have new variants. | New Key Actions guidance recommends 'sites with high nosocomial rates should consider testing COVID negative patients daily'. | 11/1/21 – agreed to increase swabbing on outbreak wards to 3 times per week. |

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| • regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data) | • NCA Virology lab as part of their accreditation system.<br>• Errors reported to WWL Microbiologist should these occur. | None | N/A |
| • screening for other potential infections takes place | • National policy is followed for the screening of patients for other infections e.g. MRSA and CPE. | None | N/A |
| **9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections** | | | |
| **Key lines of enquiry** | **Evidence** | **Gaps in Assurance** | **Mitigating Actions** |
| Systems and processes are in place to ensure that:<br>• staff are supported in adhering to all IPC policies, including those for other alert organisms | • IPC Policies and SOPs are approved at IPCC and are on the Intranet and kept up to date.<br>• IPC and microbiology advice is available 24/7.<br>• IPC level 1 and 2 e-learning is mandatory in line with national guidance | None | N/A |
| • any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff | • All new guidance is acted upon in a timely manner<br>• Where necessary SOP's are updated<br>• 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.<br>• 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. | None | N/A |

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| | • PPE store also at Leigh and Wrightington.<br>• 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:<br>• 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.<br>• A comprehensive programme of support has been developed for all staff, including: Access to rest spaces with trained volunteers to provide a listening ear; in-reach support for teams when requested (e.g. at times of higher stress), training for managers in supporting staff; a 24/7 telephone helpline; staff counselling (including remotely); development of roles as clinical wellbeing leads and wellbeing champions; communications and information about self-care and sources of support. This is accessible by all staff, including those who are at-risk. Regarding those staff that are shielding, developing tailored support in addition to the above, in terms of accessing support remotely, and having access to information about supporting positive mental health when shielding.<br>• 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.<br>• Home working supported for all staff where possible. | None | N/A |

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| | • Staff vaccination programme began 23/12/20.<br>• March 21: Working areas for vaccinated high risk staff has been extended | | |
| • that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff | • Personal risk assessments have been completed by line managers with the support of Occupational Health.<br>• Records of the outcomes from the self-declarations forms logged and maintained within HR. | None | N/A |
| • staff required to wear FFP3 reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally | • Face fit testing is available across all acute sites and at one location in the community and is run by the H&S team.<br>• All mask fit testers have been trained in line with national legislation.<br>• A SOP has been developed and shared with all Testers.<br>• Mask fit training records are held centrally.<br>• Some staff cannot wear a close fitting FFP3 mask e.g. due to facial hair. Air powered hoods are available if required. | None | N/A |
| • staff who carry out fit test training are trained and competent to do so | • Fit test training is overseen by the Trust H&S team and conducted by staff who have been trained in line with national legislation and competent to do so | None | N/A |
| • all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used | • Face fit testing sessions are continuing on a regular basis to ensure staff can receive fit test training in the FFP3 masks currently available | Face fit testing continues but the Central Register of staff tested indicates that not all staff are tested to a model that is currently in stock. | The Central Register has been shared with Divisions along with a request to prioritise staff that require retesting, initially those working in positive, symptomatic and asymptomatic, and |

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| | | | where AGPs are undertaken. |
| • a record of the fit test and result is given to and kept by the trainee and centrally within the organisation | • Record of the fit test and result is given to the staff member and mask fit training records are held centrally by the H&S team. | None | N/A |
| • for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods | • Individuals that fail a fit test are tested on an alternative model until options are exhausted. If a secure fit cannot be achieved staff are advised to use a mechanical respirator and hood. Records are kept by the individual and held centrally by the H&S team | None | N/A |
| • for members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm | • Included within the Respiratory Protective Equipment- Training Guidance SOP<br>• Individuals that continue to fail fit tests and are unable to be provided with alternative respirators and hoods are provided with the opportunity for redeployment in line with Occupational Health and HR policies.<br>• The Trust has a designated Redeployment team who oversee staff skill mix, knowledge and experience | None | N/A |
| • a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health | • Documented records of staff redeployment are kept in line with Occupational Health and HR policies | None | N/A |
| • following consideration of reasonable adjustments e.g. respiratory hoods, personal re- usable FFP3, staff who are unable to | • Documented records of staff redeployment are kept in line with Occupational Health and HR policies | None | N/A |

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| 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 | | | |
| • Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board | • A centrally held mask fit register is maintained and is available. | A member of the Board had weekly oversight of a summary of the register during the first wave. | Advice from the Director of Corporate affairs will be sought on the best mechanism for this regular review. |
| • consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent / emergency care pathways as per national guidance | • Healthroster system used for nurses which includes Staff risk status.<br>• Medical rotas for medical staff.<br>• Where safe and practicable staff are only moved between similar colour coded areas in response to acuity and dependency of patients. There has also been a reduction in the volume of temporary staff working across the Trust.<br>• Head of E&F reviewed non-clinical staff allocation but it was not possible to achieve everywhere. | Some staff do have to move between different areas on a daily basis. This includes circulating staff such as porters and phlebotomists. | Staff are trained in the use of PPE and carry hand gel.<br>Guidance for circulating staff is included in colour coded ward guidance on ward entrances. |
| • all staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas | • National guidance has been adopted and promoted. Staff reminded regularly via Newsletters and Posters. Also in COVID SOP.<br>• Office space has been redesigned to ensure social distancing.<br>• All community premises have been reviewed for social distancing and a number of work areas have been designated as no longer in use. | Learning from recent outbreaks identifies areas at risk are break and staff rooms | Action being taken to review all areas again and guidance reiterated to all staff via variety of communications.<br>All staff are expected to wear masks on |

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| | • Wards asked to include minimum numbers at staff handovers. | | trust sites inside and outside action being taken to enact this. |
| • health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone | • Space planning exercise undertaken at the start of the pandemic.<br>• Maximum staff allowance per room assessments completed and supportive guidance provided to Departmental managers<br>• Environmental risk assessments completed | Lessons learnt form outbreaks have identified that improvements are still required in social distancing within non-clinical areas, e.g. offices, break rooms. | Social distancing, care sharing rules re-emphasised through senior meetings and Trust Newsletter and COVID Safety Champions. |
| • staff are aware of the need to wear facemask when moving through COVID-19 secure areas | • Trust SOP for Masks in place and circulated to all departments. Regular reminders given at senior nursing and medical meetings for cascade, provided within Trust Newsletters and by the use of posters and roller banners. | None | None |
| • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing | • Staff absence is recorded for payroll purposes through e-roster and through e-SVLs. This means that data taken from ESR can be 4/6 weeks in arrears. In order to comply with the daily SITREP requirements, absence data is recorded either in spreadsheets submitted by Divisional representatives or from the e-roster.<br>• E-roster is currently rolled out to the majority of nurses and some AHPs.<br>• 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.<br>• The Trust continues to actively manage and support | Workforce data flows and the lack of accurate real time workforce data is on the corporate risk register (HR126), scoring 15. | Empactis absence management system to be introduced |

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| | staff through attendance management procedures. The Strategic HR lead completes a monthly review of all long-term sickness absence cases with HR Business Partners. Staff have access to COVID-19 swab tests via a Trust drive through facility at Leigh along with tests through regional centres and home testing. All staff who require swab tests can be accommodated and this has been communicated through internal mechanisms.<br>• December 20: All staff have been offered own lateral flow testing kit.<br>• Jan 21: Central Unplanned Absence Team established to contact staff on first day of absence and support managers.<br>• 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.<br>• 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 | N/A |

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| **Title of report:** | Register of referrals received by the Clinical Ethics Group |
| **Presented to:** | Board of Directors |
| **On:** | 31 March 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 have been no new referrals 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 March 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 |

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

| | |
|---|---|
| **Title of report:** | Monthly Trust Financial Report – Month 11 (February 2021) |
| **Presented to:** | Finance and Performance Committee |
| **On:** | 29th March 2021 |
| **Presented by:** | Ian Boyle [Chief Finance Officer] |
| **Prepared by:** | Heather Shelton [Head of Financial Management] |
| **Contact details:** | T: 01942 77 (3759) E: heather.shelton@wwl.nhs.uk |

**Executive summary**

| | In Month | | | Year to Date | | |
|---|---|---|---|---|---|---|
| | Actual £000's | Revised Plan £000's | Var £000's | Actual £000's | Revised Plan £000's | Var £000's |
| Income | 38,938 | 33,634 | 5,304 | 390,606 | 382,449 | 8,157 |
| Expenditure | (34,842) | (35,903) | 1,061 | (385,910) | (387,241) | 1,331 |
| Financial Performance | 2,924 | (3,313) | 6,236 | (7,164) | (16,365) | 9,201 |
| Cash Balance | 67,560 | 42,847 | 24,713 | 67,560 | 42,847 | 24,713 |
| Capital Spend | 1,452 | 1,388 | (64) | 24,953 | 19,016 | (5,937) |

## Key Messages:

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

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

The WWL Way

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

- The Trust is reporting a surplus of £2.9m in month and a deficit of £7.2m year to date.

- Cash is £67.6m at the end of Month 11.

- Capital spend is £25.0m year to date. This includes £7.4m on COVID-19 associated projects which will be fully reimbursed via non-interest bearing PDC.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

| | |
|---|---|
| **Title of report:** | Gender Pay Gap Report |
| **Presented to:** | Board of Directors |
| **On:** | 31 March 2021 |
| **Presented by:** | Consent Agenda |
| **Prepared by:** | Lyndsay Wallwork, Senior HR Business Partner |
| **Contact details:** | Lyndsay.Wallwork@wwl.nhs.uk |

**Executive summary**

This report provides an analysis of the Trust`s Gender Pay Gap information as at 31 March 2020 and is the fourth round of annual mandatory reporting the Trust has undertaken.

The data highlights as at 31 March 2020 the Trust has a 31.46% mean average gender pay gap with females earning **£6.86 an hour less** than males. As at March 2020 the Trust has a 15.13% median hourly rate gender pay gap with females earning **£2.53 an hour less** than males. This position has improved in comparison with 2018 & 2019 data.

A key factor underpinning the Trust`s gender pay gap is due to a significant proportion of male staff being constituted within the Medical & Dental staff group which is within the higher earning quartiles. If we exclude Medical & Dental staff from the Trust wide gender pay gap figures the Trust`s mean average gender pay gap is **3.16%** which equates to females earning **0.48pence** less than male staff per hour. Section 2.4 of the report provides granular analysis of the pay gap at staff group level.

As at 31st March 2020 male staff proportionately continue to be heavily constituted within the highest earning quartile (quartile 4) with **35.62%** of all male staff being situated within quartile 4 when they represent **19%** of the overall Trust workforce. A key factor is due to the Medical & Dental workforce being predominantly male at 74% and this staff group are predominantly constituted within the highest earning quartile.

As at 31st March 2020 female staff proportionately continue to have lower representation in the highest earning quartile at 70.6% compared with female staff representing 79% of the overall workforce. However, this is an improved position from 2019 report when female staff represented 64.3% of the highest earning quartile.

The 2020 bonus gender pay gap highlights an improving position over a 4-year timeframe with a mean gender pay gap of **53.6%** in 2020 compared with **75%** in 2017. The bonus pay is primarily related to clinical

excellence awards that are awarded to recognise and reward Consultants who perform `over and above` the standard expected in their role

Gender Pay Gap actions are included within the Inclusion & Diversity Objectives which has been submitted as a separate paper for consideration and approval by the Committee.

**Link to strategy**

People Strategy

**Risks associated with this report and proposed mitigations**

**Financial implications**

There are possible risks of employment tribunal claims relating to discrimination arising from the gender pay gap which would have financial implications in terms of legal and compensation costs. However, to date no claims of this nature have arisen within the Trust.

**Legal implications**

As noted above there are possible risks of employment tribunal claims relating to discrimination arising from the gender pay gap. To date no claims of this nature have arisen within the Trust.

**People implications**

Gender Pay Gap is a complex issue and there are many contributing factors including external societal factors and internal workforce factors. The people issues which arise from the gender pay gap are wide ranging and at the heart of this issue is fairness and equality of opportunity for female staff within the organisation. Actions which respond to the gender pay gap are included within the Inclusion & Diversity Objectives which has been submitted as a separate paper for consideration and approval by the Committee.

**Wider implications**

It is noted there are possible risks of adverse publicity being generated due to the Trust`s gender pay gap, however, to date no publicity of this nature has arisen in response to the publishing of the Trusts previous Gender Pay Gap data over the past 3 years.

**Recommendation(s)**

The Committee is recommended to receive the report and approve the Gender Pay Gap reporting for national reporting.

**Statutory Gender Pay Gap Reporting**

## 1 Background

On the 31 March 2017, it became mandatory for public sector organisations with more than 250 employees to report annually on their gender pay gap.

The gender pay gap differs from equal pay and the two terms are not interchangeable. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

The gender pay gap shows the differences in the **average pay** between men and women. If a workplace has a particularly high gender pay gap, this can indicate there may a number of issues to deal with, and the individual calculations may help to identify what those issues are.

The Trust is obliged to publish the following information on our public-facing website and report to government by the 31st March 2021:

- The difference between the mean hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees ( 'the mean gender pay gap');
- The difference between the median hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees ('the median gender pay gap');
- The difference between the mean bonus pay paid to male relevant employees and that of female relevant employees ('the mean gender bonus gap');
- The difference between the median bonus pay paid to male relevant employees and that of female relevant employees ('the median gender bonus gap')
- The proportions of male and female relevant employees paid bonus pay ('the proportions of men and women getting a bonus'); and
- The proportions of male and female relevant employees in the lower, lower middle, upper middle and upper quartile pay band ('the proportion of men and women in each of four pay quartiles').

## 2 Gender Pay Gap Reporting Key points

Appendix 1 includes a full copy of the Trust`s Gender Pay Gap information which has been obtained from the Electronic Staff Record (ESR) standard reports. The ESR standard reports are nationally produced to ensure the NHS meet their gender pay gap reporting requirements and the reporting period for the gender pay gap data is as at 31 March 2020.

2.1 Key Points to note are:

- The Trust workforce is 81% female and 19**%** male
- The Trust Medical & Dental workforce is 69% male and 31% female with 26% of the Trust`s overall male workforce being constituted within the Medical & Dental staff group
- As at March 2020 the Trust has a 31.46% mean average gender pay gap with females earning **£6.86 an hour less** than males. The mean average gender pay gap in 2020 has improved in comparison with 2019 data when as at 31st March 2019 females earned **£7.92 an hour** less than males with a 35.53% mean average gender pay gap
- As at March 2020 the Trust has a 15.13% median hourly rate gender pay gap with females earning **£2.53 an hour less** than males. The median gender pay gap in 2020 has improved in comparison with 2019 data when as at 31 March 2019 females earned **£3.09 an hour less** than males with a **19.98%** median gender pay gap.

- As at 31st March 2020 **29.42%** of male staff are situated within the highest earning quartile (quartile 4) compared with male staff representing 19% of the overall workforce. A key factor is due to the Medical & Dental workforce being predominantly male at 69% and this staff group are predominantly constituted within the highest earning quartile.
- As at 31st March 20 female staff proportionately continue to have lower representation in the highest earning quartile at 70.58% compared with female staff representing 79% of the overall workforce. This position has improved compared with March 2019 data when 64.38% of female staff were constituted within quartile 4.
- The 2020 bonus pay highlights an improving position over a 5-year timeframe with an average bonus gender pay gap of **65%** in 2017, **60%** in 2018, **55%** in 2019 and 53% in 2020. The median gender pay gap is **75%** in 2017, **71.05%** in 2018, **55.56%** in 2019 and **35.93%** in 2020. The bonus pay is primarily related to clinical excellence awards that are awarded to recognise and reward Consultants who perform `over and above` the standard expected in their role. It should be noted the Consultant workforce is predominantly male at 76.3%.

## 2.2 Gender Pay Gap Granular reporting

In response to the gender pay gap reporting the Trust has undertaken a granular analysis of the gender pay gap data by staff group to identify any hot spot areas. Medical & Dental and Administrative & Management staff groups continue to be areas where gender pay is a particular concern.

The medical & dental staff group has a 23.42% mean gender pay gap with female medical & dental staff earning **£9.43 per hour less** than male medical & dental staff. This is due to female medical & dental staff being primarily constituted within this staff group`s lower pay quartiles with only 13.9% of female medical & dental staff being constituted within the medical & dental highest pay quartile (quartile 4).

If we exclude Medical & Dental staff from the Trust wide gender pay gap figures the Trust`s mean gender pay gap is **3.16%** which equates to females earning **0.48pence** less than male staff per hour. This compares with the Trust`s overall gender pay gap (inclusive of Medical & Dental staff) of 31.46% which equates to females earning **£6.86 an hour less than male staff.**

An analysis of the gender pay gap for the Administrative & Management staff group highlights this staff group has a 29.28% average pay gap with female administrative & management staff earning **£5.25 an hour less** than male administrative & management staff. Males within this staff group are significantly constituted within the highest pay quartile at 43.6% male in quartile 4 compared with 12% male in quartile 1, 8% male in quartile 2 and 27% male in quartile 3.

It should be noted that in a number staff groups there is a negative pay gap ie. females earn more than males and these are within Additional Clinical Services staff group (includes HCA, Nursing Auxiliaries, ST & T Assistants) with a -4.65% pay gap (females earn **48 pence** more than male staff per hour), Allied Health Professionals staff group -1.36% pay gap (females earn **25pence** more than male staff per hour) and Healthcare Scientists staff group -11.52% pay gap (females earn **£1.91** more than male staff per hour).

**Appendix 1**
**Gender Pay Gap Report summary data**
**As at 31st March 2020**

### 2.1 Table 1- Average & Median Hourly rate

| Gender | Avg. Hourly Rate | Median Hourly Rate |
|---|---|---|
| Male | £21.84 | £15.54 |
| Female | £14.94 | £13.19 |
| Difference | £6.86 | £2.35 |
| Pay Gap % | 31.46% | 15.14% |

### 2.1.1 Average Hourly rate

As at 31st March 2020 the Trust has a 31.46% mean average gender pay gap with females earning **£6.86 an hour less** than males. In comparison with March 2019 data the mean average pay gap has improved and as at 31 March 2019 females earned **£7.92 an hour less** than males with a 35.53% mean average gender pay gap.

### 2.1.2 Median Hourly rate

As at 31st March 2020 the Trust has a 15.14% median hourly rate gender pay gap with females earning **£2.35 an hour less** than males. In comparison with March 2019 data the median gender pay gap in 2020 has improved and as at 31 March 2019 females earned **£3.09 an hour less** than males with a 19.98% median gender pay gap.

### 2.2 Table 2- % male and female employees in each pay quartile

| Quartile | Female | Male | Female % | Male % |
|---|---|---|---|---|
| 1 | 1258 | 244 | 83.75% | 16.26% |
| 2 | 1267 | 240 | 84.07% | 15.93% |
| 3 | 1301 | 204 | 86.45% | 13.55% |
| 4 | 1063 | 443 | 70.58% | 29.42% |

This calculation requires an employer to show the proportions of male and female full-pay relevant employees in four quartile pay bands with quartile 1 being the lowest paid and quartile 4 being the highest paid. All employees are placed into the cumulative order according to their pay which is undertaken by dividing the workforce into 4 equal parts.

Compared with quartiles 1-3 males are most highly constituted within quarter 4 at 29.42% compared with an average of between 13.55%- 16.25% within the other quartiles. Comparatively the reverse is true for females and they constitute 70.58% of quartile 4 compared with an average of between 83.75%- 86.45% within the other quartiles.

The information compares % within the individual quartiles. However, if we review the broader picture comparing the overall workforce constitution there are 1131 male employees and of these 443 are within

quartile 4 which represents 39.2% of all male employees. Comparatively of 4889 female employees only 808 females are constituted within quartile 4 which represents only 21.7% of all female employees.

In comparison with 2019 reporting there have been improvements in the composition of females within the pay quartiles, namely increases of female staff within quartiles 2- 4 in the 2020 reporting data.

**2.3 Bonus information**

**Table 3**

| Gender | Avg. Pay | Median Pay |
|---|---|---|
| Male | £16,069.02 | £9,414.18 |
| Female | £7,459.01 | £6,032.04 |
| Difference | £8,610.01 | £3,382.14 |
| **Pay Gap %** | **53.58%** | **35.93%** |

**Table 4**

| Gender | Employees Paid Bonus | Total Relevant Employees | % |
|---|---|---|---|
| **Female** | 9.00 | 5236 | 0.17% |
| **Male** | 80.00 | 1186 | 6.75% |

The data in tables 3 & 4 relates to clinical excellence awards for medical staff as this is the only payment identified within the ESR standard report which falls within the set definition of `bonus pay`. Clinical Excellence Awards recognise and reward Consultants who perform `over and above` the standard expected in their role. The payments within the Trust`s bonus information contains both local and national Clinical Excellence Awards. The Local CEA`s are administered within the Trust on an annual basis and the national CEAs are determined externally and administered by the Department of Health.

The data highlights that the average bonus pay gap for females as at March 2020 is 53.58% and the median pay gap is 35.93%. In comparison with March 2019 the position has improved and as at 31st March 2019 there was 55% average bonus pay gap and 55.56% median pay gap. As at 31st March 2020 0.17% of female staff received a bonus payment in comparison with 6.75% of male staff. When reviewing these figures consideration should be given to the overall consultant workforce profile which is predominately male at 76.3%.

# Slavery and human trafficking statement

Wrightington, Wigan and Leigh Teaching Hospitals NHS FT ("WWL") is an NHS foundation trust, providing acute hospital and community care to the population of Wigan Borough and beyond. Each year we treat over 87,000 inpatients and over 480,000 outpatients and we deal with around 94,000 Emergency Department attendances. We also provide around 44,000 walk-in centre appointments and deal with over 177,000 referrals from GPs. We employ over 6,000 members of staff and have an annual turnover of c.£397m. Further detail about what we do can be found on our website.

**Policies and initiatives**

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

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

At WWL, we:

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

For our workforce, we:

- Confirm the identities of all new employees and their right to work in the United Kingdom, and pay our employees in line with national terms and conditions, such as Agenda for Change
- Have dedicated policies in relation to grievances and raising concerns and we have a good working relationship with our staff side partners which gives our employees an outlet to raise any concerns about poor working practices
- Have an independent Freedom to Speak Up Guardian that colleagues can contact in person, by telephone or email to raise concerns about their own circumstances or those of others

For procurement and our wider supply chain, we:

- Encourage suppliers and contractors to take their own action and understand their obligations under the Modern Slavery and Human Trafficking Act 2015
- Ensure that due diligence is carried out prior to selecting new suppliers to work with us
- Provide information and support to suppliers who have been identified as not following this best practice
- Reserve the right to end business relationships where suppliers have failed to meet their obligations and/or meet our ethical standards

The procurement team will:

- Wherever possible, include the use of selection and award criteria with an appropriate weighting given to modern slavery criteria in tenders
- Aim to check and draft specifications to include a commitment from suppliers to support the requirements of the Act
- Will not award contracts where suppliers will not commit to complying with the Act
- Continue to support the use of regional and national public sector frameworks which incorporate selection and award criteria to support goals of the Act

During the financial year 2021/2022, we will:

- Ensure that all procurement staff undertake modern slavery and human trafficking training to raise awareness of this important issue within the team and the wider organisation
- Not award contracts where suppliers cannot commit to complying with the Act
- Review our terms and conditions of business to ensure that they reflect our obligations under the Act
- Undertake an audit of our supply chain with the aim of ensuring that all suppliers meet the obligations of the Act and to identify high-risk categories within our supply chain so that we can work with the suppliers who provide these goods and/or services to ensure they have robust processes in place

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 31 March 2022.

The Board approved this statement at its meeting on 31 March 2021.

Signed: _____

**Silas Nicholls**
**Chief Executive**

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

| | |
|---|---|
| **Title of report:** | Use of the common seal during FY2020/21 |
| **Presented to:** | Board of Directors |
| **On:** | 31 March 2021 |
| **Presented by:** | Director of Corporate Affairs |
| **Prepared by:** | Director of Corporate Affairs |
| **Contact details:** | T: 01942 822027 E: paul.howard@wwl.nhs.uk |

**Executive summary**

This report outlines the occasions on which the foundation trust's common seal has been applied during financial year 2020/21.

**Link to strategy**

There is no link to the organisational strategy.

**Risks associated with this report and proposed mitigations**

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

**Financial implications**

There are no financial implications arising from this report.

**Legal implications**

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

**People implications**

There are no people implications arising from this report.

**Wider implications**

There are no wider implications to highlight.

The WWL Way

**Recommendation(s)**

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

## 1. Background

1.1. All foundation trusts are required to have a common seal.[1] The constitution of Wrightington, Wigan and Leigh Teaching Hospitals NHS FT provides that the seal shall only be affixed under the authority of the Board of Directors. [2] The Board has previously resolved that attestation by any two directors shall be deemed to be affixing the seal under the board's authority.[3]

1.2. A seal must be applied in order for the foundation trust to execute documents as a deed. Certain types of document are not legally binding unless they are executed by deed; the most common being those that deal with transfers of land, some leases or tenancies, mortgages, powers of attorney and certain business agreements. It can also sometimes be beneficial to execute other documents as a deed rather than as a simple contract because the time limit for bringing a claim under a deed is double the time limit for a simple contract (12 years as opposed to 6 years).

1.3. The board has reserved to itself responsibility for reviewing the use of the common seal, and this report is presented in order to satisfy that requirement.

## 2. USE OF THE COMMON SEAL

2.1. Since the last report to the board, the common seal of Wrightington, Wigan and Leigh Teaching Hospitals NHS FT has been applied on 3 occasions, as shown in the table below:

| Seal № | Date seal applied | Description of document | Use attested by: |
|---|---|---|---|
| 01 | 1 Sep 2020 | JCT Minor Works Building Contract between Wrightington, Wigan and Leigh NHS FT as the employer and Schofield and Sons Ltd as the contractor in relation to the formation of a new café and entrance area at Wrightington Hospital | 1. A. Balson<br>2. R Mundon |
| 02 | 6 Oct 2020 | Deed of assignment of copyright between PDH Advisory Ltd and Wrightington, Wigan and Leigh Teaching Hospitals NHS FT | 1. S Nicholls<br>2. A Balson |
| 03 | 9 Nov 2020 | Agreement between Veolia Energy and Utility Services UK PLC and Wrightington, Wigan and Leigh NHS FT, subsequent to a JCT Design and Build contract dated 2 October 2020 | 1. A. Balson<br>2. R Mundon |

2.2. All occasions on which the common seal is applied are recorded in a register which is held by the Director of Corporate Affairs. This is available for inspection by directors on request.

[1] Sch.7, para.29(1) National Health Service Act 2006

[2] At Paragraph 20.2

[3] On 29 May 2019 (minute reference 100/19)

## 3. RECOMMENDATIONS

3.1. The board is recommended to note the occasions on which the common seal has been applied during financial year 2020**/**21**.**

# Register of directors' interests as at 26 March 2021

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

| Name | Role | Any interest or position held in any firm, company or business which has or is likely to have a trading or commercial relationship with the FT | Interest in an organisation providing health and social care services to the NHS | Position of authority in a charity or voluntary organisation in the field of health and social care | Any connection with any organisation, entity or company considering entering into a financial arrangement with the FT | Details of any secondary employment (executive directors only) |
|---|---|---|---|---|---|---|
| **NON-EXECUTIVE DIRECTORS** | | | | | | |
| **ARMSTRONG, Robert** | Chair | Vice-Chair, Belong at Home Limited (CRN: 06802726) | Vice-Chair, Belong at Home Limited (CRN: 06802726); Director, Borough Care Services Limited (CRN: 02603702) | Co-Chair of Governance, Centre of Excellence Safety of Older People CIC (Reg. No.: 12554455)<br>Chair, ACCEA NE Sub-Committee | Nil | N/A |
| **AUSTIN, Clare** | Non-Executive Director | Associate Dean, Research and Innovation and Director of Medical School, Faculty of Health, Social Care and Medicine, Edge Hill University | Nil | Nil | Associate Dean, Research and Innovation and Director of Medical School, Faculty of Health, Social Care and Medicine, Edge Hill University | N/A |
| **BRADLEY, Rhona** | Non-Executive Director | Nil | Non-Executive Director, Home Group Housing Authority | Chief Executive and Company Secretary, Addiction Dependency Solutions (CRN: 01990365, charity number: 702559) \| Director and trustee, The London Pathway (CRN: 07210798, charity number: 1138741) | Nil | N/A |
| **ELLIOT, Steven** | Non-Executive Director | Cancer lead, NHS Salford CCG<br>Partner is a director of Health First ALW and Wigan GP Alliance LLP (Reg. No.: OC411316) | Non-Executive Director at Health First ALW CIC (Reg. No. 07576630)<br>Wife is a director of Health First ALW and Wigan GP Alliance LLP (Reg. No.: OC411316) | Nil | Cancer lead, NHS Salford CCG<br>Medical Advisor, NHS England<br>GP Partner, Westleigh Practice<br>Wife is director of Wigan GP Alliance LLP (Reg. No.: OC411316) | N/A |
| **GUYMER, Michael** | Non-Executive Director | Director, One Redwood Limited (CRN: 08599564) | Nil | Member, NHS Procurement Customer Board \| Chair, NHS Northern Procurement Customer Board | Nil | N/A |
| **HAYTHORNTHWAITE, Ian** | Non-Executive Director | Nil | Nil | Nil | Nil | N/A |
| **LOBLEY, Lynne** | Non-Executive Director (Senior Independent Director) | Nil | Nil | Nil | Nil | N/A |
| **WARNE, Anthony** | Non-Executive Director (Vice-Chair) | Nil | Professor Emeritus, University of Salford<br>Non-Executive Director, Blackpool Teaching Hospitals NHS FT | Nil | Nil | N/A |

| Name | Role | Any interest or position held in any firm, company or business which has or is likely to have a trading or commercial relationship with the FT | Interest in an organisation providing health and social care services to the NHS | Position of authority in a charity or voluntary organisation in the field of health and social care | Any connection with any organisation, entity or company considering entering into a financial arrangement with the FT | Details of any secondary employment (executive directors only) |
|---|---|---|---|---|---|---|
| **EXECUTIVE DIRECTORS** | | | | | | |
| **ARYA, Sanjay** | Medical Director | Nil | Wife is General Practitioner in Bolton | Member of Executive Committee, British International Doctors' Association and Bihar Jharkhand Medical Association (voluntary) | Nil | Private practice (out of hours) |
| **BALSON, Alison** | Director of Workforce | Nil | Nil | Nil | Nil | Nil |
| **BOYLE, Ian** | Chief Finance Officer | Nil | Nil | Nil | Nil | Nil |
| **FLEMING, Mary** | Chief Operating Officer | Nil | Nil | Nil | Nil | Nil |
| **HOWARD, Paul** | Director of Corporate Affairs | Director, PDH Advisory Ltd (CRN: 09800579)<br>Governor, Wigan and Leigh College | Nil | Nil | Nil | Nil |
| **MILLER, Anne-Marie** | Director of Communications and Stakeholder Engagement | Nil | Nil | Nil | Nil | Nil |
| **MUNDON, Richard** | Director of Strategy and Planning | Nil | Nil | Nil | Nil | Nil |
| **NICHOLLS, Silas** | Chief Executive | Nil | Nil | Nil | Nil | Nil |
| **TINDALE, Rabina** | Chief Nurse | Nil | Nil | Nil | Nil | Nil |

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

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|---|---|
| **Title of report:** | Directors' fit and proper person checks |
| **Presented to:** | Board of Directors |
| **On:** | 31 March 2021 |
| **Presented by:** | Director of Corporate Affairs |
| **Prepared by:** | Deputy Company Secretary |
| **Contact details:** | T: 01942 778855 E: hollie.holding@wwl.nhs.uk |

**Executive summary**

It is a requirement of the foundation trust's provider licence that no "unfit person" may be appointed as a director without the written approval of NHS Improvement. The foundation trust is also required to ensure that its directors' contracts contain a provision permitting summary termination in the event of them being or becoming an unfit person and to enforce that provision promptly upon discovering them to be an unfit person, except with the written approval of NHS Improvement. The board will wish to note that this is included in all directors' contracts.

Similarly, Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires the foundation trust not to appoint or have in place as a director someone who does not meet the requirements stated within the Regulation.

All directors complete a "fit and proper person" declaration each year to confirm their continuing compliance with the requirements. In addition, independent checks against information in the public domain are undertaken each year. Professional registration checks are undertaken for posts where such registration was included in the person specification as an essential requirement of the role. Fitness to practice checks are also undertaken for those with clinical registration.

The results of these checks are shown in the attached table and the board can be assured that no areas of concern have been identified.

**Link to strategy**

There is no link to the organisational strategy.

**Risks associated with this report and proposed mitigations**

The content of this report is intended to mitigate the risk of breaching the terms of the foundation trust's provider licence or the Regulation shown above.

**Financial implications**

There are no financial implications arising from this report.

**Legal implications**

The content of this report relates to a legal requirement and serves to provide assurance as to the organisation's compliance.

**People implications**

There are no people implications arising from this report.

**Wider implications**

There are no wider implications to highlight.

**Recommendation(s)**

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

# Directors' fit and proper person checks 2021

| Name | Role | Self-declaration received? | Search of register of disqualified directors | Search of bankruptcy and insolvency register | Search of register of disqualified and removed charity trustees | General search of public information via internet search engine | Professional registration checks |
|---|---|---|---|---|---|---|---|
| **NON-EXECUTIVE DIRECTORS** | | | | | | | |
| **ARMSTRONG, Robert** | Chair | ✔ | No match | Entry with the same name but for an individual with a different date of birth and location. No match | No match | No adverse information identified | N/A |
| **AUSTIN, Clare** | Non-Executive Director | ✔ | No match | Entry with the same name but for an individual with a different date of birth and location. No match | No match | No adverse information identified | N/A |
| **BRADLEY, Rhona** | Non-Executive Director | ✔ | No match | No match | No match | No adverse information identified | N/A |
| **ELLIOT, Steven** | Non-Executive Director | ✔ | No match | Entry with the same name but for an individual with a different date of birth and location. No match | No match | No adverse information identified | GMC registration confirmed and no fitness to practise issues identified. |
| **GUYMER, Michael** | Non-Executive Director | ✔ | No match | No match | No match | No adverse information identified | N/A |
| **HAYTHORNTHWAITE, Ian** | Non-Executive Director | ✔ | No match | No match | No match | No adverse information identified | N/A |
| **LOBLEY, Lynne** | Non-Executive Director (Senior Independent Director) | ✔ | No match | No match | No match | No adverse information identified | N/A |
| **WARNE, Anthony** | Non-Executive Director (Vice-Chair) | ✔ | No match | No match | No match | No adverse information identified | N/S |

| Name | Role | Self-declaration received? | Search of register of disqualified directors | Search of bankruptcy and insolvency register | Search of register of disqualified and removed charity trustees | General search of public information via internet search engine | Professional registration checks |
|---|---|---|---|---|---|---|---|
| **EXECUTIVE DIRECTORS** | | | | | | | |
| **ARYA, Sanjay** | Medical Director | ✔ | No match | No match | No match | No adverse information identified | GMC registration confirmed and no fitness to practise issues identified. |
| **BALSON, Alison** | Director of Workforce | ✔ | No match | No match | No match | No adverse information identified | ✔ |
| **BOYLE, Ian** | Chief Finance Officer | ✔ | No match | Entry with the same name but for an individual with a different date of birth and location. No match | No match | No adverse information identified | CIPFA membership verified. |
| **FLEMING, Mary** | Chief Operating Officer | ✔ | No match | Entry with the same name but for an individual with a different date of birth and location. No match | No match | No adverse information identified | N/A |
| **HOWARD, Paul** | Director of Corporate Affairs | ✔ | No match | Multiple entries with the same name but for individuals with different dates of birth and locations. No match | No match | No adverse information identified | N/A |
| **MILLER, Anne-Marie** | Director of Communications and Stakeholder Engagement | ✔ | No match | No match | No match | No adverse information identified | N/A |
| **MUNDON, Richard** | Director of Strategy and Planning | ✔ | No match | No match | No match | No adverse information identified | N/A |
| **NICHOLLS, Silas** | Chief Executive | ✔ | No match | No match | No match | No adverse information identified | N/A |
| **TINDALE, Rabina** | Chief Nurse | ✔ | No match | No match | No match | No adverse information identified | NMC registration confirmed and no fitness to practise issues identified. |

| | |
|---|---|
| **Title of report:** | Board Diversity Policy |
| **Presented to:** | Board of Directors |
| **On:** | 31 March 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**

At its meeting on 27 May 2020, the Board of Directors approved its first Board Diversity Policy and agreed that it would be reviewed on an annual basis. That review is being undertaken slightly earlier than the anniversary of its initial approval to allow the review to coincide with the start of the new financial year. One minor change is proposed and is highlighted in red on the attached document.

**Link to strategy**

One of the strategic priorities of the organisation is to be an employer of choice. One of the fundamental parts of the WWL People Promise – Employment Essentials – confirms that we will value and embrace diversity and create a workplace where everyone can flourish. The content of the report supports this approach at board-level.

**Risks associated with this report and proposed mitigations**

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

**Financial implications**

There are no financial implications arising from this report.

**Legal implications**

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

**People implications**

Operation of this policy is intended to result in positive people implications.

**Wider implications**

There are no wider implications to highlight.

**Recommendation(s)**

The Board of Directors is recommended to approve the Board Diversity Policy as presented.

# Board Diversity Policy

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

## 1. Introduction and scope

1.1. At Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust we are committed to the principles of equality, diversity and inclusion, both across the organisation and at board level. We recognise the benefit and value of diversity and we are committed to the creation of an inclusive culture where everyone has the opportunity to achieve their potential.

1.2. This policy applies specifically to the Board of Directors and there are separate policies which cover diversity and inclusion across our wider workforce.

## 2. How appointments are made

2.1. The appointment of executive directors is the responsibility of the Remuneration Committee, which comprises all non-executive directors and the Chief Executive (except in relation to the appointment of a Chief Executive where it comprises the non-executive directors alone) and the committee acts under delegated authority from the board. The appointment of a Chief Executive also requires the approval of the Council of Governors.

2.2. Non-executive directors are appointed by the Council of Governors at a general meeting. Recommendations as to appointment are provided by a dedicated committee, the Nomination and Remuneration Committee, which oversees the recruitment process on the council's behalf.

2.3. The Remuneration Committee's terms of reference require it to regularly review the structure, size and composition of the board (including the balance of skills, knowledge and experience) and to make recommendations to the board or the Nomination and Remuneration Committee of the Council of Governors for any changes.

2.4. The terms of reference of the Nomination and Remuneration Committee require it to periodically review the balance of skills, knowledge, experience and diversity of the non-executive directors and, having regard to the views of the board and relevant guidance on board composition, make appropriate recommendations to the Council of Governors.

## 3. Policy statement

3.1. We believe that a broad range of skills, backgrounds, knowledge and experience is a key component of an effective board.

3.2. All appointments to the board will be made on merit against objective criteria, in the context of the overall balance of skills and backgrounds that the board needs to maintain in order to remain effective. Protected characteristics will be taken into consideration generally when evaluating the skills, knowledge and experience desirable to fill each board-level vacancy.

3.3. This policy sets out the process to be followed by the Remuneration Committee (for executive director vacancies) and the Council of Governors through its Nomination and Remuneration Committee (for non-executive director vacancies) during the recruitment process in order to attract candidates from diverse backgrounds who would enhance the balance of skills and backgrounds on the board.

**4. Encouraging candidates from different backgrounds**

4.1. The relevant committee will encourage the participation of candidates from diverse and under-represented backgrounds during recruitment processes in the following ways:

- when using an executive search firm, we will seek to engage one that is a signatory to the Executive Search Firms' Voluntary Code of Conduct;
- we will ensure that the brief given to the search firm (where used) and the candidate information pack include appropriate emphasis on diversity of skills and background, independence of approach and other personal qualities in addition to the usual requirements around career experience and compatibility with the values and behaviours of the organisation with a view to enhancing the overall effectiveness of the board;
- we will work with the search firm (where used) to design an inclusive search process that is open and accessible to candidates from any background and which encourages the widest possible field, and we will do this ourselves where the vacancy is managed in-house;
- we will ensure that we use inclusive language in all of our advertising and other recruitment media;
- we will encourage the search firm (where used) to produce long lists which include candidates from under-represented backgrounds of appropriate merit, and we will do so ourselves where the vacancy is managed in-house;
- we will consider high-performing senior executives from under-represented backgrounds who may not have previous board experience in executive and non-executive director roles, subject to the requirement for potential candidates to meet minimum requirements;
- we will ensure that all voting members of the final interview panel have completed appropriate training in recruitment which includes issues such as unconscious bias; and
- we will ensure that our interview panels are in themselves diverse.

4.2. Both committees are responsible for considering succession plans for directors and when non-executive directors are coming towards the end of their fixed term of office the Nomination and Remuneration Committee considers whether to recommend their reappointment to the Council of Governors. In carrying out these responsibilities, the committees shall have regard to this policy and the composition and skills requirements of the board at that time.

## 5. Responsibilities of the Chair

5.1. The Chair will ensure that boardroom diversity is considered as part of the annual evaluation of the board's effectiveness.

5.2. The Chair will ensure that a bespoke and comprehensive induction programme is provided to each new director which aims to address any gaps in a new director's knowledge and which is designed to be inclusive.

5.3. The Chair will take on an ongoing mentoring role for new directors, and may arrange for buddying arrangements to be implemented, with the agreement of the new director and the proposed buddy. As part of this arrangement, the potential for reverse mentoring will also be taken into account.

## 6. Monitoring and reporting

6.1. The annual report of the foundation trust shall include information on the policy on diversity and inclusion used by the committee, including the policy objectives and how this links with the foundation trust's strategy. It will also include information on how the policy has been implemented and progress on achieving objectives.

## 7. Review

7.1. This policy shall be reviewed by the Board of Directors on an annual basis.

7.2. The policy will continue to be informed by guidance from relevant reviews conducted in other sectors, such as the Hampton-Alexander Review (2020) on gender and the Parker Review (2020) on ethnicity.

| | |
|---|---|
| **Title of report:** | Community Health Investment Partnership (CHIP) Scheme |
| **Presented to:** | Board of Directors |
| **On:** | 31 March 2021 |
| **Presented by:** | Consent agenda |
| **Prepared by:** | Ged Murphy |
| **Contact details:** | T: 07827 991373 E: Ged.Murphy@wwl.nhs.uk |

**Executive summary**

This report seeks Board approval, following review and endorsement by the Finance and Performance Committee at its meeting on 29 March 2021 to progress a further scheme during the current financial year.

**Link to strategy**

The current and future capital spend on site development, maintenance and equipment refresh.

**Risks associated with this report and proposed mitigations**

The Trust currently has c£7m on its balance sheet and needs to complete this transaction whilst there is additional Capital Departmental Expenditure Limit (CDEL) approval in 2020/21 from within the region, in addition to the Trust core capital programme for 2020/21 of £21.5m. This is a non cash transaction from a Trust perspective as this forms part of the overall investments made in the last financial year with Wigan Council.

**Financial implications**

Capital resourcing is becoming more challenging with the introduction of ICS CDEL limits and the GM ICS CDEL envelope is significantly oversubscribed already and will need to be scaled back before the 12th April 2021 submission date.

**Legal implications**

The legal implications arising from this report are governed by the previously agreed CHIP agreement.

**People implications**

There are no direct people implications in this report.

**Wider implications**

The schemes funded to date through the CHIP process are intended to reduce the demand for acute hospital services from key patient groups by enabling them to live safely within the borough minimising the risk of hospital admissions and providing a better quality of life.

**Recommendation(s)**

The Board of Directors is asked to

1) Note the update on the previous investment decisions
2) Approve the investment of £2.975m in the Walkden House Scheme as set out in the report.

# Report

## 1. Background

The Trust established the Community Health Investment Project (CHIP) joint project with Wigan Council to invest in community based assets that would mitigate the increasing demand for unscheduled care in the hospital and/or improve the health and well being of Wigan residents.

In 2019/20 the Trust invested in the following schemes with a proposal for the Park life scheme to be progressed in 2020/21.

**CHIP Investment schedule**

| | Scheme Details | Total Cost £m | WWL investment (prior) £m | Completion Status |
|---|---|---|---|---|
| Etherstone Street | 12 apartments with dementia support facilities | 2.05 | 1.02 | 95% |
| Ullswater | 20 supported living bungalows | 4.09 | 2.04 | 90% |
| Hyndelle | 26 apartments and 7 bungalows - extra care | 5.73 | 2.86 | 90% |
| Sandalwood | 40 Extra care units | 7.00 | 3.42 | <10% |
| Wharfdale | 39 elderly extra care units | 7.00 | 3.50 | <10% |
| Park life | 3 Football hubs in deprived/worst health areas of Borough | 14.40 | 7.20 | Awaiting Final Scheme details |
| | | | 20.05 | |

## 2. Update

The COVID pandemic has impacted on many of the originally envisaged project delivery timescales but a number have become operational and more details of those schemes including feedback from the service users are included at Appendix 1.

Etherstone Street went live in July 2020, Ullswater was phased with the bungalows live from April 2020 and the Autism Unit opened July 2020 and, Hyndelle live from September 2020.

Wharfdale and Sandalwood were delayed due to contractor in administration. These have been re-tendered and are now on site. They are expected to be completed mid 2022.

The pandemic has significantly impacted on normal hospital activity due to national restrictions so ongoing work to understand the full benefits of these schemes will continue in the future.

The balance of the Trust investment was intended to be invested in the Park Life scheme during 2020/21. This is a partnership between the Council and the FA to improve active sport participation but the scheme has experienced significant delays due to the pandemic. Work

continues to bring this scheme to fruition which will have long term health benefits for Wigan residents.

The CHIP Group met (12th February 2021) to consider progress and future schemes in light of the delays to the Park Life scheme and after careful consideration it was agreed that the scheme that would best fit the CHIP objectives was a scheme at Walkden House. The Trust investment would be c£2.975m in 2020/21 from the balance of Trust funds lodged with the Council in the last financial year. This scheme went live on 28th January 2021.

This scheme will provide 20 apartments for extra care plus communal facilities which will offer modern purpose built accommodation to support resident to live safely in a community setting that meets their needs thereby minimising the risk of unscheduled care events and hospital admissions.

**3. Financial Implications**

The Trust invested £20m with the Council following Board approval in March 2020 with £12.8m already being invested. The Walkden House proposal will be funded from the unallocated element and therefore there is no cash impact on the Trust but the expenditure does count against the CDEL limits introduced by NHSI.

Following extensive dialogue and lobbying within the GM ICS and the NW region it has been agreed that this CDEL impact will be offset by other regional underspends. A similar arrangement will be needed for the outstanding balance if there is not to be an adverse impact on the Trust capital programme in future years.

**4. Legal Implications**

The investments and associated governance arrangements were set out in the original CHIP agreement that previously reported to the Board and remain unchanged.

**5. Conclusions**

The joint working initiatives at a locality continue to grow and the CHIP schemes have demonstrated the potential benefits of collaborative working in the locality for the Trust and the Council for the benefit of the residents of Wigan. There is a balance of c£4.2m of Trust CHIP funds being held by Wigan Council which will be invested in schemes that are consistent with the objectives of the CHIP agreement.

Whilst this represents a non cash transaction for the Trust the Committee is reminded of the introduction of CDEL ICS fixed envelopes which were introduced after the inception of the CHIP project. As and when suitable schemes are identified for progression the £4.2m balance will count against CDEL limits so dialogue will continue at an ICS and regional level to manage this potential impact.

**6. Recommendations**

1) Note the update on the previous investment decisions
2) Approve the investment of £2.975m in the Walkden House Scheme as set out in the report.

**APPENDIX 1**

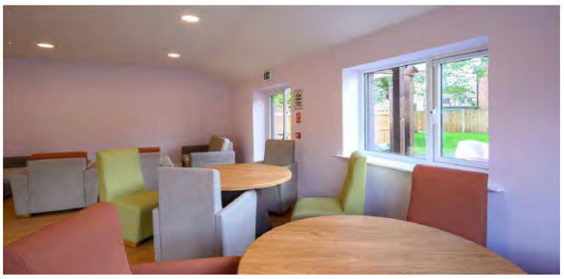
**CHIP DEVELOPMENT SUMMARY**

Investment has been made in the development of a range of housing with care schemes to help enable residents with health and care needs to live well and as independently as possible in their community, reducing demand on local health and care services. This note provides a short update on identified schemes.

**Hyndelle**

The Hyndelle development is complete and provides specialist accommodation and support facilities across a single site inclusive of 12 self-contained flats and 14 individual apartments.


The facility offers the latest in assistive technology and sensory equipment in helping meet peoples support needs with complex autism, including an interactive immersive sensory room and specialist built outdoor and communal space.





COVID-19 has impacted the development and the safe transition of individuals into the supported living facility. 5 of 12 residents have now moved in and are being supported within the Hyndelle Lodge facility.

This includes 3 residents who have moved into the facility from isolated single tenancy arrangements and are now benefiting from improved social connection and interaction. Another resident has recently been repatriated back to their local area from an out of borough residential placement, living much closer to family, friends, and support network.

Other placements are progressing, including proposed moves for individuals identified for the 14 individual apartments.

**Ulleswater (Marigold)**

Specialist, purpose built autism and learning disability scheme that has 12 individual supported living units together with a sensory room and adapted communal areas. There are also two separate bungalows on site.

The scheme opened in August 2020 and is fully operational, providing specialist support to 14 residents. The accommodation has had a huge impact in meeting the care and support needs of residents whilst providing a safe, caring homely feel to individuals, families and the wider community.

*Case Study:*

K is a young lady with complex physical and health needs. K was previously supported at Berkley Care home with 24-hour nursing supporting her prior to moving to Marigold and was mainly with elderly people. K has flourished since moving to Marigold, loves the vibrant atmosphere and sense of community whilst building new friendships. K loves taking part and interacting in activities in the communal lounge and in the community. K's health and wellbeing has been positively impacted and has significantly benefited from the visual stimulation and music in the interactive suite. The facility is delivering improved outcomes for K in a more appropriate setting within the community, with people of a similar age to fully interact with. The complex health professionals have already recognised the positive impacts Marigold brings to K's life.

**Etherstone Street**

Etherstone Street provides 12 apartments over three storeys, which are fully accessible. This development is a bespoke facility designed as an early intervention and prevention model for people who are 55 years old and over or have an identified medical need where the scheme will improve their health and wellbeing.

Etherstone Street meets both lifetime homes and dementia friendly standards and is designed to build on the assets of residents and people in the local community to create a home for life and reduce the need for more intensive health and care support.

All apartments offer open plan living comprising of a kitchen and living room a wet room as standard and a large bedroom with the facility to create an additional bedroom if required. To give residents peace of mind there is a secure door entry and CCTV system in place.

The scheme is also connected to a neighbouring day centre to create a rounded offer of support that improves wellbeing.

*Recent Quotes from Residents:*

*"It is the best thing that I have done moving from my other place, my quality of life has felt a lot better, I don't feel as isolated. The apartment is belting, its bright, there is plenty of space, accessible, I am on the top floor so have a lovely view and parking right outside. I would not have managed on my own at my previous place with stairs and a bath, it has been brilliant here, everything on one level, the wet room has been a godsend and I have been able to continue doing things for myself rather than having help. Living here as helped why I have been shielding and continue to have treatment it's such a pleasant, friendly, and safe place to live".*

*"My flat is my little piece of heaven, the perfect apartment, the view, lighting, and airiness is more than I could have hoped for, thank you from the bottom of my heart".*