Board of Directors public meeting

Wed 26 May 2021, 13:00 - 16:00

Agenda

13:00 - 13:00
0 min

1. Declarations of interest

Information *Ian Haythornthwaite*

13:00 - 13:02
2 min

2. Minutes of previous meeting

Decision *Ian Haythornthwaite*

2. Minutes - Public board - March 2021.pdf (9 pages)

13:02 - 13:12
10 min

3. Staff story: Allied Health Professionals

Discussion *Lesley Hadley*

Verbal item

13:12 - 13:22
10 min

4. Chief Executive's report

Discussion *Silas Nicholls*

4. Chief Executive's report.pdf (3 pages)

13:22 - 13:42
20 min

5. Committee chair's reports

Discussion *Non-Executive Directors*

Verbal item

13:42 - 13:57
15 min

6. Board assurance framework

Discussion *Paul Howard*

To follow

6. BAF - May 2021.pdf (31 pages)

13:57 - 14:17
20 min

7. Performance report

Discussion *Executive Directors*

7. Performance report.pdf (4 pages)

14:17 - 14:32
15 min

8. Safe staffing report

Discussion *Rabina Tindale*

8. Safe Staffing Report for TB May 2021.pdf (9 pages)

14:32 - 14:42
10 min

9. Maternity (Ockenden) reports

Discussion *Rabina Tindale*

9. Maternity Provider Board Level report May 2021 .pdf (6 pages)
9. April 2021 Provider Board level measures.pdf (4 pages)
9. Maternity Dashboard April 2021.pdf (5 pages)
9. Maternity Dashboard 2021.pdf (4 pages)
9. Ockenden Board Report - May 2021.pdf (37 pages)
9. Maternity Steis Incident Board Report .pdf (14 pages)

14:42 - 14:52
10 min

10. Transformation programme update

Discussion *Karlyn Forrest*

10. Transformation Plan 21-22 - Trust Board_.pdf (10 pages)

14:52 - 15:02
10 min

11. Proposal to establish a Research Committee

Discussion *Karlyn Forrest*

11. Research Committee proposal.pdf (9 pages)

15:02 - 15:02
0 min

12. Consent agenda

12.1. Register of Clinical Ethics Group referrals

12.1 CEG referrals.pdf (3 pages)

12.2. Public finance report

12.2 Public finance report.pdf (2 pages)

12.3. Committee terms of reference for ratification

To follow

12.3.1 ToR - Finance and Performance Committee.pdf (4 pages)
12.3.2 ToR - People Committee.pdf (4 pages)

12.4. NHSE/I board self-certifications

12.4 Board self-certifications.pdf (9 pages)

15:02 - 15:02
0 min

13. Questions from the public

15:02 - 15:02
0 min

14. Date, time and venue of next meeting

28 July 2021, 12:00, location TBC

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

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

HELD ON 31 MARCH 2021, 12.00 NOON

BY VIDEOCONFERENCE

Present:	Mr R Armstrong	Chair (in the Chair)
	Mr I Boyle	Chief Finance Officer
	Dr S Arya	Medical Director
	Prof C Austin	Non-Executive Director
	Mrs A Balson	Director of Workforce
	Lady R Bradley DL	Non-Executive Director
	Dr S Elliot	Non-Executive Director
	Ms M Fleming	Chief Operating Officer
	Mr M Guymer	Non-Executive Director
	Mr I Haythornthwaite	Non-Executive Director
	Mrs L Lobley	Non-Executive Director
	Miss A-M Miller	Director of Comms. and Stakeholder Engagement
	Mr R Mundon	Director of Strategy and Planning
	Mr S Nicholls	Chief Executive
	Mrs R Tindale	Chief Nurse
	Prof T Warne	Non-Executive Director
In attendance:	Miss H Holding	Deputy Company Secretary
	Mr P Howard	Director of Corporate Affairs
	Mrs L Sykes	Lead Governor

35/21 Chair and quorum

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

The Chair welcomed the Director of Communications and Stakeholder Engagement, and the Chief Nurse to their first Board of Directors' meetings.

36/21 Apologies for absence

No apologies for absence were received.

37/21 Declarations of interest

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

38/21 Minutes of previous meeting

The minutes of the previous meeting held on 25 January 2021 were **APPROVED** as a true and accurate record. Note was made that there were no outstanding actions on the action log.

39/21 Chief Executive's report

The Chief Executive presented an update which was circulated with the agenda. He drew attention to the changes to the Executive Team as outlined by the Chair at the start of the meeting, and added that Dr Sandeep Ranote's secondment as Medical Director for Mental Health and Clinical Integration has come to an end. He thanked Dr Ranote for the work she has undertaken whilst at WWL and looked forward to working with her across the Wigan system.

The new Community Assessment Unit opened at the start of March, which will care for some of the borough's most elderly and frail patients in a therapy-led way, which is intended to reduce pressure on admissions to meet the needs of the aging population and is a vital component in providing the right care in the right place at the right time.

Further, work has started on a new £1m development at Leigh Infirmary. The Jean Heyes Rehabilitation Unit will provide an intermediate care inpatient facility with dedicated rehabilitation and reablement to support patients to reach their potential following a period of illness or injury.

To mark the one-year anniversary of the COVID-19 pandemic, the Tree of Hope at Royal Albert Edward Infirmary site was lit up in yellow on the National Day of Reflection (22 March 2021), and leaders from across the health and social care sector joined together to show their respect. A one-minute silence was held across the foundation trust.

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

40/21 Patient Story

The Chief Nurse presented the patient story verbally, which detailed the potential unsafe discharge of a patient, and poor communication. She provided an overview of the reasons why the patient had been admitted, alongside her underlying health conditions. Feedback had been collated as part of the COVID-19 admission questionnaire, which outlined the circumstances surrounding why the patient and her family had found communication from the ward poor, and that the fundamentals of care had been missed in this instance.

Prof. Warne detailed that complaints had been discussed at the Quality and Safety Committee meeting the previous week, and welcomed the approach to the complaint workshops being put in place to provide learning and support to staff.

The Director of Workforce recognised that impact had on the instance by the stricter pandemic visiting restrictions. She referred to the 'all about me' system and noted that it would have been helpful in this instance in providing the staff on the ward with basic information. The Chief Nurse agreed that initiatives such as these are fundamental across the organisation and community to ensure that patient needs are met.

The Chief Operating Officer noted thanks for the patient and her family for allowing their story to be told. The Medical Director agreed, and emphasised how much he relied on families when undertaking ward rounds. He hoped that the visiting tree which has been developed will allow for a relaxing of restrictions, and avoid similar instances.

The Board of Directors received and noted the update provided.

41/21 Committee Chair's reports and Board Assurance Framework

The Board of Directors received an update on Committee activities, alongside an update on each Board Assurance Framework (BAF).
Mr Guymer opened this item by providing an update on the activities of the Finance and Performance Committee. The Committee met ahead of the Board of Director's meeting and had received a positive update around performance, especially in light of the difficulties and constraints caused by the pandemic. An extraordinary Finance and Performance Committee meeting would be arranged for April 2021 to receive the interim finance budget. The Performance Board Assurance Framework delivery remained at amber-red.

With regard to the People Committee, Mrs Lobley detailed that positive assurance had been presented to the committee at its previous meeting surrounding the improvements in recruitment, in particular in nursing and the development of the care maker role. An improvement ha been seen in staff absence, as staff are returning to work with the approach set out by the Central Allocation Team. The People Board Assurance Delivery rating reduced from red to amber.

The Director of Strategy and Planning provided an update around the COVID-19 vaccination programme. The foundation trust has delivered 6142 first doses to WWL and affiliates, which is 83% of the workforce. By working through the vaccine hesitancy issues, it is expected that around 90% will be met over the next few weeks. By the end of this week, the foundation trust will have delivered 4229 second doses to WWL staff, which is around 57% workforce and 69% of those receiving the first dose.

The Director of Workforce detailed that there has been a deterioration in the retention of staff. The Chief Operating Officer will be taking a lead on leadership, objectives, civility and embedding culture of as part of her new role of Deputy Chief Executive with a view to developing compassionate leadership and improving culture across the organisation. In addition, the Director of Communications and Stakeholder Relations will lead on lea on working with the senior management team, and the Chief Nurse will continue to embed improved ways of working across nursing leadership.

Prof. Warne provided an update on the activities of the Quality and Safety Committee. An increased number of STEIS incidents had been reported at its previous meeting, in the main around pressure ulcers. Considerable work is ongoing to address learning from complaints as alluded to in the patient story. Further, the committee was pleased to receive action plans around pressure ulcers and falls. There have been no changes to the deliver rating of the Board Assurance Framework for patients.

The Director of Strategy Planning detailed that whilst there are no changes to the deliver rating of the Partnerships Board Assurance Framework, discussions are ongoing across the Integrated Care System and at a sub-regional level around the white paper and the changing landscape.

Mr Haythornthwaite detailed the meeting of the Audit Committee in February 2021. The Committee reviewed the external audit plan, approved the accounting policies, received a progress report on internal audit and reviewed the draft internal audit plan for 2021/22, and an update around Freedom to Speak Up.

The Board of Directors received the updates.

42/21 Performance Report

The Board received an update on performance at the foundation trust.

The Chief Executive opened this item by outlining the positive news that pressures as a result of the pandemic were starting to reduce, which is as a result of a combination of the impact of the vaccination programme and the national lockdown measures. Pressures within critical care remain due to the high acuity of patients admitted. Decompression plans continue to be drafted, alongside plans to commence elective recovery and reduce waiting lists.

The Chief Nurse detailed an update around dedicated plans to reduce pressure ulcers. The senior teams will focus on a harm free care agenda, and targeting category 3 and category 4 ulcers, to avoid deterioration.

The Chief Nurse confirmed for Mrs Lobley that the impact had by enhanced infection, prevention and control measures, in particular cleaning at the foundation trust had been successful in reducing the infection rate.

With regard to safeguarding, the Chief Nurse confirmed for Dr Elliot that the task and finish group has been stood down. Action plans established by the group continue to be monitored on a monthly basis by the Safeguarding Effectiveness Group, and reported back to the Quality and Safety Committee.

The Chief Operating Officer confirmed that the decline in COVID-19 admissions at the foundation trust is reflective of the position across the borough. She detailed the focus on recovering services, and designating wards away from COVID-19 status' according to their speciality status to ensure that patients are admitted to the right

ward. With regard to elective recovery, patients are being managed according to clinical risk, which is in line with the national directive to treat urgent cancer patients and eradicate long waiting lists where patients have waited over 52 weeks.

The Board of Directors received the updates.

43/21 Strategy 2030

The Director of Strategy and Planning presented the Strategy 2030 which had been circulated with the agenda. He detailed that significant internal and external engagement has taken place across a range of workshops over the last 18 months to inform the strategy. It had originally been intended for launch pre-pandemic, therefore the opportunity has been taken recently to refresh the same, reflecting on COVID-19.

The strategy provides a framework for the corporate objectives, and is built around the four Ps; Patients, People, Partnerships, and Performance and aligns to the intentions set out in the government's 'white paper' around WWL and the Healthier Wigan Partnership's role in the Greater Manchester Integrated Care System (ICS).

The Director of Communications and Stakeholder Relations outlined that the launch of the strategy is timely for the launch of the internal and external communications strategy.

The Director of Strategy and Planning confirmed for Prof. Austin that the strategy and the corporate objectives links to the three Is; Integrate, Innovate and Innovate.

Mrs Lobley welcomed the strategy. She noted the need for more images within the strategy of patients. The Director of Communications and Stakeholder Relations agreed and outlined how the pandemic has paused activities where the Communications Team can photograph such instances, therefore a bank of images has been used on this occasion. Lady Bradley agreed, and outlined that she would welcome more diverse images in terms of teams and representations of staff groups.

The Board of Directors received the update and noted its content.

44/21 Approach to disciplinary policy

The Director of Workforce presented the disciplinary process and policy review report which had been circulated with the agenda. The report identified the national recommendations around NHS organisations having fair, systematic and consistent disciplinary processes which promote treating staff with kindness and dignity, acknowledging that mistakes happen and informal routes to resolve should be adopted where appropriate.

The Director of Workforce outlined how the proposed to the policy ensure focus on the wellbeing and support of an individual who is experiencing conduct in the organisation.

Reporting of the disciplinary process is presented quarterly to the People Committee.

The Board of Directors APPROVED the disciplinary policy presented.

45/21 Mortality update: Q3 2020/21

The Medical Director presented the Q3 Mortality Report which had been circulated with the agenda.

The Medical Director drew attention to figures within the report and noted that there had been an increase in mortality in line with the excess deaths across the country due to the COVID-19 pandemic. He was pleased to note that the number of COVID-19 positive admissions are reducing at the foundation trust, and at the time of the meeting there are only 13 positive patients onsite.

The Summary Hospital Level Mortality Indicator (SHMI) improvement plan will track and timeline the actions in place, which is reported to the Quality and Safety Committee. The Medical Director confirmed for Mrs Lobley that this plan addressed areas including cancer, heart failure and UTIs. Further, it will allow for a review of how instances can be avoided by earlier escalation within community and primary care. A review of how escalation at a medical and nursing level will also be undertaken to address raising concerns and avoiding further deterioration.

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

46/21 Safe staffing report

The Chief Nurse presented the Safe Staffing Report which had been circulated with the agenda and provided the Board of Directors with assurance around the ongoing monitoring of nurse staffing levels across inpatient lines, in line with national guidance.

Attention was drawn to key updates within the report, including the positive reduction of district nursing vacancies which has also reflected on a decrease in pressure ulcers. Further, recruitment and retention within the medicine division has also reduced as a result of the international recruitment scheme. The foundation trust are provided the additional support required to ensure that onboarding is provided within the initial four week period.

The Chair was pleased to receive the positive impact had by the steady flow of international recruits to the foundation trust.

In response to question from Mrs Lobley around incorporating patient feedback into the safe staffing report, the Chief Nurse alluded to the patient story presented earlier in the meeting and outlined how feedback from patients and families is triangulated with a view to taking learning and improving patient experience, quality and safety at the foundation trust.

Mr Haythornthwaite questioned the actions being taken to retain nursing recruitment at the foundation trust. The Chief Nurse confirmed that various areas of work are ongoing with regard to retaining nursing staff at the foundation trust, in particular work alongside universities with a view to employing more student nurses, and looking at different portfolio roles from nursing appetencies to advanced nurse practitioners. The Chair added that the alliances built with local colleges and university's will be vital in recruiting nursing staff for the future.

Prof. Austin referred to nursing vacancies at the higher grades, and questioned how nurses are supported to apply for promotions in those grade. The Chief Nurse outlined how additional work is ongoing to free up capacity to enable staff development to provide them with experience and opportunity to apply for the same.

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

47/21 Corporate objectives FY2021/22

The Board of Directors received an update with regard to the Corporate Objectives for 2021/22. The Chief Executive opened the item by outlining how the objectives set out what the foundation trust plans to achieve during the FY2021/22, and focus on 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 objectives, and set out the risks to achieving the same.

Mr Haythornthwaite outlined that regular updates on progress towards delivering the objectives are presented to the Board of Directors. The Director of Corporate Affairs outlined how the Board Assurance Framework has been redrafted to provide updates on progress against delivery, and enable a focus on specific areas at the request of the Board.

The Board of Directors APPROVED the Corporate Objectives for 2021/22.

48/21 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 appointment of the Deputy Chief Executive is APPROVED

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

3. THAT the infection prevention and control board assurance framework be received and noted

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

5. THAT the monthly Trust Financial Report (Month 12) be received and noted

6. THAT the gender pay gap report be received and noted

7. THAT the Modern Slavery Statement 2021/22 be received and noted

8. THAT the use of the common seal be received and noted

9. THAT the register of directors' interest be received and noted

10. THAT the fit and proper persons directors report be received and noted

11. That the Board Diversity Policy be received and noted

12. That the Community Health Investment Partnership (CHIP) Scheme be APPROVED

49/21 Date, time and venue of next meeting

The next meeting of the Board of Directors will be held on 26 May 2021 by videoconference.

Action log

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

Title of report:	Chief Executive's report
Presented to:	Board of Directors
On:	26 May 2021
Presented by:	Chief Executive
Prepared by:	Director of Corporate Affairs
Contact details:	T: 07867 462561 | E: paul.howard@wwl.nhs.uk

Executive summary

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

Link to strategy

There is no link to the organisational strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

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

Legal implications

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

People implications

There are no people implications to draw the board's attention to.

Wider implications

There are no wider implications to highlight.

Recommendation(s)

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

1. Appointment of new Chair Designate

1.1. At its meeting on 22 April 2021, the Council of Governors appointed Mark Jones as the next Chair of WWL when Robert Armstrong retires from the role at the end of October 2021 after seven years in post. Whilst Mark does not take up post until 1 November 2021 he will be spending time in the organisation until this point to meet staff, visit our locations and to get a feel for WWL. Robert and I are delighted to welcome him to WWL.

1.2. Mark has had a long and respected international and domestic career in the pharmaceutical industry and since retiring has gained experience as a Non-Executive Director at Liverpool Heart and Chest Hospital NHS Foundation Trust (LHCH). Robert and I are thrilled to welcome someone with Mark's wealth of knowledge, experience and expertise to WWL and throughout the recruitment process, Mark clearly demonstrated his passion for our patients, carers, staff and governors and his commitment to our values.

2. International Day of the Midwife, International Nurses' Day and National ODP Day

2.1. In May we celebrate both the International Day of the Midwife (5 May) and International Nurses' Day (12 May) and our Chief Nurse Rabina showed her appreciation by providing goodie bags for every nurse and midwife. She also presented hampers and awarded trophies for our Registered Nurse of the Year, Unregistered Nurse of the Year and Learner of the year.

2.2. On International Nurses' Day, Rabina went on a walkabout at Royal Albert Edward Infirmary with Hillary Garett, the Deputy Chief Nurse for NHS England who was very impressed by the compassion and commitment shown by staff.

2.3. Our third celebration for members of our WWL family came in quick succession, with the hard work and commitment of our Operating Department Practitioners recognised on National ODP Day (14 May). We look forward to celebrating every aspect of our WWL family throughout the rest of the year and beyond.

3. Internal communications

3.1. I'm pleased to report that we have started to reinvigorate our internal communication mechanisms with a new look weekly newsletter, *WWL News*, which showcases an introductory vlog each week from members of the executive team. I have kickstarted my monthly blogs again and I am pleased to announce that we will also be hosting our new monthly *Leaders' Forum*, virtually, at the end of May for senior managers at which we will launch our new *Strategy 2030*.

4. We Can Talk

4.1. I was excited to be involved in the recent launch of a new training tool to empower our staff to have open conversations with patients around mental health. 'We Can Talk' was created in partnership with hospital staff, mental health experts and young people with lived experience, thanks to funding from Health Education England. The training will help our staff across the Trust to improve their knowledge, skills, and confidence in supporting young people who are experiencing mental health difficulties.

4.2. The past year has been incredibly difficult for so many young people who have had their educational and personal lives disrupted. Talking about mental health issues isn't always easy but, in my experience, the most important thing is to acknowledge the elephant in the room which is why I was thrilled to support this initiative.

5. Recommendation

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

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Board assurance framework

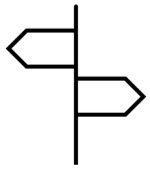
May 2021

The content of this report was last reviewed as follows:

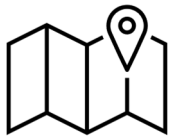
Quality and Safety Committee:	14 Apr 2021
Finance and Performance Committee:	24 May 2021
People Committee:	---
Audit Committee:	---
Executive Team:	25 May 2021

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

How the Board Assurance Framework fits in

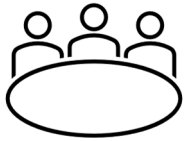


Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how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



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

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



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

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

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

Understanding the Board Assurance Framework

RISK RATING MATRIX (CONSEQUENCE x LIKELIHOOD)

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

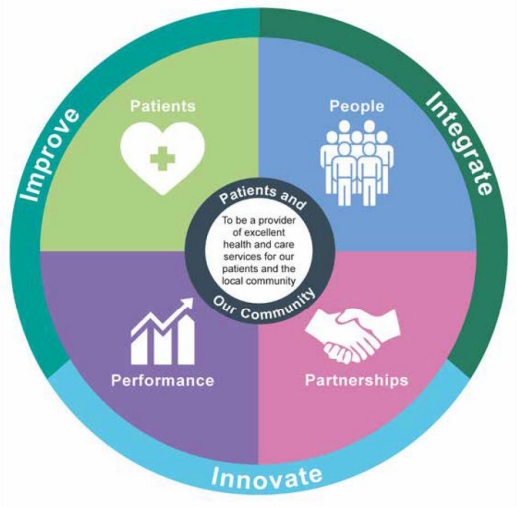
DIRECTOR LEADS

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

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

Our approach at a glance

Our Strategy 2030



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

FY2021/22: A year of balance

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

Recovering from the impact of COVID-19

- Supporting our workforce
- Recovering the elective care programme

Progressing key elements of the strategy that make us unique

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

Ensuring we have a robust foundation to build on

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

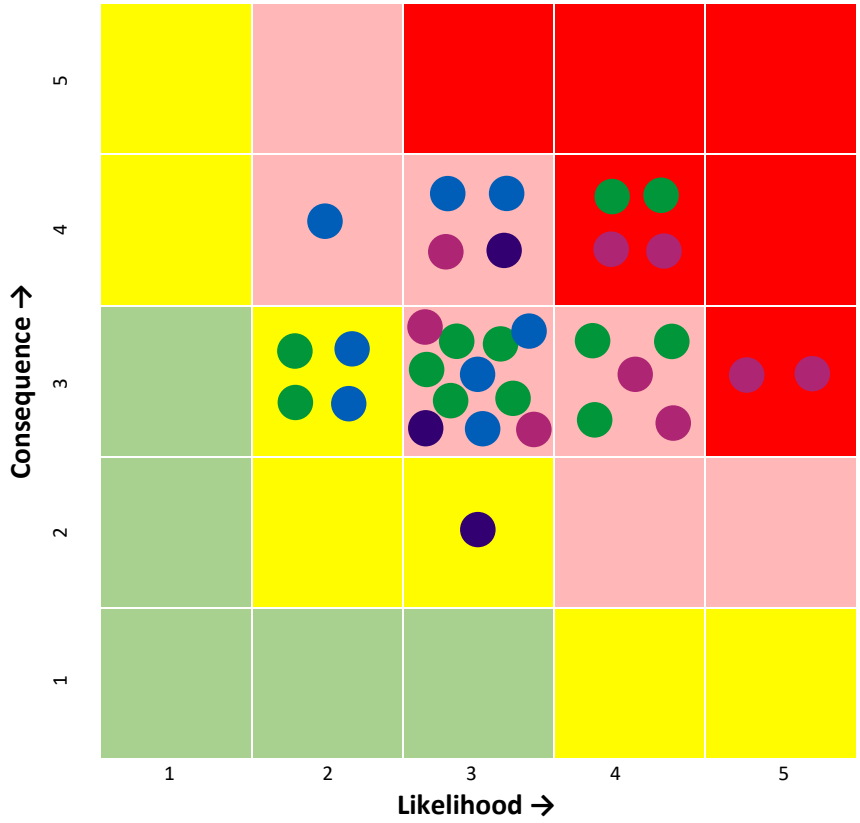
Risk management

We recognise that it is best practice for organisations to have in place an agreed risk appetite statement to direct and govern decision-making at both Board and operational level. An agreed risk appetite sets the framework for decision-making across the organisation to ensure consistency of decisions and the embedding of an agreed organisational value base. We also recognise the importance of monitoring strategic risks (those which have the potential to compromise our ability to deliver our corporate objectives) to allow early intervention when needed.

Our risk appetite statement is as follows:

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

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



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

Patients

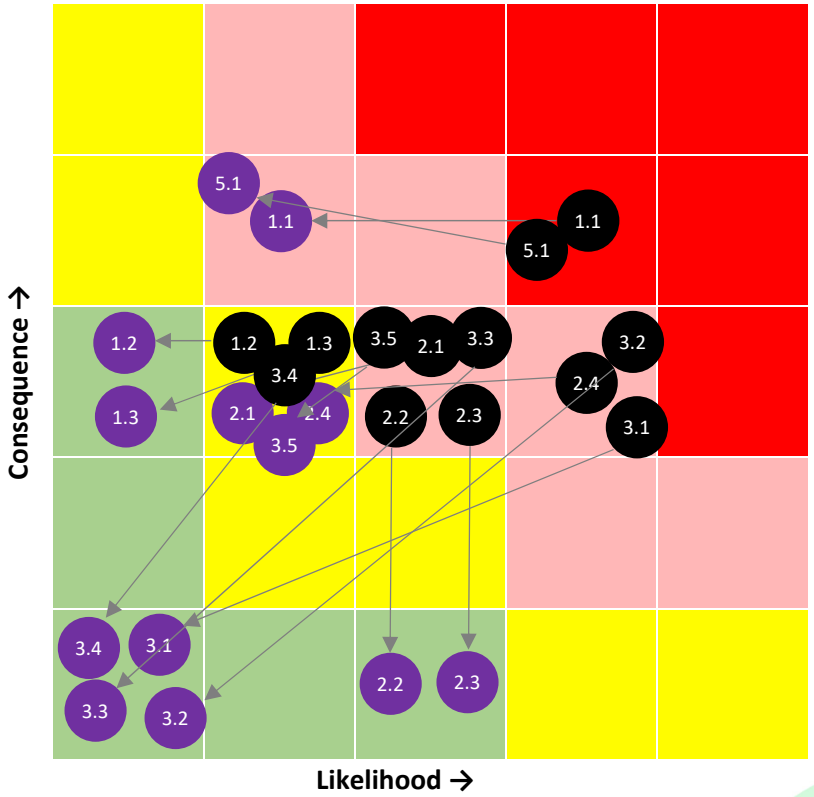
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

Monitoring: Quality and Safety Committee

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

People

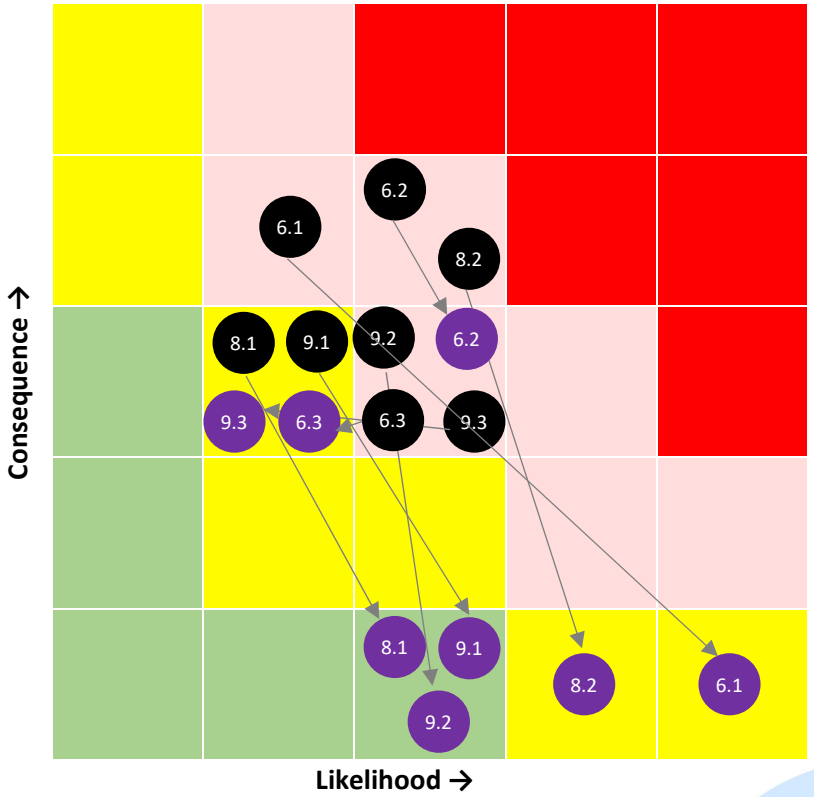
To create an inclusive and people-centred experience at work that enables our WWL family to flourish

Monitoring: People Committee

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

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

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



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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
6.1 There is a risk that the necessary funding to deliver the stepped care model for physical and mental may not be prioritised, meaning that the service cannot be provided.	L2 x C4 8 High	L2 x C4 8 High	L1 x C5 5 Moderate	Business case drafted and subject to review prior to submission to BCOG Working with GM Resilience Hub where appropriate Transferred OHD MSK and counselling services into Steps 4 Wellness function for better resource efficiency	Apr 2021	Key roles to provide full stepped care model (included in business caes)	Steps 4 Wellness to prioritise and recruit to required structures, following business case decsion

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

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

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

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

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

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

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

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

Performance

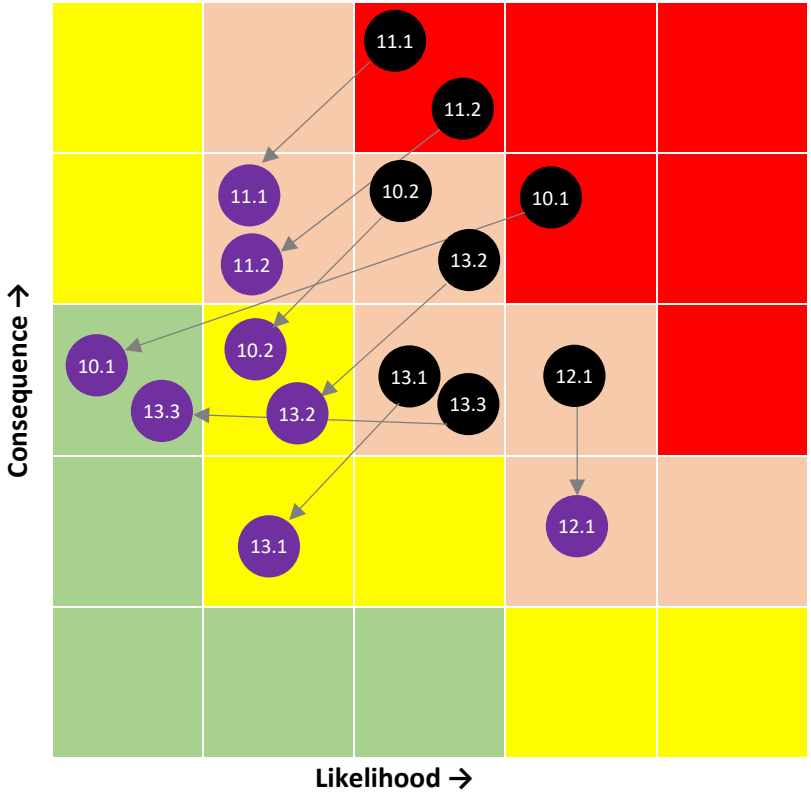
Our ambition is to consistently deliver efficient, effective and equitable patient care

Monitoring: Finance and Performance Committee

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

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

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



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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
10.1 There is a risk that because the overall waiting list is growing due to increased numbers of referrals, the waiting list is growing more quickly than we are able to address the backlog which would lead to us not being able to reduce the backlog in a timely way across all three indicators	C4 x L4 16 Significant	C4 x L4 16 Significant	C3 x L1 3 Low	Regular reviews of risk stratification are undertaken according to clinical priority WWL manages patient lists in accordance with risk stratification National communications being issued around how patients will be contacted for review (Ext)	May 2021 May 2021 ---	Lack of capacity to undertake reviews of allocated risk stratification across all specialties. Patients to be given mechanism for getting in contact with GP or WWL if deteriorating.	Currently being reviewed by senior leadership teams. Joint correspondence from WWL and CCG being sent to every patient to update them and provide contact information.

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
10.2 There is a risk that the value of core (or core +) activity exceeds the funding available because we have to use additional bank/agency or independent sector provision, or we are unable to access ERF funding if we exceed our trajectory, meaning that all work cannot be undertaken.	C4 x L3 12 High	C4 x L3 12 High	C3 x L2 6 Moderate	Work is ongoing to value the plan that we have submitted and to triangulate that with the activity plan. GM Elective Recovery Reform Group in place with two programmes of work; (1) capacity and demand across GM and (2) reform. Deputy Chief Executive attends for WWL. (Ext.) Reviewing how we can address the issue by activating elective recovery fund at GM level. (Ext) Continue to access independent provider capacity.	May 2021 May 2021 May 2021 May 2021	Nil at present; final submission is due in June. The next phase is then to describe the additional capacity available, the costs of doing so and what using that capacity will mean.	---

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

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

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

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

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

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

Partnerships

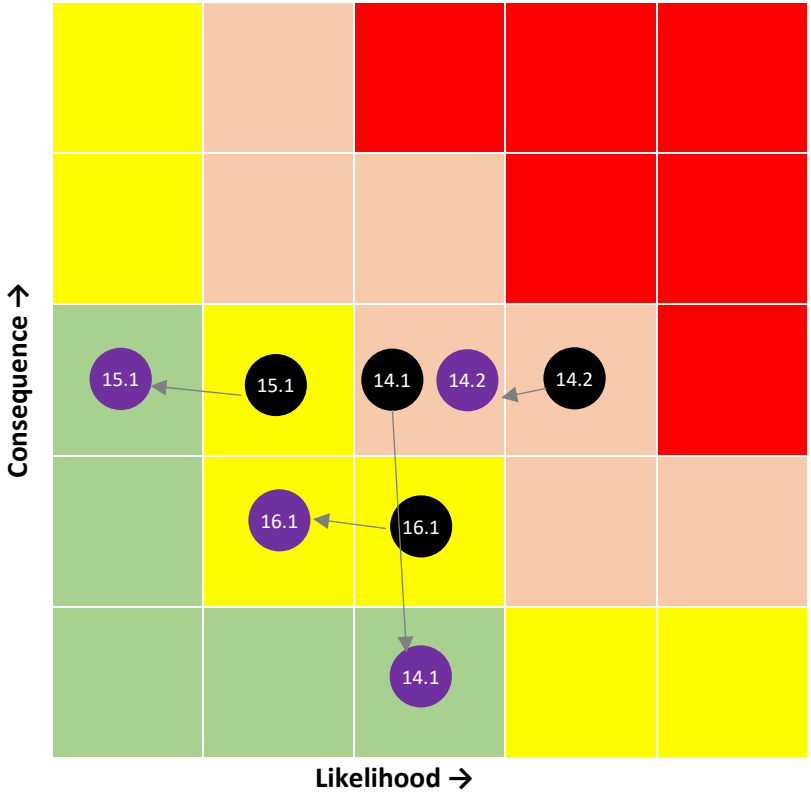
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

Monitoring: Board of Directors

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

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

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



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

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

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

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

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

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

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	WWL M1 Scorecard
Presented to:	Board of Directors
On:	26th May 2021
Presented by:	Director of Strategy & Planning
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

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.

The WWL Way

Report: M1 WWL Balanced Scorecard: April 2021

QUALITY & SAFETY

	Month	ON/OFF Track	Why?
Patient Safety (Safe)			
Never Events	M11	On Track	0 in month, 2 YTD
Number of Serious Incidents	M11	Off Track	5 in month, 86 YTD
Sepsis - Screening and Antibiotic Treatment (Grouped)	M11	Off Track	**Red Flag:** On Track (Ward & AE) **Elevated Score:** AE On Track, Ward Off Track
Serious Pressure Ulcers (Lapses in Care)	M11	Off Track	1 Incident in month, 35 YTD (Community & Hospital Acquired)
Serious Falls	M11	On Track	0 in month, 4 YTD
Infection Prevention and Control (Grouped)	M11	Off Track	5 / 6 in month, 6 / 6 YTD; Metrics Off Track
Clinical Effectiveness (Effective)			
SHMI Rolling 12 months	M7 2021	Off Track	Latest position: 115.3
National Patient Safety Strategy (Grouped)		*Under Development*	
Patient Experience (Caring)			
Complaints Responses	M11	Off Track	49.9% M11, 34.6% YTD; Target 90%
Improved Discharge (Grouped)		*Under Development*	
Patient Experience		*Not Currently Collected*	

ACTIVITY & EFFECTIVENESS

	Month	ON/OFF Track	Why?
A&E Performance (Single)	M01	Off Track	89.76% M01, 89.76% YTD; Target 95%
Cancer Performance (Grouped)	*M12*	*Off Track*	*2 / 7 in month, 2 / 7 YTD; Metrics Off Track*
RTT Performance (18 Weeks)	M01	Off Track	60.09% M1; Target 92%
RTT Performance (52 Weeks)	M01	Off Track	2935 patients waiting 52+ weeks
Diagnostics Patients waiting under 6 weeks	*M12*	*Off Track*	*92.94% ; Target 99%*
Recovery plan - NHS E/ I	M01	Off Track	3 out of 4 measures achieved
Recovery plan - WWL	M01	*On Track*	*128% of 2019 Activity; Target 90%*

PEOPLE

	Month	ON/OFF Track	Why?
Employment Essentials			
Clinical Vacancy Rate	M12	Off Track	5.66% M12, 6.96% M11, 9.5% M9; Target 5.0%
Agency vs NHSI Ceiling	M12	Off Track	£1,304k M12, £643k M11, £1,096K M8; Target £502K per month
Premium Cost Spend	M11	Off Track	£2,123K M11 (9.28% over budget); M1 update not yet available
Go engage			
Your voice scores (engagment enablers, feelings & behaviours)	Q3	Off Track	3.8 Q4, 3.91 Q3; 3.77 Q2; Target 4
Your voice response rate	Q3	Off Track	18.0% M4, 12.0% Q3, 19.2% Q2; Target 50%
Route Planner			
Mandatory Training over rolling 12 months	M01	Off Track	88.9% M1, 89.9% M11, 87.0% M9; Target 95%
PDR`s over rolling 12 months	M01	Off Track	74.7% M1, 72.7% M11, 74.5% M9; Target 90% (N.B. Excludes M & D Staff)
Steps for Wellness			
Sickness Abence	M12	Off Track	5.38% M12, 7.02% M10, 8.15% M8; Target 4%
Time Lost due to other unplanned absence	M12	Off Track	3.16% M12, 3.21% M10, 4.6% M8; Target 4%
Covid Risk Assessments	M01	Off Track	91.13% M1, 91.11% M11, 90.23% M9; Target 95%

FINANCE

Financial Position (£000s)

	In Month			Year to Date			H1	Full Year
	Actual £000's	Plan £000's	Var £000's	Actual £000's	Plan £000's	Var £000's	Plan £000's	Plan £000's
Income	36,568	36,131	437	36,568	36,131	437	217,244	TBC
Expenditure	(35,509)	(35,161)	(348)	(35,509)	(35,161)	(348)	(210,100)	TBC
Surplus / Deficit	(158)	(232)	74	(158)	(232)	74	(70)	TBC
Cash Balance	39,998	37,826	2,172	39,998	37,826	2,172	33,875	TBC
Capital Spend	209	801	592	209	801	592	6,302	11,022

Reported position : M01

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

The WWL Way

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

M1 WWL Balanced Scorecard: April 2021

QUALITY & SAFETY

Board are asked to note that further work is being undertaken to further strengthen the quality safety and patient experience metrics within this report.

Patient Safety (Safe)

The Trust had no Never Events since the last Q&S meeting in February. With regards to Serious incidents, during March 2021 there were 9 incidents escalated to StEIS. 3 out of 9 of these incidents were relating to serious falls with a further 2 relating to treatment delays. The Trust has seen a decrease in the number of StEIS reported HAPUS; 2 were reported in March. The other 2 Serious Incidents related to 1 unexpected potentially preventable death and 1 ward closure due to norovirus.

The Trust has seen an increase in the number of MRSA; this is considered possibly due to the increase in admission pressures. There has been a moderate increase in the number of CDT cases; there have been no obvious links. The annual total of CDT case is 42; this is significantly over the trajectory of 20. MSSA infections have increased, there was no common source but these cases are still undergoing the RCA process.

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 115.28. WWL is currently 2nd worst Trust in the North West for this indicator, work continues across the Borough to improve this indicator. Mel Hailey has currently been seconded to review and develop improvement programmes to try and address the Trust's SHMI.

Patient Experience (Caring)

For the month of March, only 9 of the 43 complaints which were due a response were achieved within the timescales agreed with the complainant at the start of the process which equates to 21%. During the month of March the majority of the complaints related to clinical treatment, Communication, and Values and Behaviours, - also reported is patient care, and discharge concerns. There were no requests for records from the PHSO. Two remote sessions were held for circa 40 staff in total in March entitled "A journey through complaints and communication using empathy". It is hoped that this really well evaluated training can be progressed in 2021/22.

ACTIVITY & EFFECTIVENESS

Excellent continued progress against the A&E national standard, despite increased attendances.

Continued improvement against cancer pathway

Reduction in the number of patients waiting over 52 weeks

Achievement against the Trust Elective Recovery Plan for April

Risks associated with the overall growth in waiting list and increasing demand on A&E.

PEOPLE

Employment Essentials

Our recruitment activities have continued with a virtual recruitment event. International recruitment from India has been placed on pause nationally as a result of the Covid situation in India. An outline business case has been approved to progress an alternative temporary staffing solution for the medical workforce and our e-roster roll out programme for medical staff is progressing as planned.

Go Engage

Our family - Our future - Our focus was presented to the Trust Board workshop as our engagement reset with focus on four areas; culture (civility, psychological safety & compassionate leadership), well-being, leadership & team development and communications & visibility. Shared objectives for staff engagement / culture and comms / visibility will be in place for the Executive team and cascaded to senior leaders.

Route Planner

The full Learning Needs Analysis should be completed in the coming month, with identified training needs for all roles within the Trust. This will be taken to the Executive team for validation and sign-off. Any funding gaps will be subject to normal business case process. Mandatory training recovery plans are being developed with every division to improve compliance levels post covid escalation. My Route Plan appraisals have not been mandated through the pandemic due to staffing pressures. This will commence again from April 21 and the Corporate objectives will be cascaded through the My Route Plan appraisal process in 2021/22. A proposal is being worked through with the Silver Workforce Sub Group regarding Mandatory training and how we increase compliance (as a result of the impact of covid) and will be preparing a paper for ETM with a recommended approach.

Steps 4 Wellness

NW work continues around future focused well-being and attendance management frameworks. Work is progressing around a new approach to stress management and an outline business case has been developed to enable the Trust to deliver stepped care models for physical and mental health, from prevention to complex needs, on a sustainable basis. Covid vaccination rate for WWL staff (first dose) now stands at 90% and 80% for both doses.

FINANCE

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

In month 1, the Trust reported a deficit of £0.2m, which was £0.1m favourable to plan.

Cash is £40.0m at the end of month 1 which is £2.2m above the plan.

Capital expenditure is £0.2m for month 1 which is £0.6m below plan.

Please see the monthly finance report for further commentary.

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

Title of report:	Safe Staffing Report
Presented to:	Trust Board
On:	26 May 2021
Presented by:	Rabina Tindale, Chief Nurse
Prepared by:	Allison Luxon, Deputy Chief Nurse
Contact details:	T: 01942 82 2176 E: allison.luxon@wwl.nhs.uk

Executive summary

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

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

The Board are asked to note:

- The improving picture with regards to overall nursing vacancies, with significant reduction in B5 and B2 vacancies.
- The planned recruitment event for registered staff in April 2021, and progress made with recruiting to B2 vacancies across the Trust in response to the National directive to have zero B2 vacancies by April 2021.
- The increase in the reporting of red flags within nursing aligned with the proactive use of SafeCare to monitor patient acuity. In addition, there is significant assurance of actions taken to mitigate these risks by the closure of actions and supporting information within the SafeCare module, and the embedded practice of using SBAR's to identify risk and subsequent mitigating actions to be taken.
- The increased fill rates across inpatient areas of the Trust. This can be triangulated with a reduction in vacancies, deployed staff returning to their substantive areas, and improved fill rates of temporary staff across the Trust. Further work is required to reduce agency expenditure and for the lead in times for NHSP shifts across nursing.
- No red flags have been raised with respect to Maternity Services within the reporting period. Maternity Services continue to assess their staffing requirements to fulfil the requirements of the Ockenden Report and Continuity of carer. It is likely that this will require additional investment in the service.

- 2 StEIS reported hospital acquired pressures have been reported in Month. A more strategic improvement plan is being developed to enable the provision of evidence of practice change.

- 3 Falls with harm have been reported which have highlighted lack of awareness of the Enhanced Observations Policy. This policy is currently under review and will be relaunched with supporting education when this is completed.

- 5 CDT's have been reported within month.

- There were no staffing incidents noted at the time that the harms occurred.

Link to strategy

Delivery of safe care

Risks associated with this report and proposed mitigations

- Registered and unregistered nurse recruitment is being proactively managed, and the Trust is seeing an overall reduction of vacancies at both B5 and B2 levels. Further work is required to understand turnover by grade of staff and to evaluate the Trust offer to improve retention.
- The report highlights a lack of adherence to both the Pressure Ulcer Policy and the Enhanced Care Policy. A strategic Pressure Ulcer Improvement plan is being developed and once approved will be launched. The Enhanced Observation Policy is also under review and will require relaunch once completed. Review of clinical induction and how key policy are highlighted to staff is also required.

Financial implications

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

Legal implications

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

People implications

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

Wider implications

- Increased scrutiny from Commissioners and Regulators

Recommendation(s)

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

Safe Staffing Report – March 2021.

1.0 INTRODUCTION

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

2.0 SAFER STAFFING EXCEPTION REPORT

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

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

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

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

3.0 CURRENT POSITION – March 2021

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

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

The overall fill rates for registered and unregistered staff continues to improve. Specific areas for registered nurses within the report relate to the medical assessment areas and CDW; this triangulates with the vacancy and sickness rates for these inpatient areas reflected within the table at Appendix 1. There were no open areas with red registered staff indicators for nights within the reporting period. This reflects the continued work ongoing within the divisions to ensure that the E-Roster Policy is being applied within clinical areas and represents a significant improvement from the last report received by the Board.

In March there were 235 WTE vacancies (qualified and unqualified). Of these, 80 WTE had appointed to and 36 WTE were due to be filled via the pipeline of either student nurses or international nurses, which have been allocated to specific wards or departments. Therefore, the total number of registered nursing vacancies not recruited to is currently showing as 102 WTE qualified and 2 WTE unqualified. The reduction in unregistered vacancies is due to the proactive appointment of care makers with appropriate qualifications into these roles and a focused recruitment campaign. The Trust is on trajectory to fill all Band 2 vacancies by April 2021 in line with the national directive.

Of the overall registered nurse vacancies 55.63 WTE are at B5 level with the greatest number of vacancies within the acute provider arm of the Trust. A further virtual recruitment event is scheduled in April 2021. In addition, there are 20 International Nurses who have completed their OSCE training and are due to be aligned to vacancies across clinical areas.

There have been improvements in the use of the SafeCare module to record the redeployment of staff in response to shortfalls in staffing and the acuity of patients. In March 2021, 527 staff were redeployed from their substantively appointed areas; this figure sits out with the substantive staff redeployed in the longer term in response to the COVID pandemic. On scrutiny of the location the staff were redeployed from, the majority of these were Wrightington staff redeployed to support their own division, either on the Wrightington site or on Aspull Ward, with some support to other acute areas of the Trust.

The number of nursing red flags raised has increased significantly from the last report received (Appendix 2, Table 4), from 2 to 63. This triangulates with improved utilisation of the SafeCare module in recording the acuity of inpatients, and the increased scrutiny of staffing from the senior nursing teams. There have been 11 red flags raised in the reporting period by nursing teams relating to their being less than two registered nurses on duty. All these actions have been closed within the module with assurance provided that risks have been mitigated by the redeployment of staff.

Nurse staffing SBARs continue to be utilised across the inpatient areas of the Trust and provide assurance that staffing shortfalls are visible and actioned.

Within the community division staffing shortfalls and case mix continues to be reviewed daily and a risk stratified approach taken in the deployment of staff. There were no significant patient safety events reported in March 2021 and no harms reported as a result of staffing levels.

NHSP fill rates have also improved which has supported overall Trust staffing. The overall fill rate for March 2021 was 91% of shifts requested; 81% NHSP, 10% agency staff. The average lead time for requesting shifts was 24 days. Bank and agency utilisation continues to be higher than expected and reasons for this include vacancies, higher than expected sickness levels, increased patient acuity, back fill for staff still redeployed, and staffing for unfunded areas that remain open due to continued emergency pressures. It is recognised that further work is required to gain accuracy with regards to booking reasons, and to increase the lead in time for booking requests via NHSP. Tier 3 agencies are no longer being utilised by the Trust which should reduce agency expenditure.

There have been no red flags raised within March 2021 in Maternity services. Maternity Services continue to progress divisional plans to achieve the recommended 90:10 split in the workforce and to progress the introduction of Band 3 roles. This movement of staff is in line with National recommendations and further commentary will be provided with regards to this in the maternity staffing review. Work continues to progress the recommendations of the Ockenden Review which includes assessment of additional midwifery resource to deliver the recommended structure. In addition, the service is reviewing their midwifery resource required to support them to deliver Continuity of Carer.

CHPPD data from the Model Hospital is provided in Appendix 2 Table 6; this data was refreshed in February 2021. The Trust continues to compare favourably for CHPPD for overall staffing against peers and national benchmarking data and this was reflected in the improved fill rates for registered staff in February 2021.

The quality metrics provided within Appendix 1 demonstrate an reduction in the number of harms across the bedded areas of the Trust from pressure ulcers. 2 hospital acquired pressure ulcers were reported to StEIS within the reporting period (MAU and CDW). At the time of the reporting of these incidents there were no nursing red flags raised within these areas. It should, however, be noted there are high vacancy levels within MAU and therefore the proportion of temporary staff working within the area would have been increased. Themes from review of the concise investigation continue to be lack of registered nurse oversight and lack of consistency in the grading of skin

damage. The lack of improvement in these areas continues to be of concern to the Trust and the regulators. The Trust TVN lead plans to develop in April a strategic improvement plan to address both education and practice across all areas of the Trust; this plan will also address the requirement for more proactive intervention in the avoidance of lower graded pressure ulcers which should see a reduction in overall pressure ulcer rates across the Trust. The Board should note that there has been no StEIS reportable incidents for pressure ulcers from the community division for the past 4 months.

With regards to registered nurse oversight of patient care, the Chief Nurse plans to introduce a ward manager and a matron forum. These forums will provide supervision, leadership development and awareness sessions aiming to empower and further promote local ownership of improvement projects and the sharing of best practice.

There have been 3 falls with harm reported in March: Pemberton, Astley and ASU. All falls have been subject to concise investigation and review by the Falls Scrutiny Panel. The common theme with regards to these falls has been staff lack of awareness of the Enhanced Care Policy, and lack of evidence of multidisciplinary review post falls. This policy is currently under review by the Professional Practice Team and will be subject to relaunch once this is completed. The Falls Improvement Operational Group continues to review mechanisms to mitigate the risk of falls and to improve compliance with MDT review post falls.

5 CDT's have been reported within the reporting period. All have been subject to concise review and where learning has been identified local action plans have been developed. These cases are awaiting review by the CCG currently.

At year end the Trust had 43 CDT cases reported against a threshold of 20. Lapses in care were attributed in 9 cases to date. The Board should note that this figure may increase as there are 12 cases outstanding CCG review.

There was one medication incident resulting in patient harm reported on Orrell ward. When reviewing this incident, there was no associated link with staffing levels at the time the incident occurred.

4.0 ACTIONS BEING TAKEN

With regards to recruitment, there is a planned virtual recruitment event scheduled in April 2021; the 20 International nurses will need to be allocated to vacancies within clinical areas.

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

Review and development of a Strategic Pressure Ulcer Improvement Plan.

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

Review of the Enhanced Observations Policy.

5.0 RECOMMENDATIONS

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

Appendices

Appendix 1 Safe Staffing Exception Reports
March 2021

Scheduled Care Medicine

	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	96.1%	162.9%	3.8	171.2%	161.0%	7.4	12.32%	0.00%	4.71%	2		0/3		0/1		
Astley	95.9%	155.7%	3.3	144.6%	173.3%	6.7	14.21%	0.00%	1.94%	6		0/2				
Bryn North	162.5%	155.4%	12.7	89.9%	142.1%	11.6	Unable to report vacancies as there is no budget recorded for this department			7						
Bryn South	88.0%	94.2%	4.5	118.1%	139.7%	8.7						0/6				
Coronary Care Unit	170.5%	106.1%	8.4	308.8%		4.0	3.86%	17.40%	27.10%	3		0/1		0/1		
Highfield	0.0%	0.0%	0.0	0.0%	0.0%	0.0										
Ince	127.3%	95.4%	4.7	112.1%	145.6%	6.2	9.42%	15.67%	22.34%	4		0/1		0/1		
Pemberton	92.6%	109.8%	5.4	164.2%	131.0%	6.4	8.29%	0.00%	0.00%	3	1	1/1		0/1		
Shevington	122.1%	109.6%	3.6	164.5%	163.9%	6.5	3.49%	0.00%	9.88%							
Standish	93.5%	99.0%	2.9	127.9%	171.0%	5.7	2.84%	13.75%	26.00%	4		0/7		0/2		
Winstanley	0.0%	0.0%	0.0	0.0%	0.0%	0.0	15.03%	0.00%	1.11%			0/1				0.00%

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	118.9%	116.0%	28.0	90.5%		3.8	3.27%	0.00%	0.00%		1			0/3		
Langtree	83.2%	100.8%	2.6	159.6%	238.2%	4.2	5.71%	7.84%	27.50%	3		0/3		0/1		
Orrell	97.4%	100.6%	3.3	128.3%	143.0%	5.8	6.70%	3.44%	7.93%		1	1/3		1/1		
Swinley	98.5%	114.8%	3.5	143.4%	191.1%	4.0	7.48%	3.11%	10.68%			0/3		0/2		
Maternity Unit	98.7%	94.4%	15.2	87.7%	80.6%	3.7	1.71%	12.11%	14.87%	3				0/1		
Neonatal Unit	110.7%	116.1%	12.3	137.1%		2.3	3.18%	0.00%	0.10%							
Rainbow	101.2%	104.3%	9.2	177.7%	99.9%	4.7	9.65%	0.00%	0.00%	3				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	94.7%	100.3%	3.2	146.0%	180.0%	6.44	6.24%	19.23%	28.73%	11		0/1				
Ward A	17.8%	7.5%	25.1	10.4%	7.5%	18.67	4.76%	18.89%	18.43%							
Ward B	139.4%	165.5%	5.3	126.9%	123.6%	4.89	7.68%	23.65%	12.82%			0/4		0/1		
JCW	0.0%	0.0%	0.0	0.0%	0.0%	0.0	7.14%	23.30%	29.90%							

Division of Medicine – Unscheduled Care

	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Vacancies (%) - Registered Nursing Band 5-8	Datix Incidents - related to staffing/Red Flags	CDT	Falls (Harm / No Harm)	PU (Grade 1&2 / Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the hospital staff did everything they could do to control your pain?	Have you been given the care you felt you required when you needed it most?
A&E Emg Care	114.2%	128.6%		178.7%	226.5%		1.11%	10.55%	20.89%	3		0/5				
A&E Paeds	119.9%	98.6%					5.82%	0.98%	0.98%					0/1		
A&E NP's	70.2%	0.0%		36.9%												
CDW	62.9%	85.6%		117.3%	100.3%		11.71%	15.82%	25.85%							
Lowton	92.4%	105.5%		137.1%	176.5%		11.96%	0.00%	16.38%	1		0/5		01		
Medical Assessment Unit	75.9%	118.5%		134.2%	164.8%		8.40%	16.48%	40.83%	13	2	0/3		0/2		

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

Appendix 2

	March 2021	
No of areas	Red Metrics Registered Staff Days	Red Metrics Registered Staff Nights
24	**4**	**0**

Table 1. Red Metrics in Inpatient Areas March 2021

Month	Registered WTE	Unregistered WTE
March	102	2

Table 2. Nurse Vacancies March 2021 Trust Wide)

	March 2021
Specialty	B5 vacancies
Medicine	17.09
Surgery	14.67
Specialist Services	19.92
Community Services	3.96
Corporate	0
Total	**55.64**

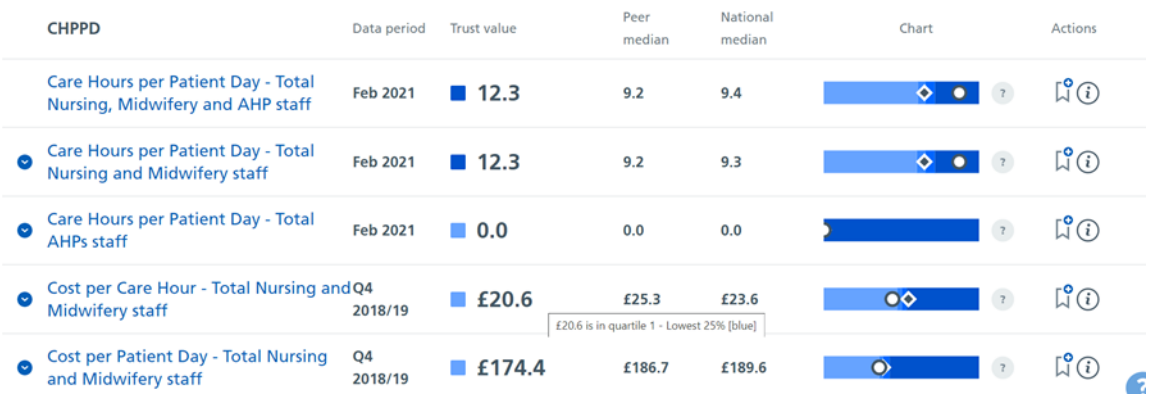
Table 3. B5 Nurse Vacancies March 2021 by Division

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

Table 4. Nursing Red Flags March 2021

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

Table 5. Maternity Red Flags March 2021.



CHPPD	Data period	Trust value	Peer median	National median	Chart	Actions
Care Hours per Patient Day - Total Nursing, Midwifery and AHP staff	Feb 2021	12.3	9.2	9.4		
Care Hours per Patient Day - Total Nursing and Midwifery staff	Feb 2021	12.3	9.2	9.3		
Care Hours per Patient Day - Total AHPs staff	Feb 2021	0.0	0.0	0.0		
Cost per Care Hour - Total Nursing and Midwifery staff	Q4 2018/19	£20.6	£25.3	£23.6		
Cost per Patient Day - Total Nursing and Midwifery staff	Q4 2018/19	£174.4	£186.7	£189.6		

£20.6 is in quartile 1 - Lowest 25% [blue]

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

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Maternity Provider Board Level report
Presented to:	Trust Board
On:	26.05.2021
Presented by:	Rabina Tindale
Prepared by:	Cathy Stanford Acting Divisional Director of Midwifery and Neonates
Contact details:	Cathy.stanford@wwl.nhs.uk 01942 773107

Executive summary

The provider trust and its board, supported by the senior maternity and neonatal triumvirate and the board-level perinatal safety champion at its centre, ultimately remain responsible for the quality of the services provided and for ongoing improvement to these**.** Since 2017 all trust boards have been required to have a board-level safety champion, whose remit is to bring together a range of internal sources of insight to provide strategic oversight and leadership for perinatal safety.

NHS England and Innovation (Dec 2020) set out six requirements to strengthen and optimise board oversight for maternity and neonatal safety:

1. To appoint a non-executive director to work alongside the board-level perinatal safety champion to provide objective, external challenge, and enquiry.
   - WWL is compliant with this, Named NED in place.
2. That a monthly review of maternity and neonatal safety and quality is undertaken by the trust board.
   - Achieved through Maternity Dashboard and exception report.
3. That all maternity Serious Incidents (SIs) are shared with trust boards and the LMS, in addition to reporting as required to HSIB.
   - These will be shared with the Board on a Quarterly basis or by exception when required.
4. To use a locally agreed dashboard to include, as a minimum, the measures set out in Appendix attached drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.
   - Achieved through attached Board provider dashboard and exception report.

5. Having reviewed the perinatal clinical quality surveillance model in full, in collaboration with the local maternity system (LMS) lead and regional chief midwife, formalise how trust-level intelligence will be shared to ensure early action and support for areas of concern or need.
    - Regional Maternity Serious Incident Group (SIG) meets monthly to receive lessons learned from GM Trusts moderate and above incidents, feedback learning from HSIB cases and any relevant Neonatal cases. External review of cases through the LMS in place as appropriate. WWL is compliant with Perinatal Mortality Review Tool (PMRT) recommendations for reviewing all stillbirths and Neonatal Deaths.

6. To review existing guidance, refreshed how to guides and a new safety champion toolkit to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model
    - To be presented at Safety Champion meeting in May, the toolkit outlines the key roles and responsibilities of the Board Level and obstetric, midwifery and neonatal safety champion leads.

Link to strategy

Quality Strategy

Risks associated with this report and proposed mitigations

Regulator concern if metrics persistently

Financial implications

N/A

Legal implications

Possible if poor maternal or fetal outcomes

People implications

Poor performance measures will deter women from choosing WWL maternity Services

Wider implications

Poor performance measures will reflect badly on the Trust and may invoke regulatory actions

Recommendation(s)

The board are asked to review the provider template attached and provide any feedback for any metrics that they wish to be included going forward or request any further information that may be required on any of the metrics reported.

CS May 2021

The board are asked to note the dashboard and overview of indicators as outlined below.

Report

Introduction

It is intended that each quarter the Board will receive the summaries of all incidents graded moderate and above. These will include summaries of IPIR's and complete concise and Steis investigation reports, inclusive of any cases reported to the Health-service Safety Investigation Branch (HSIB).

Exception Report

There are no concerning metrics to report in April. However, it is noted that the Board raised some concerns regarding the Induction of Labour (IOL) rate as this was flagged as red on the Maternity Dashboard.

WWL Maternity services fully adheres to NICE and Royal College recommendations regarding the criteria and indications for IOL.

The Saving Babies Lives (SBL) Care Bundle was launched following an MBRRACE report in 2015 that highlighted significant variation in stillbirth rates across England, with poor detection of fetal growth restriction and small for gestational age babies, it recommended the need for improvements in fetal monitoring, improved success rates for women reducing or stopping smoking by the time of birth and improved management of women experiencing changes in their baby's movements.

Since its introduction mothers reporting reduced fetal movements, and infants suspected to be small for gestational age have been consistently the top 1&2 of all reasons for induction of labour.

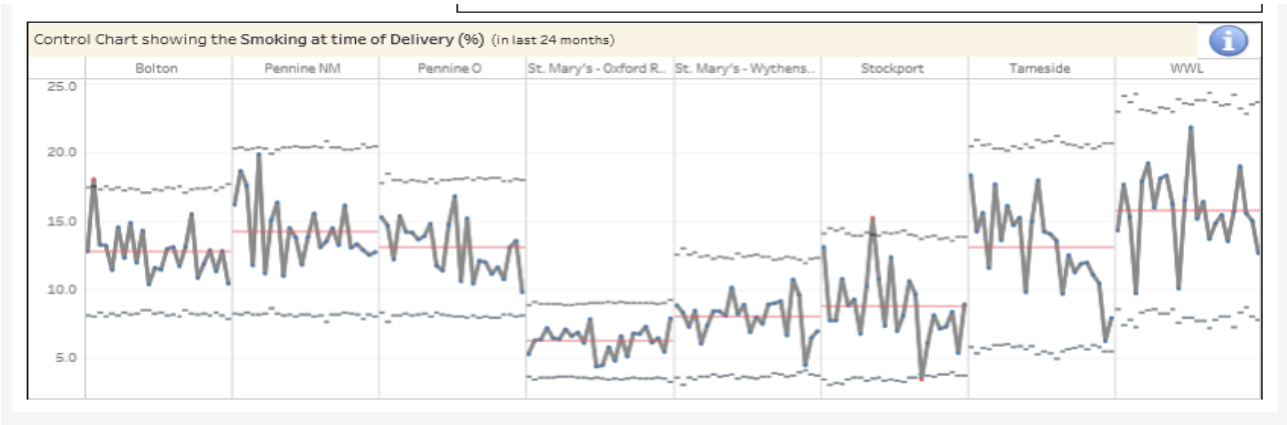
The SBL Care Bundle was designed to help Trusts reduce still births, early neonatal deaths and intrapartum brain injuries and achieve the national ambition to reduce the rate of these poor outcomes by 50% by 2030. Additionally, implementation of the 5 elements of the SBL Care Bundle is a requirement to be eligible for Clinical Negligence Scheme for Trusts (CNST) discount scheme.

The bundle consists of 5 elements that have been proven to reduce stillbirth numbers:

- Element 1 Reducing smoking in pregnancy
- Element 2: Risk assessment and surveillance for fetal growth restriction
- Element 3: Raising awareness of reduced fetal movement (RFM)
- Element 4: Effective fetal monitoring during labour
- Element 5: Reducing Pre-Term Birth (additional element added March 2019)

Implementation of National recommendations to detect any early indicators that may lead to a poor fetal outcome, has resulted in an increase in the IOL rate. Additionally, women identified as having risk factors such as Maternal age, high BMI, and medical conditions such as Diabetes and Hypertension will also be offered IOL to minimise the risk of poor outcomes.

Fetal surveillance through serial ultrasound scanning as recommended within the SBL care bundle means that more women now meet the criteria for scanning throughout their pregnancy where risk factors have been identified. WWL has an excellent detection rate of small for gestational age (SGA) infants and is consistently within the top 10% of trusts for identifying this risk factor. Whilst WWL sits just above the GM average, the acuity of women within the borough is known to be higher, as smoking (Currently 17% smoking at booking and the highest in GM) and high BMI rates (26% <30 and 11% <35) are prevalent within the population, along with high social and economic deprivation levels, as 29 of Wigan's 200 neighbourhoods fall within the 10% most deprived neighbourhoods in England. This equates to around 16 per cent of Wigan's total population. All these factors increase the likelihood of women having a small for gestational age baby.



Maternity services have now signed up to the Greater Manchester Baby Clear programme and have invested in the appointment of a smoking cessation lead midwife and HCA support to reduce the rates of women who are still smoking at time of delivery (SATOD).

IOL rates should not be viewed in isolation and should always be bench marked against a services outcome measures in relation to Stillbirth and Hypoxic Ischaemic Encephalopathy (HIE) and early Neonatal Death

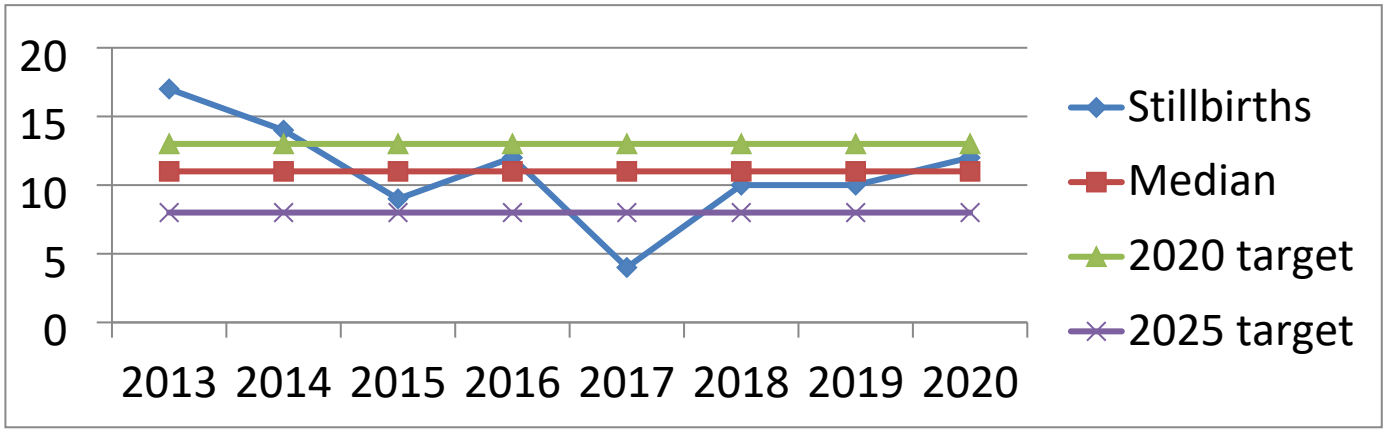
The stillbirth rate for WWL has met the 25% reduction in numbers by 2020 and remains on target to achieve 50%. (See below)

Stillbirth/ NND/HIE Rates.

Year	Number of Stillbirths	Total number of Births	Mortality rate per 1000 births (not adjusted)	Neonatal Deaths	Hypoxic Ischaemic Encephalopathy
2020	12	2354	5.10	1	0
2019	10	2484	4.42	4	1
2018	10	2638	4.17	1	1
2017	6	2820	2.13	2	2
2016	13	2785	4.67	2	1

CS May 2021

Stillbirth Trajectory



Top 10 Reasons for Induction of Labour					
	2016	**2017**	**2018**	**2019**	**2020**
1	RFM	SGA	SGA	SGA	RFM
2	SGA	RFM	RFM	RFM	SGA
3	Post Dates	Post Dates	Post Dates	Post Dates	Post Dates
4	Diabetes	Diabetes	Diabetes	Hypertensive Conditions	Hypertensive conditions
5	Hypertensive Conditions	Hypertensive Conditions	Hypertensive Conditions	Diabetes	Diabetes
6	Mat Medical Conditions	Mat Medical Conditions	Obstetric Cholestasis	Large for Gestation	Mat Medical Conditions
7	Fetal Conditions	Past Obstetric History	Large for Gestation	Mat Med Conditions	Fetal Conditions
8	Past Obstetric History	IVF	Mat Medical Conditions	IVF	IVF
9	IVF	Fetal Conditions	Fetal Conditions	Fetal Conditions	Obstetric Cholestasis
10	Obstetric Cholestasis	Misc Medical Conditions	Large for Gestation	Obstetric Cholestasis	Large for Gestation
Total	1094	1161	1079	1058	1040
Births	2785	2820	2638	2484	2354

MatNeoSIP Quality Improvement Programme.

The Maternity and Neonatal Safety Improvement Programme (previously the Maternal and Neonatal Health Safety Collaborative) aims to improve the safety and outcomes of maternal and neonatal care by ensuring consistent, effective high-quality healthcare for all women, babies, and families across maternity and neonatal care settings in England. It contributes to the national ambition of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 50% by 2025.

MatNeoSIP is led by the National Patient Safety team and covers all maternity and neonatal services across England. It continues to be supported by 15 regionally based patient safety collaboratives and is hosted locally by Health Innovation Manchester. By working in partnership with the GMEC local maternity systems it offers a unique opportunity for sharing best practice as well as learning and improvement through interaction, collaboration, and information sharing.

At WWL we will be using quality improvement methodology to improve the early recognition and management of the deterioration of women and babies and support the national aim of reducing the rate of still births, neonatal death, and brain injuries during or soon after birth; and to reduce the national rate of preterm births from 8% to 6%. We will be looking specifically at the Ockenden recommended immediate action of improving outcomes by ensuring completion of robust risk assessment at every face-to-face antenatal contact. We are aiming for 60% completion by October 2021 and 95% by March 2022. This will ensure early identification of risk factors and allow for efficient and effective referral pathways and continued access to care provision by a suitably trained health professional and/or service.

We endeavour to do this by utilising the Greater Manchester and East Cheshire risk assessment proforma within the green handheld pregnancy notes for completion at each antenatal contact. Data will be collected quantitively using a regular randomised spot check method and formally audited to ensure ongoing compliance and any changes/updates communicated with staff.

By implementing the MatNeoSIP quality improvement programme at WWL we can strive to ensure care continues to be of high quality and is efficient, appropriate, and effective. In doing so this will enable robust ongoing review of risk factors and referral to the most suitable place, by an appropriately trained health professional and personalised to meet the individual needs of the woman and her family to ensure optimal outcomes.

Agenda item: 9

Board level measures

Wrightington, Wigan And Leigh NHS Foundation Trust

CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Good	Good	Good	Good	Good	Good

Maternity Safety Support Programme	Select Y / N:	If No, enter name of MIA

	2021					
	Jan	Feb	Mar	Apr	May	Jun
Findings of review of all perinatal deaths using the real time data monitoring tool (quarterly reports)		See attached Appendix 1 in Board Report				
Findings of review all cases eligible for referral to HSIB.		Summary of cases to be provided for April Board Report	To be submitted with April Board papers	To be submitted with April Board papers		
The number of incidents logged graded as moderate or above	7	6	5	6		
Training compliance for all staff groups in maternity as per CNST requirments (need 90% compliance rate for all staff groups by July 2021)						
Cardiotocograph (CTG) training and competency assessment	Midwives 82% Consultant 72% Registrars 75%		Midwives 92.8% Consultant 100% Registrars 90.4%	Midwives 98% Consultant 100% Registrars 90.4%		
Practical Obstetric Multi-Professional Training (PROMPT) (emergency Skills Drills Training)	Midwives 42% HCA's 21% Consultant 18% Registrars 24% Anaesthetists 18%	Midwives 62% HCA's 42% Consultant 81% Registrars 90% Anaesthetists	Midwives 78% HCA's 53% Consultant 90% Registrars 100% Anaesthetists 81%	Midwives 88% HCA's 67% Consultant 90% Registrars 100% Anaesthetists 88%		

	Anaesthetic Staff 0%	81% Anaesthetic Staff 0%	Anaesthetic Staff 0%	Anaesthetic Staff 3%		
Minimum safe staffing in maternity services including:						
Prospective Consultant Delivery Suite Cover (60 as standard for WWL)	60	60	60	60		
1:1 care in labour	99.40%	100%	99.42%	99.38%		
Supernumeray Shift Co-ordinator	100%	100%	100%	100%		
Number of Datix submitted when shift co-ordinator not supernumerary	0	0	0	0		
Service User Voice feedback		Bi-monthly meetings in place. No services users currently sitting on the committee. Actively recruiting women.	The Maternity section of the Trust website is to be re-vamped with input from staff and members of the MVP. There will also be collaboration with MVP for review of Patient Leaflets. There will also be a further 10 Steps Walkabout.	Meetings have taken place with regards to revamping the maternity pages of the trust website. Ongoing recruitment by MVP chair continues		
Staff feedback from frontline champions and walk-abouts	N/A	N/A	Information regarding CoC to be cascaded to staff… webinar has been facilitated with staff and National CoC leads as requested and agreed. Additional staff training for BCG vaccinations ahs been requested New equipment	Safety Walkabout to take place on 21 May 2021		

			requests (Biliblankets, light boxes) has be forwarded to Matron to explore funding. More user-friendly pool to be explored by management team. Access to NIPE system for locum paediatric staff to be explored.			
Healthcare Safety Investigation Branch (HSIB)/NHS Resolution (NHSR)/CQC or other organisation with a concern or request for action made directly with Trust	1 from CQC re Maternity Emergnecy Theatre	0	0	0		
Coroner Reg 28 made directly to Trust	0	0	0	0		
Progress in achievement of CNST 10		To be presented at March Board Meeting.	8 Safety Actions compliant. On track to achive remaining 2 by July 15 deadline . See Board Report	8 Safety Actions compliant. On track to achive remaining 2 by July 15 deadline . See Board Report		
Number of StEIS Reportable Incidents/HSIB case	1	0	1	0		
Number of Stillbirths	1	1	0	0		
Number of Neonatal Deaths	0	1	0	0		
Number of Maternal Deaths	0	0	0	0		

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	

Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	

Title of report:	Maternity Dashboard
Presented to:	Trust Board
On:	26.05.2021
Presented by:	Rabina Tindale
Prepared by:	Cathy Stanford Acting Divisional Director of Midwifery and Neonates
Contact details:	Cathy.stanford@wwl.nhs.uk 01942 773107

Executive summary

Maternity performance is monitored through local and regional Dashboards, The Maternity Dashboard serves as a clinical performance and governance score card, which helps to identify patient safety issues in advance so that timely and appropriate action can be instituted to ensure a woman-centred, high-quality, safe maternity care.

The use of the Maternity Dashboard has been shown to be beneficial in monitoring performance and governance to provide assurance against locally or nationally agreed quality metrics within maternity services a monthly basis.

The key performance targets are measured using a RAG system which reflects national, regional and local performance indicators.

• Green – Performance within an expected range.

• Amber – Performing just below expected range, requiring closer monitoring if continues for 3 consecutive months

• Red – Performing below target, requiring monitoring and actions to address s required.

Link to strategy

Quality Strategy

Risks associated with this report and proposed mitigations

Regulator concern if metrics persistently

Financial implications

N/A

Legal implications

Possible if poor maternal or fetal outcomes

People implications

Poor performance measures will deter women from choosing WWL maternity Services

Wider implications

Poor performance measures will reflect badly on the Trust and may invoke regulatory actions

Recommendation(s)

The board are asked to note the dashboard and overview of indicators as outlined below.

Maternity Dashboard April 2021

Introduction

The Maternity Dashboard provides a monthly overview of the Maternity Directorate performance against a defined set of key performance and safety indicators.

Each month data is collated from the maternity Information system Euroking to monitor outcomes against key performance metrics. These metrics are regularly reviewed against local and national standards (Appendix 1).

The maternity dashboard is reviewed at Directorate, Divisional and Corporate Clinical Governance Meetings.

The metrics are measured using a RAG system.

• Green – Performance within an expected range

• Amber – Performing just below expected range, requiring close monitoring if continues for 3 consecutive months

• Red – Performing below target, requiring monitoring and actions to address.

April 2021 Exception report

Green

Most of the dashboard remains green. There have been no cases reported to the Healthcare Safety Investigation Branch (HSIB) or babies diagnosed with HIE 2 or 3.

There were 0 Maternity complaints in April and the service continues to receive positive feedback letters and messages from Women regarding the excellent care they have received.

The Midwife to Birth ratio remains positively high at 1:24. however the service is moving towards establishing continuity teams which is case load based. The Staffing establishment is in line with Birthrate+ recommendations for implementing Continuity of carer. A full staffing review has been undertaken to understand the requirements for core staffing and the Continuity of Carer targets of 51% to be reached by March 2022.

The overall Caesarean section rate has significantly reduced in April to 26.5% which is below the national average, however this rate will continue to fluctuate month on month.

Induction of Labour(IOL) has shown a positive reduction to 38% which is the GM average rate which is indicative of the fluctuations that will naturally be seen within any Maternity data.. IOL should not be viewed in isolation and should always be looked at in conjunction with outcomes such as Stillbirth and HIE rates.

1-2-1 care in labour remains positively high at just under 100%, and Skin to skin contact at birth has greatly improved continuing to remain above the 80% target in the last 3 quarters.

MDT training (Virtual) remains on target to achieve the required 90% compliance for all eligible staff groups. Plans are in place to return to face to face training in June if restrictions remain on plan to be lifted.

To achieve accurate booking numbers and compliance rates with bookings completed by 12.6 weeks this is reported retrospectively. The service continues to meet the 90% standard.

It is recommended that the mothers of all babies born less than 34 weeks gestation are offered 2 single doses of intramuscular steroids within 7 days prior to the birth of the baby to aid fetal lung maturity. The national compliance is expected to be 85. There were 3 eligible singleton births in April and 100% compliance was achieved.

There were no Stillbirths or Neonatal Death's in April **(**The stillbirth ratio for 2020 was 3.41 which is within the National average rate.)

Amber

The number of registerable births has reduced this month and in addition the normal birth rate has also reduced below the 60% target to 58.6%, which is due to the increase in the instrumental delivery rate. However, it should be noted that these rates will always fluctuate and on average they remain broadly within the expected range.

The number of mothers who have opted to breastfeed has remined steady at just under 52% initiating breast feeding. The midwifery team in conjunction with the infant feeding team continue to actively promote the benefits of breastfeeding to all mothers and families.

Red

Unexpected term admission to Neonatal Unit (NNU) have increased in month which will be monitored as this is usually a low rate for WWL. Which coincides with an increase in the number of babies with an Apgar score <7 at 5 mins. All these births will be reviewed as they meet the requirements for an internal immediate post incident review (IPIR

Agenda item: 9

Maternity Dashboard 2021

					2020 Data					2021 Data									
		Goal	Red Flag	Measure	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Q1	Q2	Q3	Q4	YTD
Activity	Number of Registerable Births	>200	<180	2020 Births	167	220	241	202	193	192	182	208	181		582	181			763
	Number of Bookings(retrospective 1 month)	≥240	≤200	2020 Bookings	216	247	233	226	246	238	252	285	231		775	231			1006
	Normal Births as % of births	>=60%	<55%	Nat Standard	62.3%	54.5%	53.9%	66.8%	62.2%	52.6%	57.7%	60.1%	58.6%		56.9%	58.6%			57.3%
	% of Successful Planned Home Births			Births/month	1.2%	0.9%	0.8%	2.0%	2.1%	2.6%	3.8%	1.9%	2.2%		2.7%	2.2%			2.6%
	Instrumental Deliveries as % of births	<12%	>15%	Nat Average	9.6%	10.0%	17.8%	9.9%	7.8%	15.6%	12.6%	10.6%	14.9%		12.9%	14.9%			13.4%
	Total Caesarean Sections as % of births	<29%	≥34%	GM Average	27.5%	35.5%	28.2%	32.2%	30.1%	31.8%	29.7%	29.3%	26.5%		30.2%	26.5%			29.4%
	% Emergency Caesaean Sections				17.4%	23.2%	14.5%	18.3%	17.6%	20.8%	18.7%	17.8%	14.4%		19.1%	14.4%			18.0%
	% Elective Caesarean Sections				10.8%	12.3%	13.7%	13.9%	12.4%	10.9%	11.0%	11.5%	12.2%		11.2%	12.2%			11.4%
	Number of successful VBAC deliveries			Births/month	2	3	2	7	3	8	6	3	5		17	5			22
	%of Caesarean Sections at Full Dilatation			Births/month	15.2%	9.0%	1.5%	7.7%	10.3%	9.8%	7.4%	1.6%	8.3%		6.3%	8.3%			6.7%
	Induction of Labour as % of women delivered	<38%	>=42%	Births/month	44.3%	35.0%	38.2%	39.6%	40.9%	42.7%	41.2%	45.2%	38.1%		43.1%	38.1%			41.9%
	% of women induced when RFM is the only indication <39 weeks				1.2%	1.4%	0.8%	2.0%	0.0%	1.0%	1.6%	1.4%	1.1%		1.4%	1.1%			1.3%

	% of women induced for Suspected SGA				7.8%	6.8%	6.2%	6.4%	7.3%	6.8%	12.1%	12.0%	7.7%		10.3%	7.7%			9.7%
	Average Postnatal Length of Stay	≤1.5	≥1.8	Births/month	1.6	1.5	1.7	1.6	1.5	1.4	1.6	1.6	1.5		4.6	1.5			6.1
	Number of In-utero transfers in from other units				2	1	0	1	1	1	0	0	0		1				1
	Number of In-utero transfers out to other units				1	1	6	0	0	0	4	1	0		5				5
	%of Women Smoking at Booking			2020 Bookings = 17%	14.0%	16.2%	18.5%	14.6%	10.2%	15.1%	10.7%	8.4%	11.7%		34.3%	100.0%			46.0%
	% of Women Smoking at Delivery	14%	17%	2020 Births	15.7%	19.0%	15.1%	14.5%	12.1%	15.3%	16.6%	10.1%	15.1%		42.0%	100.0%			57.1%
	Percentage of Babies in Skin-to-Skin within 1 hour of birth	≥80%	≤70%	Regional average	86.7%	80.4%	80.9%	84.1%	82.9%	81.7%	80.7%	82.2%	80.7%		81.6%				#VALUE!
	Percentage of Women Initiating Breastfeeding	≥55%	≤50%	2020 Births	51.2%	46.1%	50.2%	55.7%	51.8%	57.1%	57.5%	51.9%	51.4%		55.3%				#VALUE!
	Percentage of Women booked by 12+6 weeks	≥90%	≤80%	Nat Standard	88.0%	88.3%	91.0%	92.9%	94.3%	92.0%	88.5%	92.3%	90.9%		91.0%	90.9%			91.0%
Workforce	Prospective Consultant hours on Delivery Suite	60 hours	< 60 hours	Nat Standard	60	60	60	60	60	60	60	60	60		180	60			240
	Midwife: Birth Ratio	≤ 1:28	≥1:24	WTE/Births	1.23	1.22	1.23	1.25	1.25	1.25	1.24	1.25	1.24		1.74	1.24			1.98
	1:1 Care in Labour	100%	<100%	Nat Standard	98.59%	99.42%	98.99%	98.80%	100%	99.40%	100%	99.42%	99.38%		481	151			632
	Percentage of shifts where shift Co-ordinator unable to remain supernumerary	0%	<100%	Nat Standard	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
	Diverts: Number of occasions unit unable to accept admissions				0	0	0	0	0	0	0	0	0		0	0	0	0	0

	Diverts: Number of women during period affected by unit closure				0	0	0	0	0	0	0	0	0		0	0	0	0	0
	Attendance at Skills Drills/Mandatory Training	≥8%	<8%	Training Database	11.6%	10.0%	9.3%	10.5%	11.9%	13.4%	10.4%	16.8%	11.7%		13.6%	11.7%			13.1%
Maternal Morbidity	3rd/4th Degree Tear as % of births	<3%	≥4%	2020 Births	1.2%	1.4%	3.4%	3.0%	1.6%	3.2%	3.3%	2.9%	3.9%		3.1%	3.9%			3.3%
	with unassisted births (normal)			2020 Births	1.2%	0.5%	1.7%	2.0%	1.6%	2.6%	1.7%	1.5%	1.1%		1.9%	1.1%			1.7%
	with assisted births (Instrumental)			2020 Births	0.0%	0.9%	1.7%	1.0%	0.0%	0.5%	1.7%	1.5%	2.8%		1.2%	2.8%			1.6%
	% of Episiotomies in Normal Birth			Births/month	10.6%	10.0%	8.5%	4.4%	7.5%	7.9%	4.8%	8.8%	7.5%		7.3%	7.5%			7.3%
	PPH >2.5L as % of births			Births/month	0.6%	0.0%	1.2%	0.5%	1.0%	0.5%	0.0%	0.5%	0.0%		0.3%				10.0%
	Number of Blood Transfusions ≥ 4 Units			Births/month	1	0	1	1	1	1	0	1			2				2
	Number of Women Requiring Level 2 Critical Care			Births/month	4	4	0	2	2	2	3	1	1		6	1			7
	Number of Women Requiring Level 3 Critical Care			Births/month	1	0	0	0	0	0	0	1	0		1				1
	Maternal Deaths			Nat rate per 1000	0	0	0	0	0	0	0	0	0		0				0
	Number of women re-admitted within 28 days of delivery	≤1	>2	16 in 2020	1	2	2	0	1	2	2	1	1		5	1			6
Neonatal Morbidity & Mortality	Stillbirths **			Nat rate 3.5 per 1000 births	1	1	0	1	0	1	1	0	0		2				2
	Early Neonatal Deaths (before 7 days)			Nat rate per 1000 births	0	0	0	0	1	0	1	0	0		1				1
	Number of Neonates with Apgars <7 at 5 minutes (≥37 weeks gestation)	≤1	>2	GM av 10 per 1000	1	2	4	2	0	1	1	1	3		3	3			6

	HIE 2 &3 > 37 weeks (reported retrospectively)			GM av 1.95 per 1000	0	0	0	0	0	1	0	0	0		1				1
	Shoulder Dystocia as % of births			Births/month	1.2%	2.7%	0.8%	0.5%	0.0%	0.0%	2.2%	1.0%	2.2%		1.0%	2.2%			1.3%
	Singleton Babies born <30 weeks gestation			Births/month	3	1	0	1	1	0	2	1	0		3				3
	% whose mother received magnesium sulphate	100%	90%	Rolling% of eligible babies	100.0%	100.0%	0	100.0%	100.0%	0	100.0%	100.0%	0		100.0%				100.0%
	Singleton Babies born <34 weeks gestation			Births/month	8	3	7	2	2	4	4	3	3		3				3
	% whose mother received full course of steriods (1 week prior to delivery)	100%	90%	Rolling% of eligible babies	75.0%	33.3%	71.4%	0.0%	50.0%	75.0%	75.0%	33.3%	100.0%		63.6%	100.0%			71.4%
	Unexpected Term Admissions to NNU as % of births > 37 weeks gestation.	3.50%	>4.5%	Births> 37 weeks /month	3.4%	2.5%	1.8%	2.6%	2.9%	4.6%	1.2%	4.3%	4.8%		3.4%	4.8%			3.8%
	Number of babies re-admitted with 28 days of birth	<16	>20	194 in 2020	12	15	18	14	12	21	9	14	17		44	17			61
Risk Management	Number of indicents reported				53	57	91	42	53	67	58	51	61		176	61			237
	Number of Concise Investigations				0	0	0	0	0	0	1	2	0		3	0	0	0	3
	Number of StEIS Reported Incidents				0	0	0	0	0	1	0	1	0		2	0	0	0	2
	Number of Midwifery Red Flags Reported				0	0	0	0	0	0	0	0	0		0	0	0	0	0
	Number of Complaints				0	0	0	1	0	0	1	0	0		1	0	0	0	1
	Number of Letters of Claim Received				0	0	0	0	0	0	0	0	0		0	0	0	0	0

*ratio can only be calculated at year end. 2018 MBRRACE WWL adjusted ratio 3.8

Title of report:	Ockenden Report progress with recommendations.
Presented to:	Trust Board
On:	26.05.2021
Presented by:	Rabina Tindale Chief Nurse
Prepared by:	Cathy Stanford Acting Divisional Director of Midwifery and Neonates
Contact details:	T: 01942 773107 E: cathy.stanford@wwl.nhs.uk

Executive summary

Ockenden Review of Maternity Services.

Part 1 of the Ockenden Report was published on 10 December 2020. This report looked at Maternity services within Shrewsbury and Telford NHST following concerns that had been raised over the care and management the patients received from maternity services. The report covered a period of 19 years from 2000-2019. It included Stillbirths, Maternal Deaths, Neonatal deaths, and severe Brain Injuries in the neonate.

In total 250 cases have been reviewed so far. There were however 1862 families who had contacted the Trust with concerns and 750 cases of poor outcomes were identified.

The main themes that have come out of the Report are:

- Lack of Kindness and compassion
- Executive leadership turnover at The Shrewsbury and Telford Hospital NHS Trust impacted organisational knowledge and memory
- Inappropriate risk assessments and inappropriate place of birth
- Lack of maternal and fetal monitoring
- Poor consultant oversight of high-risk women
- Lack of escalation
- Failure to recognise abnormal CTG
- Reluctance to undertake C/Sections
- Lack of MDT management of women with complex medical risk
- Lack of investigation and poor-quality investigations

Link to strategy
Quality Strategy

Risks associated with this report and proposed mitigations
Trust reputation

Financial implications
Some financial implication regarding funding for specialist posts.

Legal implications
None

People implications
Safe effective and caring service to mothers and babies

Wider implications
The inability to demonstrate compliance with the recommendations will reflect badly on the Service and may instigate regulatory oversight

Recommendation(s)
It is requested that Board of Directors review the contents of this paper to gain assurance that the issues relating to the Ockenden report have been and are continuing to be considered.
The Board is asked to note what has been done so far, what further actions are required to achieve compliance with the recommendations in the immediate term and what longer term actions will be required to provide assurance going forward.

Report
NHS England requested that maternity services implement all 7 IEAs described in the document and they have additionally identified 12 urgent clinical priorities from these 7 IEAs.
All maternity services have been asked to provide assurance that they comply with these 12 urgent clinical priorities.

The assessment and assurance tool has now been developed into an action plan where any gaps have been identified. The action Plan is being monitored by a Task and Finish group led by the Medical Director and Chief Nurse.

Overall, there are no actions identified as red with the majority being, green / fully compliant or amber / working towards.
An evidence portal has been set up for all Trusts to submit their evidence of compliance for regional and national oversight. This must be completed by the 14 June 2021 and will require a substantial amount of evidence against each action, to demonstrate compliance or working towards. It is expected that following the submission for Regional and National oversight there will

be a Quality Assurance visit from the Regional Team as additional monitoring of compliance and support in achieving the recommended standards.

Governance & Next Steps

Additional Governance oversight of the on-going action plan is received from the Directorate Obstetric and Gynaecology Clinical Cabinet and the Divisional Quality Executive Group
This assessment and review is ongoing and will remain a priority focus within Maternity Governance.

Higher level overview of the 7 Immediate and Essentialia Actions is detailed below within the action plan. Please be advised that each action has several additional actions within it to demonstrate overall compliance some of which may be green, and others still being worked towards.

Appendices

Appendix 1: Assessment and Assurance Tool (Action Plan)
Appendix 2: Quality Surveillance Model Proposal
Appendix 3: Terms of reference - Safety Special Interest Group

NHS

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Maternity services assessment and assurance tool

Section 1

Immediate and Essential Action 1: Enhanced Safety

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

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

Link to Maternity Safety actions:

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

Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?

Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model

All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?	RAG
Safety in Maternity units to be strengthened by increasing partnerships between Trusts and within local networks							

The Trust has a robust process in place for the review and reporting of all perinatal deaths. The Trust utilises the Perinatal Mortality Review Tool (PMRT) process for the review of all >22week gestation stillbirths (SB) and neonatal deaths (NND). Parental involvement in the review is invited and encouraged in consultation with the Bereavement Midwife and Consultant lead and use of the PMRT parental engagement tools. Quarterly reports on perinatal deaths (SB & NND) are tabled at the Obstetrics and Gynaecology clinical issues group and Clinical Cabinet, where lessons learnt, action plans and safety actions are identified and agreed. External reviewers are requested to attend both stillbirth and neonatal PMRT review meetings as required and dependant on availability as no formal regional process is in place. The Trust has a policy in place for the Management of Incidents and serious incidents (SI's) which follows the National guidance on the Management of serious incidents. As indicated in the policy all serious incidents are report to Steis . Additionally, there is a local maternity SOP which specifically details the requirements for all maternity serious incidents. The executive Scrutiny Group receives Immediate Post Incident Reviews (IPIR) on a weekly basis where consideration is given for further review and lead investigators identified as appropriate. The Trust and Maternity service also report all eligible cases to the Healthcare Safety Investigation Branch (HSIB). Plans are now in place for monthly reporting of all serious incidents to Trust Board which will include any lessons learned and recommendations. As recommended within the Ockenden Report and the Perinatal surveillance tool the Trust also submit monthly all moderate and above incidents the LMS Safety Serious incident Group (SIG) for shared learning and dissemination. Final reports from serious incident investigations are shared with families upon completion.							
The National Perinatal Mortality Review Tool to review perinatal deaths and identify Themes and trends Significant areas where lessons can be learned with individual cases are added to any action plans for individual cases. Action Plans Monitored at the Obstetrics and Gynaecology Clinical Cabinet and or Serious Incident Requiring	The PMRT Tool is used to standardise review of all cases that are eligible and to feed into other maternity reviews such as Immediate Post Incident Review (IPIR) and/or Concise investigations when required. Findings from the PMRT data reports are compiled into a quarterly report that is cascaded throughout the Maternity Service to update all staff. Any improvement actions including actions from the Saving Babies Lives care bundle (V 2.0) are discussed in this review.	Weekly tabletop meetings are in place for discussion of incidents that require a PMRT review. These are attended by the MDT with the appropriate clinicians involved. **Eligible cases include:** Stillbirth Neonatal Death Maternal Death Mothers/ Families are asked to contribute to all Maternity and Neonatal investigations and feedback is always provided in agreement with the family in a format that is agreed. Reduction in avoidable harms and reduction in numbers of stillbirths	Quarterly PMRT reports to be submitted to Trust Board. If any specific trends in causes of stillbirths or neonatal deaths, lessons learned from reviewing the cases or broader concerns identified then these would be raised at the Maternity Service Clinical issues meeting or wider within the network as appropriate. A multi-disciplinary action plan would be developed and monitored through the appropriate forums dependent	Ongoing / Continual Sarah Howard Bereavement Lead Midwife Cathy Stanford Acting Divisional Director of Midwifery. Head of Governance Maternity and Child Health	Further support is available as requested from the region to implement external reviews by independent clinicians.	Continue with process in place, for majority of PMRT reviews. Where it is deemed there is a requirement for external review this will be sought independently or through the LMS.	

Review Panel(SIRI) if the incident has been reported to StEIS		Recommendations are implemented	on the issue identified.				
Report case to HSIB that meet the criteria for external review	All babies that meet the Each baby counts criteria are referred to HSIB and NHSR for consideration and review	Cases reported via the incident reporting system (Datix)/ Immediate review undertaken (IPIR) Case discussed at weekly PMRT meeting	Cases escalated to Trust executive Scrutiny Group (ESG) IPIR presented and discussed. Any identified shared learning is cascaded through Divisional and Corporate Trust teams.	Cathy Stanford Acting Divisional Director of Midwifery. Head of Governance Maternity and Child Health		Cases going forward will also be escalated to the Regional Safety Improvement Group (SIG)	
Maternity Dashboards	Maternity Dashboards are completed monthly and submitted to Trust Board for the monthly performance report. Additionally, WWL submits data to the GM regional dashboard	Quarterly GM dashboard meetings are held, and data is reviewed. Any units that may be an outlier with any of the metrics are asked to review and provide actions.	There is a National Maternity Dashboard launched (However not real time as 3–4-month time lag) which will pull data from MSDS submissions which WWL will continue to contribute to through the Euroking Maternity Information System.	Cathy Stanford Acting Divisional Director of Midwifery. Head of Governance Maternity and Child Health	Digital Midwife to support the increasing demands for reporting and move towards complete digital maternity records.	Continue with Head of Governance and facilitator incorporating this into their roles, which is a pressure on the Governance requirements Business case for Digital Midwife to be completed for consideration if cannot be identified from existing staffing establishment.	
Data is submitted to the Maternity Services Dataset monthly	Any discrepancies in the data when the reports are generated, or the score cards received are investigated and solutions sought with the help of BI and the MIS provider	The Trust receives a MSDS scorecard monthly outlining compliance with all criteria	Risk assessment has been completed for MSDS submission and support required.	Cathy Stanford Acting Divisional Director of Midwifery. Head of Governance Maternity and Child Health	Digital Midwife to support the increasing demands for reporting and data quality issues and the move towards a complete digital maternity record. Additionally, a Digital Midwife will support the Governance agenda	Continue with Head of Governance and facilitator incorporating this into their roles, which is a pressure on the Governance requirements	Successful submission of all criteria . confirmation received from NHSX and regional

	Any data input issues are fed back directly to staff. Any service level issues will be rectified with the appropriate team, BI, IT or the provider.				with Documentation standards and compliance with data entry and data security.		Chief Midwife.
WWL has reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution Early Notification Scheme	Independent reviews are received from HSIB and any recommendations for improvement are incorporated into an action plan which is monitored for compliance via the Trust Governance forums.	All cases that meet the criteria are reported to HSIB, Each Baby Counts and MBRRACE and NHS Resolution.	The Maternity Service are aware of the 5 Quality Surveillance principles and have advised the Trust Board of the requirement to have a Quarterly board review of Perinatal Safety.	Cathy Stanford Acting Divisional Director of Midwifery. Head of Governance Maternity and Child Health		System in place for reporting.	
Serious Incidents are discussed at: -Maternity Clinical Issues group. -Obstetrics and Gynaecology Clinical Cabinet -Surgical Divisional Quality Executive Group -Executive Scrutiny Group -Serious Incidents Requiring Review Panel(SIRI)	All serious incidents will be submitted to Trust Board for oversight and review on a monthly or quarterly basis as agreed. This will be commenced and a regular report as per the Serious Incident Framework will be submitted to Trust Board.	Serious incidents from all GM trusts will feed into the LMS Serious Incident Group (SIG) going forward. Terms of reference to be defined and agreed. Challenge is received at all Governance forums in terms of any lessons learned and recommendations for improvements	The Trust is committed to implementing the regional proposals for the Quality Surveillance Model that will be circulated in early 2021 and will commit to implementing this. Further Guidance is required about the submission to the LMS as to how and when this will be implemented.	Shatha Attarbashi Clinical Director/ Consultant Obstetrician and Gynaecologist Cathy Stanford Acting Divisional Director of Midwifery. Head of Governance Maternity and Child Health	GAP analysis will be undertaken on the proposed Quality Surveillance model. Dedicated time for Clinicians and Nursing and Midwifery staff to undertake investigations and meet the requirements within the model.	Will continue to report to the Executive Scrutiny Group (ESG) all serious incidents View the Quality Surveillance Model Proposal paper in **Appendix 2** View the terms of reference for the Safety Special Interest Group in **Appendix 3** **February 2022 update** Safety SIG has now commenced and will be meeting monthly.	Action compliant February 2021

						Template for reporting has been received	

Immediate and essential action 2: Listening to Women and Families

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

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.

Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:

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

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

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

Link to urgent clinical priorities:

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

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

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?	

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

The Wigan and Leigh Maternity Voice Partnership (MVP) has been established for many years and meets Bi-monthly with service users and representatives from provider organisations of the Maternity services. The purpose of the MVP is to improve services for women and their families involved with Maternity services and to ensure that women's voices are heard. Wigan Maternity services work closely with the MVP and partner agencies to ensure that the voice of our service users is heard and listened to and remains central to care provision.

Virtual meetings are currently in place and these are well attended by professional representatives however it is clear that service user attendance has dwindled throughout the Pandemic period and an active recruitment process is in place led by the Newly appointed chair. A recent open evening was held to encourage attendance.

The MVP have been asked to assist the maternity team with the redesign of the Maternity web pages to ensure that information is easily accessible and appropriate to women's needs, we will be focusing on access to patient information leaflets and advice and information regarding informed consent. A 15 steps walk about is also planned and the options of a virtual approach are being explored.

The MVP and maternity partners are currently sighted and working together on:

- BAME action plan and further listening events are planned that will be included in this action plan.
- Implementation of our continuity of carer models of care
- Review of the recent NHS documentation for 'Supporting pregnant women using maternity services during the COVID pandemic: Actions for NHS providers report
- Ockenden report and associated action plans

The Executive with responsibility for Maternity Services is the Chief Nurse. There is a named Non-Executive Director who supports the Board Maternity Safety Champion and attends the Maternity Safety meetings. As per the Maternity Incentive Scheme Safety Action 9, there is a pathway for escalation of all safety issues and the Safety champions meet Monthly /Bimonthly with the Non-executive Director. Concerns raised from staff are escalated through the Safety Champions.

Information related to accessing the safety champions is visible in the clinical area for staff and prior to the COVID-19 Pandemic, regular monthly walkabouts were performed by the safety champions to talk with staff. These have now been reinstated and feedback from staff from several issues has been received which will be Actioned and updates fed back to staff. Service user feedback from Friends and Family Test has been now been reinstated and the Trust participate in the National Maternity Survey which gives the Trust the opportunity to receive women's views on service provision and put in place any improvement measures where shortfalls have been identified. The Independent Senior advocate role is not currently in place as National guidance is awaited on the development and implementation of this role within individual Trusts or LMS 's.							
Established Maternity Voice Partnership in place with BI-monthly meetings. Patient feedback boards in place across the unit.	Feedback has been obtained on leaflets and visiting. 15 steps walk about undertaken by service users Patient stories have been circulated to staff to communicate the Voice of the Woman.	Service user feedback has been used to make changes and improvements across the maternity floor Consultation was also sought when changes to visiting times was introduced in the past CNST Safety Action 7 compliance. Feedback from MVP members	It is recognised that greater involvement of service users' needs to be implemented and lay representation on Directorate meetings sought.	Anne-Marie Goodall Out-Patient Matron 30 March 2021 Cathy Stanford Acting Divisional Director of Midwifery. Head of Governance Maternity and Child Health	New Chair has been appointed since last meeting. Further 15 steps challenge to be requested, as 2 years since last one undertaken. However due to Covid restrictions we will need to review how we undertake this. **March Update.** Active recruitment in process by MVP chair. open evening planned	Bimonthly meetings will continue. Meeting held with the Chair and CCG leads to discuss how we can improve service user involvement and consider how we can increase diversity with the membership. **April Update.** Remains ongoing. Recruitment drive in place. 1 service user attended last meeting	
Trust website and Facebook page	Service users have been involved in the interview process for Bereavement Midwife MVP minutes.	Increased involvement from service users MVP Charter in production from LMS	Review of Maternity website and access to information to be requested from the MVP group to identify any areas for improvement from the woman's perspective.	Sam Whelan Quality and Safety Midwife Comms Team	MVP requested to support website development	**April Update.** Meeting arranged with Comms team to identify requirements	

Demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues the identification of an Executive Director with specific responsibility for maternity service	Board Level Safety Champions in place in addition to Divisional level Safety Champions. Bimonthly meetings are scheduled. Non-Executive Director (NED) for Maternity attends these meetings.	The Maternity and Neonatal Safety Champions are: • Clinical Director for Obstetrics and Gynaecology. • Divisional Medical Director/ Consultant Paediatrician • Divisional Director of Midwifery and Neonates. Staff can identify the Safety Champions Safety Dashboard and notice boards already in place and visible in clinical areas.	Agenda to be formulated for meetings going forward	Ongoing/ Continual All safety Champions 30 March 2021	reporting mechanism to board to be formulated and agreed in regard to reports received and feedback / escalation from NED and Safety Champions.	Remains ongoing **February 2021 update.** Formal Agenda completed and will be utilised at next scheduled bi-monthly meeting, with minutes/ notes taken / action Matrix developed	
Confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard	Role Descriptor for non-exec board safety champion has been received and has been circulated to relevant safety champions. Non-Executive Director (NED) for Maternity attends Safety Champions meetings. Bimonthly meetings in place to discuss ongoing issues and challenges	Achieve compliance with CNST safety action 9.	Feedback to be requested from NED	Ongoing/ Continual Director of Corporate Affairs	The role will be reviewed in line with new requirements		
Independent Senior Advocate	This role is independent of the	Trusts must create an independent senior advocate role which reports to	External Advocate Role to be defined	This role is not part of NED or MVP role.	There will be a national model	It will require separate funding	

Role to be introduced who will report to the Trust and LMS Boards. Maternity services must ensure that women and their families are listened to with their voices heard.	trust and therefore to be funded separately and needs to be high level seniority.	both the Trust and the LMS Boards. The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.		There will be a national model including framework and principles which will be issued shortly.	including framework and principles which will be issued shortly. The role of advocate is a new position which is independent of the trust and requires a high level of seniority for impact and leverage of actions.	to ensure they are unbiased and have full objectivity. The trust will work closely within the new national framework model which is expected shortly to undertake this essential action.	

Immediate and essential action 3: Staff Training and Working Together

Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.

Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

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

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

Link to urgent clinical priorities:

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

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

What do we have in place currently to meet all requirements of IEA 3?	What are our monitoring mechanisms?	Where will compliance with these requirements be reported?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?	
Staff who work together must train together Daily ward rounds have been in place and are embedded in practice. With the recommendations from the report a second round was commenced in the evening, prior to the "Hot Week" Consultant leaving site at 19.00 hrs. currently there is no second round in place at weekends only a virtual 22.00 call to the Registrar and shift coordinator on duty. There is a guideline in place for handover of care and that outlines the process for all handovers and Consultant ward round requirements. Additionally, GM LMS have produced guidance on process and frequency for the ward rounds across GM which is still under review and consideration. Any additional requirements for further rounds within WWL may require revised job plans or further staffing,							

Twice daily safety huddles take place on the Maternity Floor to communicate acuity and activity levels and improve oversight of all areas. Multi- disciplinary training is robustly monitored and facilitated by the practice education leads and is on target to achieve the 90% of all relevant staff groups for CTG management and training and skills drills. Monthly updates of compliance are reported to the Head of Governance and circulated on Dashboards. Monthly training dates are scheduled for all relevant staff groups to attend. There are currently two Consultant Clinical leads for simulation – one Consultant Obstetrician and one Consultant Anaesthetist, who are supported by the Practice Education Lead. The Trust has recently funded a group of 15 staff to attend the Practical Obstetric Multi-Professional Training (PROMPT) course. CNST ring fenced funding has been agreed in principle and over the last 2 years maternity and Neonatal service have benefited from financial investments as Neonatal Nurses where employed to staff the Transitional care unit, and the Maternity service have installed a centralised CTG monitoring system and IT equipment for community Midwifery teams.							
Consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week Second round has been implemented with On Call Consultant present and leading. This will be undertaken at 7pm prior to on call Consultant leaving the unit.	Compliance is not currently reported. Attendance at rounds by the MDT. Documentation of management plans and ongoing monitoring arrangements. 7 day rotas are in place with Consultant on call cover	Consultant meetings Audit meetings. Obstetric and Gynaecology Clinical Cabinet Compliance with CNST Safety Action 8.	Ward round book will be completed until actions are embedded. Standardised audit forms to be created by the LMS which will be circulated. TW19-048 SOP 15 Maternity Communication and Hand Over of Care have been updated to reflect this.	Ongoing/ Continual Clinical Director and Consultant body. Sanjay Arya Medical Director	Job plans and remuneration for on-call may need to be amended. Additional staffing may be required. Awaiting National Directive and HR advice re job plan and changes in working practices. **May2021 Update** Morning and evening ward rounds in place mon-Friday. At 9am and 7pm before Hot week Consultant leaves. 10pm Virtual call with Night Registrar and shift coordinator. Weekend daily ward round AM and evening virtual call with Night Registrar and shift coordinator.	Continue with twice daily ward rounds as planned. Weekday ward rounds x2 daily in place with additional virtual evening round in place at 10pm Escalation policy/ process in place. **February 2021 Update** Guidance received from GM regional steering group that ward round should be 12 hours apart. This will require Job Planning and review of Consultant hours and clinical commitments. **March 2021 Update.** Will continue with x2 daily rounds however will not be 12 hours apart and not x2 daily at weekends. **April Update** Remain non- compliant with GM standard of 12 hrly rounds and twice at weekend	

					Additional funding requested through Ockenden Investment fund to implement weekend evening and rounds. If changes are needed to weekday 2nd round then will need considerable investment as Job Plans will need reviewing and amending, with theatre and Outpatient templated affected.	MD to meet with LMs Consultant Lead to discuss. **May 2021 Update** Bid submitted to Maternity Investment fund which includes funding for additional Consultant PA	
A MDT training as part of annual Mandatory training schedule is in place which includes: Monthly MDT PROMPT training Monthly CTG training and competency assessment. Human Factors Sepsis Recognition of deteriorating patient. Covid updates/ training	Full MDT programme of training in place and compliant with CNST current recommendations. Data Base of attendance and compliance for all staff groups in place. Quarterly updates from Leads presented at Governance forums	Data base of attendance in place to monitor the 90% compliance of all staff groups	Training and competency passports currently being rolled out to all midwifery staff. Regional CTG Training and competency package to be fully introduced fop all staff grades.	Ongoing/ Continual Keeley Jones Practice Development Midwife. Joanne Birch CTG Champion Midwife. Farina Kidwai Consultant Obstetrician PROMPT and CTG training is currently delivered virtually via interactive sessions	Continued support of the Multidisciplinary team in allocating staff to attend training Funding for ongoing training requirements. Increase CTG Champion Midwife to 0.4 WTE from 0.2 to deliver addition required training and support. Appropriate % staffing uplift to incorporate all Maternity and Obstetric training needs. Consultant SPA sessions to be reviewed for	Continue with comprehensive training package in place **February 2021 Update** Funding has been requested to secure places for cohort of staff on next PROMPT training. Plans in place to resume face to face training in June 2021 if Government guidelines allow.	

Ad hoc/ monthly skills simulations for Obstetric emergencies	Attendance logs and feedback/ debrief sheets				training and Governance requirements.		
Evidence of submission to LMS of MDT and working.	Will be monitored through LMS CTG steering group.	Obsteric and Gynaecology Clinical Cabinet LMS Steering group? Dashboard	Awaiting feedback from LMS regarding reporting mechanisms for this	TBC Keeley Jones Practice Education Lead midwife Joanne Birch CTG Champion Midwife Amit Verma Obstetric Consult CTG Champion.	None **March Update.** Still awaiting confirmation from LMS	Will continue with Data Base of attendance and compliance for all staff groups in place. **February 2021** No further update received.	
Confirmation that funding allocated for maternity staff training is ring-fenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety	Maternity incentive scheme refund is not currently ring fenced, although Funding has been received from year 1 to implement transitional care and employ Neonatal Nurses. In year 2 the Maternity Service also received money to install a centralised CTG monitoring system to improve patient safety.	Trust Board Executive team meeting	Agreement to be sought from Trust Board regarding ring fencing CNST refunds	Director of Finance. Chief executive.	Statement of commitment that year 3 CNST incentive scheme refunds will be ring-fenced for maternity. Agreement has been received in principle however further clarification of the spend needs to be discussed with DoF and new Chief Nurse when in post. **March Update.** Finance update given re maternity investments over last 2 years of CNST	Business case development for additional funding for either staffing or resource requirement. Paper submitted to board outlining all training and development needs of staff groups to comply with CNST AND SBL v2 Recommendations.	

Immediate and essential action 4: Managing Complex Pregnancy

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

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

- Women with complex pregnancies must have a named consultant lead

Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

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

Link to urgent clinical priorities:

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

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

What do we have in place currently to meet all requirements of IEA 4?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?	
All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. Robust risk assessments are undertaken at booking to identify women with complex pregnancies. All complex pregnancies are referred to a Consultant Led ANC and assigned a Consultant lead. The Trust has dedicated clinics for women with diabetes, cardiology/ hypertension, endocrinology, perinatal mental health. Additionally, we are currently reviewing the requirement for a dedicated Multiple pregnancy clinic in accordance with NICE recommendations. At these clinics, specific management plans are made and agreed in conjunction with the woman. Any women with complex medical conditions/ risks are referred to tertiary units for ongoing or joint management, such as HIV and renal and Liver conditions. Other considerations for the Trust are to look at implementing a monthly MDT meeting, review to review all complex pregnancies that are nearing delivery to improve communications for intrapartum and neonatal care. Currently spot check audits are being undertaken to monitor that women are being seen and assessed by their named Consultant and that appropriate and timely referrals have been made. The greater Manchester LMS are currently reviewing the development of maternal medicine specialist centres with a Hub likely to be within the region that local units will refer into. Current process in place are pathways for referral to the appropriate tertiary unit and guidelines outlining the management and requirements for these women with high risk and complex medical conditions							
Consultant Leads in place for high-risk women with designated medical antenatal clinics for complex medical conditions such as: Hypertension Cardiac problems, Diabetes and Endocrine Mental Health.	Will be audited as part of all clinical incident reviews. Spot check audits to be undertaken.	Will be reported to Obstetric and Gynaecology Audit meeting and audit department as a registered audit	Audits of compliance to be undertaken. Named Consultants to be clearly identified on women's case notes. (Stickers ordered for all Consultants). Work ongoing to improve continuity	30 April 2021 Quality and Safety Midwife to Audit compliance. Fatima Abu Amna Obstetric Consultant and Gynaecologist Antenatal Clinic Consultant Lead	GM LMS are considering the use of a standardised audit tool for all units to use. **March Update** Undertake spot check audit that referral processes are being followed.	**Feb update** Spot check audit completed, and findings fed back to Consultant and clinic leads. To be further discussed at clinical cabinet and improvement measures identified. **April Update**	

Multiple pregnancy Previous pre term birth.			within Consultant led Clinics. Incorporate into monthly documentation audits		Support from audit team required **May 2021 Update.** Audit of complex cases to be undertaken to identify that pathways are in place	further audit undertaken. Findings to be fed back at meeting **May 2021 Update** Monthly audits will continue until compliance sustained	
Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team.	Pathways in place for referrals to Tertiary units for highly complex conditions such as: HIV Hepatic conditions Renal conditions. Cardiac Conditions	No monitoring or reporting processes in place at present	Development of regional Maternal Medicine Centre within the GM network. Review all current pathways in place for referral to tertiary centres for consistency and appropriateness.	Dates TBC. Greater Manchester and Eastern Cheshire, Strategic Clinical Network. 30 April 2012 To be identified.	When regional Maternal Medicine Centre via a hub and spoke model is in place this will likely be a regional referral pathway developed within the GM LMS. **March Update** Undertake spot audit that pathways are being followed. Support from audit team required **May 2021 Update.** Audit of complex cases to be undertaken to identify that pathways are in place	Continue with local pathways until GM agreed pathway is in place **April Update** Spot check audit completed. Findings to be fed back at meeting **May 2021 Update** Monthly audits will continue until compliance sustained	
Understand what further steps are required by your organisation to support the development of	TBC	TBC	Following a meeting held with the national policy team on 7th December, a proposal to agree funding through a system led commissioner model	For Greater Manchester and Eastern Cheshire, it has been agreed that St Marys Hospital, Oxford Rd Campus will be the Maternal Medicine	Regional pathways to be developed to support all trusts feeding into the Maternity medicine hub. **March Update** Awaiting confirmation of Hub Location/ Trust	Continue with local pathways until GM agreed pathway is in place	

maternal medicine specialist centres.			is to be taken through GM commissioning governance and to the joint commissioning board. A request has been made for pump prime funding in Q4, to initiate project support and clinical leadership	Centre via a hub and spoke model. Two physicians with special interest in Obstetrics have commenced Maternal Medicine training.			
Regional integration of maternal mental health services. Antenatal Consultant lead supports all women who have been assessed as Amber Flag for perinatal mental health.	Currently no outcome measurements in place.	Risk assessments are completed for referral to relevant level of service.	Audits to be identified to monitor effectiveness of service Red Flag Perinatal Mental Health Clinic led by Consultant Psychiatrist in place.	Newly developed Vulnerable team in place who will support the Red Flag clinics to provide Midwifery input.	Perinatal Mental Health Midwife funding to be identified and post implemented. **March Update** Vulnerable team in place who provide care for the most vulnerable women who have experience of managing women with mental health needs. Staffing paper to be submitted to board which includes the requirement for a specialist PNMH Midwife	Continue working in conjunction with GM to support the perinatal mental health service. **February 2021 Update.** Funding requested from CCG re recruitment of Perinatal Mental Health Midwife **April Update,** Job description completed. Business case to be developed. Awaiting details of Ockenden funding for Trusts when bid will be submitted.	

Immediate and essential action 5: Risk Assessment Throughout Pregnancy

Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional

Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

Link to Maternity Safety actions:

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

Link to urgent clinical priorities:

A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

What do we have in place currently to meet all requirements of IEA 5?	What are our monitoring mechanisms and where are they reported?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?	
A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. A robust risk assessment is formally completed with the woman at booking and documented within the woman's health records. At each other antenatal contact a risk assessment is undertaken however prior to the Ockenden report these are not formally recorded. If there are any changes to the level of clinical care required, the midwife refers for medical input. Changes in care may affect the intended place of birth and any changes will be discussed with the woman and documented in the health records. The Maternity Information system is currently reviewing the work flows to incorporate the formal documentation at each attendance to record that a risk review has been undertaken and that intended place of birth is still appropriate. The personalised care and support plan are discussed at the booking appointment and documented within our electronic system (Euroking). Monthly compliance audits will be undertaken, and findings monitored until this new practice is embedded.							
Comprehensive Risk assessment completed at booking and updated during pregnancy	This is a news action and therefore communications have been sent to all staff. The Personalised Care and Support Plan (PCSP) is updated regular by named Midwives and this is monitored	Once audit programme in place this will be monitored via Obstetric and Gynaecology Audit meetings. Action plans will be monitored through Clinical Cabinet	Monitoring of compliance will be undertaken and review of the documentation to support this. Clarification sought from MIS provider(Euroking) if this can	Audrey Livesey Inpatient matron Anne-Marie Goodall. Outpatient matron Sam Whelan Quality and Safety Midwife	Risk assessment tool needs to be amended to incorporate compliance documentation. MIS provider has been contacted to enquire if there are plans to incorporate this within the system as it is a	All staff have been informed of the need to complete a risk assessment at each contact and prior to labour and delivery. Monitoring of compliance will be ongoing until the action is embedded in practice. **February 2021 Update**	

	through the Maternity Information System (Euroking) for completion not content. Documentation within maternal case notes and handheld notes should identify that a risk assessment has taken place detailing all physical assessments as well any other issues and discussion with the women around her continued plan of care and appropriate place of birth.		be added to core work flows , Perinatal Institute contacted as case note provider for updates in regard to plans to amend risk assessment templates within notes.	Fatima Abu Amna Antenatal Clinic Lead Consultant	National recommendation. **March Update** Support from audit team required	Risk assessment audit template received from GM Steering group. **April Update** Spot check audit completed. Findings to be fed back at meeting	

Immediate and essential action 6: Monitoring Fetal Wellbeing

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

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

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

The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions: **Action 6:** Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? **Action 8:** Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?							
Link to urgent clinical priorities: Implement the saving babies' lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.							
What do we have in place currently to meet all requirements of IEA 6?	**How will we evidence that our leads are undertaking the role in full?**	**What outcomes will we use to demonstrate that our processes are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**	
Monitoring fetal well-being. Implement the saving babies' lives bundle. The Trust currently has 0.2 WTE fetal surveillance Lead Midwife (CTG Champion) , who has the responsibility to provide regular training to all staff, monitoring of fetal surveillance training compliance, consolidating existing knowledge and raising the profile of monitoring fetal wellbeing within the unit. Additional funding is required to support the increase to a minimum of 0.4 WTE hours for the role. The CTG Champion Midwife leads on CTG review cases in conjunction with the Obstetric Consultant lead and together they provide support to the multidisciplinary team. There is an additional requirement for named Consultant Lead for fetal monitoring to have additional sessions for teaching and review of cases within his job plan. There is a dedicated Saving Babies Lives Care Bundle Lead Midwife, who maintains oversight of the SBL actions including Element 4, (training) along with the named Consultant. There is a comprehensive action plan in place with regular meetings of the SBL champions at regional level to monitor and review ongoing compliance with all the recommendations.							
The leads must ensure that their maternity service is compliant with the recommendations of SBL care bundle 2 and subsequent national guidelines.	Regular audit and review in place for all elements of saving babies' lives. Feedback from Perinatal institute for compliance and detection levels of small for gestational age infants.	Reduction in Stillbirths. Recognition of the small for gestational age infant. Reduction in preterm birth. Optimisation of preterm infants	Preterm birth guidelines awaiting ratification following review of Regional Guideline.	Sam Whelan Quality and Safety Midwife. Saving babies lives Midwife Lead Amit Verma Saving Babies lives Consultant Obstetrician Lead	Funding to be received for 6 months 0.6 WTE to support saving babies lives care bundle implementation.	Continue working on all elements of the SBL Care Bundle to ensure ongoing compliance.	
Comprehensive action plan in place which is monitored via Clinical Cabinet and submitted			Carbon Monoxide (CO) monitoring has been suspended throughout the pandemic and is	Julie Bancroft Smoking Cessation Lead Midwife.	Funding will be utilised to support the smoking cessation service and provide training support	Case review to be undertaken to determine and act upon all themes related to pre-term birth (prediction, prevention, and preparation) that are	

to the LMS as requested. Saving Babies Lives lead Midwife in place			being re-introduced under risk assessment where appropriate and safe to do so. Smoking cessation Midwife Service has now commenced. Baby Clear Smoking intervention programme has been rolled out.	Anne-Marie Goodall Outpatient matron.	for recognition of the growth restricted baby.	identified from investigation of incidents, perinatal reviews and examples of excellence	
CTG Champions in place Centralised CTG monitoring system in place to provide oversight and assurance for Delivery suite Coordinators and Medical staff A second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support.	Ongoing monitoring and review of clinical incidents. Midwife CTG Champion in place who leads on all aspects of CTG training, teaching and compliance in conjunction with Consultant Obstetrician.	Reduced incidence of CTG misinterpretation. Case note reviews evidencing good practice and appropriate management of the Abnormal CTG Both actively participate in training and development of staff and in the development of guidance, pathways, and competencies.	Increase in Midwife CTG Champions hours dedicated to CTG training	Joanne Birch CTG Champion Midwife Amit Verma Obstetric Consultant lead.	Additional hours to be increased from 0.2 to at least 0.4 WTE FOR CTG Champion Midwife. Funding for Baby Lifeline CTG masterclasses for all core Maternity and Medical staff	Continue with in-house training and competency packages. **February 2021 Update** Finance team asked to attend T&F group to identify costs for implementing recommendations which will include additional hours for CTG Champions. **March Update** Job descriptions to include CTG champion role and requirements. **April Update,** Job descriptions update still to be completed. Business case to be developed. Awaiting details of Ockenden funding for Trusts	

Regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines	Weekly tabletop meetings in place where incidents are discussed, Monthly clinical issues group reviews in places which focus on serious incidents and CTG issues.	Reduced incidence of CTG misinterpretation. Case note reviews evidencing good practice and appropriate management of the Abnormal CTG	Introduce regular CTG review sessions on the delivery suite facilitated by CTG Champions.	Joanne Birch CTG Champion Midwife Amit Verma Obstetric Consultant lead.	Dedicated time	Continue with in-house training and competency packages.	

Immediate and essential action 7: Informed Consent All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery. All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care Women's choices following a shared and informed decision-making process must be respected							
Link to Maternity Safety actions: **Action 7:** Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?							
Link to urgent clinical priorities: Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.							
What do we have in place currently to meet all requirements of IEA 7?	**Where and how often do we report this?**	**How do we know that our processes are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**	
Pathways of care are clearly described in written information in formats consistent with NHS policy and posted on the Trust website. Information is currently available on the Trust website this is reviewed and monitored by the corporate patient information team who ensure that all patient information leaflets are available with working links to National leaflets and that they remain updated. The Directorate have a monthly guideline meeting to review any new NICE guidelines and to update and review existing guidelines in line with Trust and national recommendations and Policy. All guidelines SOP 's and pathways are published on the Trust intranet and available to all staff. (they are not published externally on the Trust webpages). Information is available in various formats and languages.							

Work has been commenced in looking at the consent process and the information that women receive regarding informed consent. Women must be enabled to participate equally in all decision-making processes and make informed choices about their care, in order to facilitate this the Trust is looking at the IDECIDE model. Any woman who is requesting a caesarean section will be referred to the Consultant to discuss and understand her reasons for requesting a Caesarean. Women's choices following a shared and informed decision-making process are respected. Any woman who makes a choice which is not in keeping with Trust or National recommendations will be offered the opportunity to discuss these choices with the Lead Midwife for normality and a plan of care agreed following a full and informed discussion. Women's choices will always be respected; however, a risk assessment and plan of care will be put in place as required and shared with all members of the multi-disciplinary team and additional support put in place as necessary.							
All leaflets to support informed choice and consent are published to the Trust Internet site. Links to NHS and RCOG patient information available. Signposting to relevant APP's. My Birth Choices website and leaflets available	Leaflets and guidelines are monitored the Obstetric and Gynaecology Guidelines group and Clinical Cabinet. Additional oversight is monitored through Corporate governance for compliance	Monitored through Corporate Quality Executive Group	The Maternity website needs further development and updating, and this is progressing to provide more up to date information in an easily accessible format. Pathways, SOP's and Guidelines are not published on the internet. Further guidance is required as to whether this is a requirement.	Clinical Guidelines Lead Consultant Patient & Public Involvement Team. Communications team	Digital Midwife who will support the implementation of digital maternity records and access to patient portals. Will also support guideline and leaflet development and oversight of compliance. Review of Maternity website and access to information to be requested from the MVP group to identify any areas for improvement from the woman's perspective. **May 2021 Update.** Significant review of website and content is required which is currently underway, support from Comms teams in place. Once content agreed they will upload accordingly. Website to be based on Chelsea and	Women who cannot access the website are provided with paper copies for information. Links to additional relevant websites are shared with women **March Update** Informed consent policy and leaflet in development incorporating the IDECIDE principles. **April Update** Remains ongoing **May 2021 Update** Meeting held with comms team who are happy to support the redevelopment of the website. Content currently being looked at. This action will not be compliant in time for evidence submission to the portal.	

					Westminster template as model of excellence. Upon completion this needs to be assessed by the MVP chair for ease of use and level of content especially regarding consent and choice.		

Section 2							
MATERNITY WORKFORCE PLANNING							
Link to Maternity safety standards: **Action 4:** Can you demonstrate an effective system of clinical workforce planning to the required standard **Action 5:** Can you demonstrate an effective system of midwifery workforce planning to the required standard?							
We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.							
What process have we undertaken?	**How have we assured that our plans are robust and realistic?**	**How will ensure oversight of progress against our plans going forwards?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**	
Birth rate + Analysis undertaken in January 2021 to understand staffing requirements needed to implement Continuity of Carer milestones and achieve compliance of 51% by March 2022	This will be used in conjunction with the National staffing tool to identify staffing for each area and team according to case load and acuity.	Red Flag incidents such as: Lack of supernumerary shift coordinators. Unable to provide 1-2-1 care in labour Staffing Escalation policy in place	Bi Annual staffing papers to be produced and presented to Board.	Ongoing/ Continual Cathy Stanford Acting Divisional Director of Midwifery. Head of Governance Maternity and Child Health Fiona Bryant Acting Assistant Chief Nurse	Any additional funding requirements as identified through Birth rate+	Midwife to Birth ratio Daily weekly staffing reviews undertaken by matrons for each area.	

MIDWIFERY LEADERSHIP **Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in** Strengthening midwifery leadership: a manifesto for better maternity care	
The Divisional Director of Maternity and Neonates is responsible and accountable to the Chief Nurse who is an executive Director on the Board. **1) Every trust or health board delivering maternity care should have a Director of Midwifery, with a Head of Midwifery in every maternity unit within the organisation. Heads of Midwifery focus on the operational delivery of maternity care locally. They will often not have direct input into or responsibility for strategic, board-level decision-making.** **There is a Divisional Director of Midwifery in Place, but not a Head of Midwifery. Directors of Midwifery are leaders and advocates for safe, high quality maternity care, managing the strategic and operational delivery of maternity services locally.** **April Update. Business case to be developed for funding for additional posts. Awaiting information re Ockenden funding** **May Update Unable to submit bid directly to the investment fund for senior posts. Posts requested are for Bands 5/6 as per Birthrate+ report shortfall.**	
2) **A Lead Midwife at senior level in all parts of the NHS, both nationally and regionally** **N/A - Applicable to region / national team**	
3) More consultant midwives – **WWL does not currently have a Consultant Midwife, however there is a Band 7 lead for normal birth .** **March Update.** **Consider the recruitment of a Consultant Midwife** **May Update.** Funding not in place for this post	
4) Specialist Midwives in every Trust. **WWL currently has a Specialist midwife in post for Smoking cessation, Bereavement, Infant feeding and Safeguarding(from Corporate Team). There is a further requirement for a lead Perinatal Mental Health Midwife and a Diabetes Specialist Midwife.** **Information from Aqua has now been received for the Safety Culture Programme for Maternity and Neonatal Leaders at Board level and further details and programme will be sent late March 2021** **April Update. Business case to be developed for funding for additional posts. Awaiting information re Ockenden funding** **May Update 50% funding agreed by CCG for Perinatal Mental Health Specialist midwife. Job Description sent for job matching panel review. Awaiting job matching then will commence recruitment for post.**	
5) Strengthening and supporting sustainable midwifery leadership in education and research **N/A - applicable to HEIs**	
6) A commitment to fund ongoing midwifery leadership development. **WWL is currently reviewing core training requirements and offers some leadership training. Bespoke leadership programmes would be beneficial. Funding has been identified Nationally to support Maternity Leadership training for senior neonatal and maternity leaders across England. Further details are awaited.**	

7) Professional input into the appointment of midwife leaders. **The recruitment process at WWL is inclusive of Midwives and Clinicians on interview panels and focus groups for senior posts within the organisation.**							
NICE GUIDANCE RELATED TO MATERNITY							
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.							
What process do we have in place currently?	**Where and how often do we report this?**	**What assurance do we have that all our guidelines are clinically appropriate?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**	
The Trust has a process whereby all NICE guidance and Quality Standards are coordinated centrally through the Clinical Audit and Effectiveness team who support the Divisions and specialities within these to undertake a review of the guidance or standards and submit their baseline assessments to identify relevance and compliance. Where there is compliance this is evidenced accordingly and any non-compliance is identified, and either mitigated or an action plan is developed to achieve with the recommendations.							
MDT Guideline meeting in place which reviews and updates all Clinical Guidelines and SOP's	Monthly. Corporate Governance oversight in place for monitoring compliance with updating and review			Lead Consultant for guideline development and monitoring. Head of Governance for maternity and Child Health	Admin support	Continue with current embedded processes	
NICE Guidelines are reviewed and implemented with baseline assessments completed Regional Guidelines are reviewed and implemented. Regional steering groups develop specific guidelines. Such as: -Stillbirth pathways	As received. Corporate Governance oversight in place for monitoring compliance with updating These are reviewed within the regional steering groups within the LMS	Discussed and agreed at Directorate clinical Guidelines group. Bench marking is undertaken, and baseline assessment completed. % compliance is then recorded	Continue to maintain the MDT guideline and SOP/ policy reviews	Lead Consultant for guideline development and monitoring Head of Governance for maternity and Child Health	Admin support	Continue with current embedded processes	

-Hypertension -Preterm Birth -Fetal Growth Restriction -Intrapartum Fetal Monitoring -Reduced fetal Movements.		MDT regional review					

Appendix 2

GM&EC LMS Quality Surveillance Model Proposal

Executive Summary

This paper outlines the Greater Manchester & Eastern Cheshire Local Maternity System (LMS) proposal for implementing the new quality surveillance model as set out by the national Maternity Transformation Programme.
It includes roles, responsibilities and contributions of the stakeholders in the LMS to the model. It outlines the KLOE that will be regularly reviewed as part of the oversight element in this model. Timescales and a process of implementation are also suggested.

Background

In recent years there have been a number of accounts outlining poor-quality maternity care within individual Trusts. These have been identified through complaints, CQC inspections, reviews and investigations, following which supportive mechanisms are put in place to help the trust improve. There is a recognition that being able to identify these Trusts at an earlier stage provides the opportunity to offer support before serious issues arise. Additionally, the newly published Ockenden Report (2020) of serious maternity concerns at Shrewsbury and Telford Hospital NHS Trust, highlights the importance of learning lessons and embedding of high-quality safe care as standard is vital to prevent families from suffering lifelong effects. However, the current quality oversight model does not allow for this and in particular does not provide for consistent and methodical oversight of maternity services specifically.
Nationally, there is a move towards a new model of governance to improve oversight for perinatal clinical quality. This includes integrating perinatal clinical quality into developing ICS structures, and providing clear lines of responsibility and accountability for addressing quality concerns at each level of the system. This new model is expected to come into effect from April 2021 onwards.
The aim is to create a national Maternity Safety Infrastructure linking the ward to Board, to commissioner to region and on to national surveillance. This will be based upon a combination of data with intelligence, in order to gain a 360-degree assessment and helicopter view. The provider Trust and its Board would remain ultimately responsible for the quality and ongoing improvement of services.
The quality model will support the Trust to discharge its duties, while providing a safety net for issues not quickly identified and addressed.
NHS England have proposed five principles of quality surveillance for maternity services. These are outlined below.

Principles of quality surveillance

- **Principle 1: Strengthening Trust Board oversight of perinatal clinical quality** including a requirement for a quarterly board review of perinatal safety.
- **Principle 2: LMS and ICS role in perinatal clinical quality oversight**, ensuring that:

- a senior representative of the LMS is a member of the ICS chaired Local Quality Surveillance Group;
- the LMS leads on the production of a local quality dashboard;
- timely and proportionate action is taken to address any concerns identified; and:
- actions are built into local transformation plans
- Concerns are escalated to Regional quality committees

- **Principle 3: Perinatal clinical quality is routinely reviewed at a regional level committee** which has specific responsibility for perinatal quality oversight. It should involve the Regional Chief Nurse, Regional Chief Midwife and a Lead Obstetrician, who should work closely with regional neonatal leadership
- **Principle 4: National governance will be aligned to reflect the revised perinatal clinical quality model.** To ensure issues and concerns are integrated into existing national structures, the Chairs of the national Maternity Safety Surveillance and Concerns Group will be core members of the national NHSEI Executive Quality Group and the national JSOG
- **Principle 5: Agreed principles to support local, regional and national decision making** as to what would trigger further assurance or action around a perinatal clinical quality concern

LMS and ICS role in perinatal clinical quality oversight

A key element of the proposed model is the role of Local Maternity Systems (LMS) in terms of oversight. The LMS should support the ICS to oversee perinatal quality by:

a) Ensuring an experienced and senior LMS representative is a member of the ICS chaired Local Quality Surveillance Group.

b) Development and use of a local quality dashboard with hard and soft intelligence for discussion at meetings of the Local Surveillance Group.

c) Timely and proportionate action to address any concerns identified and building this into local transformation plans. The onus should be **on Trusts** to share responsibility for making improvements.

d) Reporting concerns to the MTB, Regional Chief Midwife and Lead Obstetrician and regional quality committees where necessary, with a request for additional support.

The LMS **oversees** constituent Trusts' role in quality.

- The Trust systematically identifies how and why incidents happen. Analysis is used to identify causes and to develop recommendations which address these in order to deliver safer care for service users in future.
- The Trust involves and supports patients, families and carers throughout the investigation process.
- The Trust monitors quality improvement activities to ensure changes are effectively delivered and achieve the improvements and risk reduction intended. Recommendations

should also be considered as part of an organisation's overall safety strategy so that actions are not taken in a fragmented and unsustainable way.

GM&EC current landscape

The LMS sits within and is supported by the Greater Manchester Health & Social Care Partnership Strategic Clinical Network (SCN). The role of the LMS is to support providers in quality improvement measures and does not have a role in assurance in its present format. Any concerns seen by the LMS and Strategic Clinical Network (SCN) teams are escalated through the internal governance processes including Commissioners and Transformation Board. Close liaison and information sharing is also maintained through the GMSCP Quality team.

GM&EC proposal

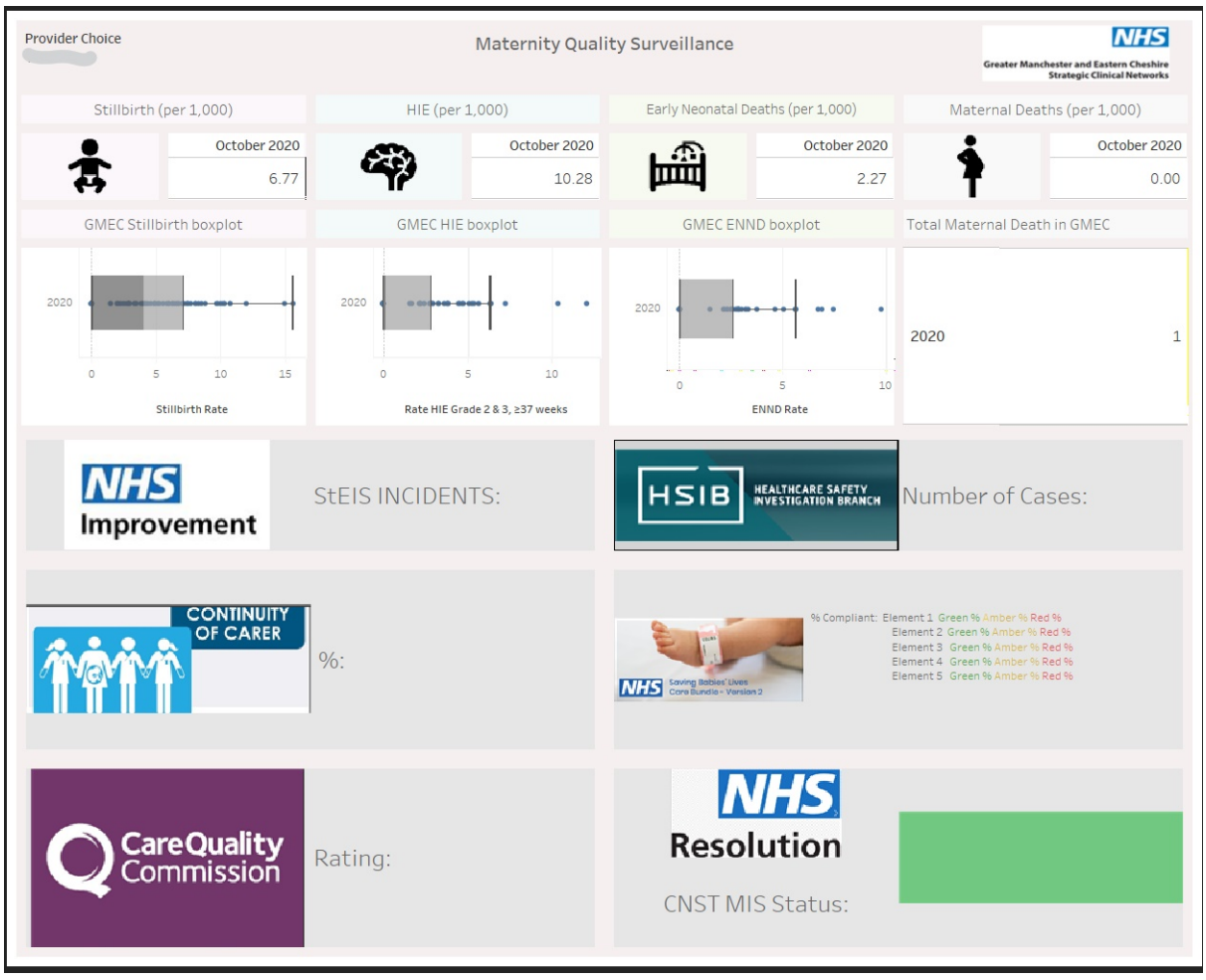
In response to the national steer towards a quality surveillance model with LMS and STPs providing oversight, the design proposed for GM&EC is as follows:

Quality Surveillance dashboard

- A Maternity Dashboard is currently maintained by the SCN and has recently moved to Tableau software. All providers have been asked to register and the process to move over to the new software is underway. The plan is to allow providers to submit data directly to Tableau.
- The Maternity Dashboard is reviewed at regular meetings of the Dashboard Special Interest Group, and data is shared and discussed at the Maternity Steering Group, which has participation from Heads of Midwifery and Maternity Clinical Leads.
- It is suggested that this existing work is built upon and a GMEC Quality Surveillance dashboard is developed on Tableau. Each provider would have a dedicated page on Tableau, covering various metrics which are updated on a regular basis. Having the data in one place which is easily accessible to all stakeholders would allow immediate identification of any patterns or issues arising and flag earlier any concerns. This could also be exported for reporting mechanisms as required for the new process of quality surveillance. Transparency is important and additionally the Maternity Voices Partnership (MVP) would be able to view this quality surveillance dashboard to gain knowledge and understanding in order to feedback to women regarding a trust's safety status.
- The metrics included would reflect national deliverables and CQC rating
- Suggestions include:
    - Number of STEIS/serious incidents/claims/complaints
    - Number of HSIB cases
    - CNST MIS status
    - CQC rating
    - SBLCB compliance
    - CoC %

- Rate of Stillbirths /HIE/Neonatal death/MD (benchmarked against median on GMEC Maternity Dashboard)
- BAME percentage of women booked
- MAT Neo SIP Maturity Matrix-to benchmark on Quality Improvement progress

A draft workup is demonstrated below to show what the Quality Surveillance Dashboard would look like for each provider, with some detail still to be added. Data for Stillbirths (SB), HIE Neonatal death (NND) and Maternal Deaths (MD) will be shown at the top which are benchmarked against the median for the GMEC Maternity Dashboard data .Each tile for other information e.g. HSIB cases, would have the relevant data and information sat behind it and accessible once the tile is opened. Further tiles could be added as required, including percentage of deprivation of population for each maternity provider, which gives a greater understanding of the specific issues which they may have to accommodate and that might affect patient safety outcomes.



- Data in the Quality Surveillance dashboard would include narrative as well as metrics to allow understanding of the context.
- The GMEC Quality Surveillance dashboard would have metrics consistent with the National Dashboard (due to launch in February 2021) to allow comparison and benchmarking. However, there will be added metrics which are of local relevance.

<u>Local Quality Surveillance Group(QSG)</u>

- LMS Senior Responsible Officer to be a member of the Local Quality Surveillance Group.
- The Quality Surveillance dashboard would be viewed and discussed at the Local Quality Surveillance Group to ensure a governance link to the Greater Manchester Health & Social Care Partnership.

Action to address concerns

- Data from the Quality Surveillance dashboard will be discussed as a standing item at the Maternity Transformation Board which is held every 6 weeks.
- All Trusts will be represented on the Maternity Transformation Board to allow appropriate actions to be allocated in response to any concerns identified.
- Trusts will be expected to build in timely and proportionate action to address concerns into local transformation plans. An update on the action or improvements required will be expected at the next Maternity Transformation Board meeting.
- Action plans in place for Kirkup, Ockenden and CQC from each provider to be discussed and updates informed.
- MVP participation will be embedded for full integration and transparency.

Reporting to region

- Issues of concern to be escalated to Regional Quality Groups /Boards via SRO
- Standing agenda item at Maternity Transformation Board of tableau provider overview.
- Additionally, the Regional Chief Midwife will attend the GMEC Maternity Transformation Board for communication and again escalation of concerns.

Governance within ICS

- Close liaison will be maintained with the Director of Nursing in the Quality team GMSCP, to ensure they are fully sighted on all concerns and regular reports associated with the ICS chaired Local Quality Surveillance Group (QSG).

Timescales and process:

The following timelines are in draft due to the emerging concerns with maternity safety across the system following the publication of the Ockenden Report and may change.

Share model with Heads of Midwifery – January 2021
Maternity and Children's Commissioner's Consortium – January 2021
Engage with GMHSCP – January 2021
Maternity Steering Group – 12th February 2021
Maternity Transformation Board – February 2021 (planned 11th Feb but this is before Steering Group?) Maybe it should be 18th Feb.

Conclusion and Next Steps:

Approval of this model (including deciding which metrics)
Agreement to implementation.
SCN to work on Quality Dashboard and have it in place by April 2021.
MTB Terms of Reference to change to reflect new LMS role of assurance.
Providers to nominate representatives to attend board.

References

Ockenden Report 2020-https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf

Appendix 3

GMEC MATERNITY SAFETY SPECIAL INTEREST GROUP

DRAFT - TERMS OF REFERENCE

Purpose and Duties

To support collaboration within Greater Manchester and Eastern Cheshire to ensure Safety Action 1 of the Immediate and Essential actions (IEA) from the Ockenden Report (December 2020) is implemented. This stipulates Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. This requirement needs to be implemented fully to ensure safer outcomes for pregnant women and babies are achieved to fulfil the recommendations of the Royal College of Obstetrics and Gynecology (RCOG), MBRRACE-UK and the Secretary of State's 2015 ambition for safer maternity care, the aims of the Maternity Transformation Project and Better Births.

1. Overarching responsibility:

The Local Maternity System (LMS) has a responsibility from the Ockenden IEA to receive all maternity Serious Incident (SI) reports for scrutiny oversight and transparency from maternity providers with onward reporting if concerns are seen. Themes or trends are highlighted to ensure learning can be shared and quality of care is improved across GMEC.

2. Core Membership:

- Maternity Safety Lead GMEC Strategic Clinical Network/Health Innovation Manchester.
- Midwifery Governance lead from each Maternity provider or designated representative
- Obstetric Governance Lead from each Maternity provider or designated representative
- Clinical Lead Midwife SCN
- Clinical Lead LMS

  Additional attendance is welcomed from Midwifery Safety Champions: Obstetric Safety Champions, Neonatal Safety Champions
  NWODN Governance Lead

3. Quorum

A minimum of five members, to include Maternity Safety Lead.

If the quorate member cannot attend, then an elected Deputy must attend on their behalf.

4. Frequency of Attendance at Meetings

The Safety SIG is to meet monthly with alternate months focus of agenda:
Month 1 -accept the submission of SI data and summary of key issues from each maternity provider and discussion of emerging trend or themes; external review of complex cases mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death not reviewed by HSIB.
Month 2 Focused work on key findings from SI and national reports with a collaborative problem-solving approach.

5. Main Functions

- Collate the SI from each maternity provider and create a supportive forum to discuss themes and trends
- Support the external review of mandated cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death not investigated by HSIB
- Produce a quarterly report on SI findings and collaborative work underway to share at mandated meetings
- Champion any QI project which addresses local themes or trends established from submitted SI locally, making appropriate links with the local Strategic Clinical Network and The Maternal and Neonatal Health Safety Collaborative
- Regularly monitor safety and outcomes in maternity services drawing on data from:
    i. MBRRACE UK reports
    ii. GMEC Maternity Dashboard
    iii. National Maternity reviews

6. Reporting Arrangements-
Quarterly Reports to be submitted to Maternity Transformation Board and Quality Board to ensure concerns and actions underway are shared for intelligence and understanding.

7.Terms of Reference Approval:

Date Approved:

Approved by:

Next review date:

Title of report:	Strategic Executive Information System (StEIS) Quarterly Summary Reports.
Presented to:	Trust Board
On:	26 .05.2021
Presented by:	Rabina Tindale Chief Nurse
Prepared by:	Cathy Stanford Acting Divisional Director of Midwifery and Neonates
Contact details:	Cathy.stanford@wwl.nhs.uk 01942 773107

Executive summary

The following report relates to serious incidents reported during quarters 1-4 2019/20 2020/21 and includes only completed investigations

There have been 4 Serious Incidents final reports submitted to the Clinical Commissioning Group (CCG)in this period with 2 remaining ongoing. 4 of these cases have been reported and investigated by the Health Service Investigation Branch (HSIB).

Duty of Candour has been met in 100% of all SI cases and there are no overdue actions at the time of writing the report.

The report which has been presented, provides an update as to the number of SI's reported on StEIS and clearly demonstrates that the Maternity Services has an open and honest culture of reporting and a robust process of investigation and provision of final investigation reports to the CCG and The Local Maternity System (LMS) which provide clear root causes and lessons learnt.

The agreed definition of a Serious Incident, both nationally and in the Trust Policy, is: 'An accident o incident when a patient, member of staff, or member of the public suffers serious injury, major permanent harm or unexpected death, (or the risk of death or injury), on hospital, other health service premises or other premises where health care is provided and where actions of health service staff are likely to cause significant public/media concern'.

The Trust follows NHS England's guidance in reporting Serious Incidents and carrying out investigations. This includes uploading all Serious Incidents onto Strategic Executive Information System (StEIS) for external review. Both local commissioners The LMS and regulators are informed of the Trust's Serious Incidents and monitor the outcomes.

Overview

The report provides summarised detail in relation to each of the Serious Incidents submitted and concise investigation reports submitted including lessons identified, recommendations and actions.

Overview of incidents, trends, themes, and lessons learned within Maternity Services are as detailed below for the completed investigations

It is therefore requested that the Board note the content of this paper and take assurance as to the robust processes in place for the robust reporting and investigation of SI's

Total SI's reported by quarter compared by year

The following table shows the trend in SI numbers within Maternity Services in all quarters of 2019/2020 and 2020/2021.

Year	Q1	Q2	Q3	Q4	Total
2019/2020	1	1	1	0	3
2020/2021	0	1	0	2	3
2021/2022	0				

Serious Incidents Reported to the CCG in 2019 - 2021

The table below provides a brief overview of the 6 StEIS serious incidents reported to the CCG, 2 of which remain as ongoing investigations awaiting final completion. All of which have Immediate post incident reviews undertaken with any immediate lessons identified and actions taken prior to the full Concise Investigation being completed.

Appendix redacted before publication

Title of report:	Transformation Plan 21/22
Presented to:	Trust Board
On:	Wednesday 26th May 2021
Presented by:	Karlyn Forrest, Director of Strategic Transformation
Prepared by:	Karlyn Forrest, Director of Strategic Transformation
Contact details:	**T:** 01942 82 2918 **E:** karlyn.forrest@wwl.nhs.uk

Executive summary

The inaugural meeting of the Transformation Board was held on the 7th May 2021, which approved the Transformation Plan for 2021/22 and received updates on the delivery and outputs of established programmes and the development plan for new programmes to be reported upon at future meetings.

As the first update to Board on the 2021/22 Transformation Plan, this paper will introduce the plan, outlining the drivers that has shaped its development, its four key themes and the eight transformation programmes within it. The aims, outcomes and measures for each programme, where developed, are also shared.

The key highlights, exceptions and priorities going as reported at the Transformation Board will then be summarised.

Link to strategy

The 21/22 Transformation Plan for WWL is built upon local, regional and national requirements and drivers for change to support the successful long-term recovery from the pandemic and deliver the strategic objectives of the trust. The plan aims to ensure that whilst transforming pathways, services and ways of working in response to the challenges facing the Trust today, the trust continues with long-term plans and to underpin the strategic direction of the organisation. This includes supporting the clinical, operational and financial sustainability of the Trust.

Risks associated with this report and proposed mitigations

None to note

Financial implications

The 21/22 Transformation Plan is a one of the key mechanisms to support the delivery of financially sustainable and efficient services. As part of the holistic benefits realisation approach to

Transformation, each programme will have a full financial and productivity review and the identified benefits will be tracked throughout the implementation and delivery of each scheme. The financial benefits of Transformation Programmes will also be reported via Divisional Assurance Meetings, forming a core part of the Divisional Cost Improvement Plans.

Legal implications

None to note

People implications

The Transformation Programme aims to support the promise within the NHS People Plan of:

"New ways of working and delivering care emphasising that we need to make effective use of the full range of our people's skills and experience to deliver the best possible patient care"

Wider implications

The 21/22 Transformation Plan aligns to the Greater Manchester Collaboration and Healthier Wigan Partnership (HWP) priorities as outlined in the paper. The programmes within the plan support delivery of the Operational Planning Guidance 21/22 set out by NHS England.

Recommendation(s)

The Board is asked to note the Transformation Plan for 2021/22 and the key delivery, output and outcome benefits reported in M1.

Report

Introduction

The Transformation Plan for 21/22 was recently approved at the inaugural Transformation Board held on the 7th May, attended by Executive Director SROs and programme leads and chaired by the Chief Executive. The Transformation Plan sets out the key and complex change programmes for the next year that will contribute to the delivery of *Our Strategy 2030*. Shaped and responding to both strategic and operational priorities, the restoration and recovery from Covid-19 is a key focus in this year's plan, which includes the Trust continuing to maximise the opportunities the pandemic has created in terms of new ways of working, delivering care to patients and working alongside our partners.

The programmes within the plan have been shaped by a range of drivers, as outlined below:

- Restoration, Recovery and management of COVID
- WWL Strategy, Corporate Objectives and operational priorities
- GM System recovery plans
- HWP Locality Plan
- Operational Planning Guidance 21/22
- NHS Long Term Plan

The Plan was developed in conjunction with Executive Leads and system partners and builds upon the priority areas from 20/21, such as Outpatient Reset, with a refresh and re-focus on these key areas, as well as incorporating new areas of focus for the year ahead.

Being the first update to Trust Board from the Transformation Board, this paper will firstly introduce the Transformation Plan for 2021/22, giving a high-level insight into the aim and outcomes of each programme before providing a summary of the progress reported in the first meeting. A brief outline of the newly created Transformation Board and the new governance arrangements is also provided. Future reports, which may be made through the Chief Executive Report depending on the level of information to be shared, will focus on delivery progress, outcomes and benefits, linking this back to strategic priorities.

Transformation Board

For the majority of 2020/21, updates and therefore assurances around the delivery of the Transformation Plan were given via monthly reports to the Executive Team Meeting, incorporating measurement dashboards and AAA (Advise, Alert, Assure) reports. Given the complexity and broad scope of the various programmes and need to increase the level of understanding and focus of each, the re-instatement of a regular transformation forum was acknowledged during the last quarter. Work was subsequently done to consider the optimum form and function of a such a forum, leading to creation of the Transformation Board.

In summary, the role of the new Transformation Board is to provide a forum to develop, co-ordinate and manage transformation activity to ensure that key, large-scale and complex change programmes deliver benefits. Transformation, which is concerned with making planned, large and irreversible changes to how care is delivered has the purpose of delivering significant and measurable improvement in outcomes. The outcomes and benefits of transformation are wide ranging, including improvements to patient access, patient and staff experience, patient outcomes and financial benefits through driving efficient and the best use of resources. The decision has therefore been taken to have the Transformation Plan and the benefits it delivers visible directly to Trust Board to avoid the pitfall of transformation becoming focused on a singular type of benefit.

This is consistent with best practice and replicates governance arrangements in other trusts where transformation is successful in being a key delivery mechanism to strategic imperatives and operational priorities.

Scope

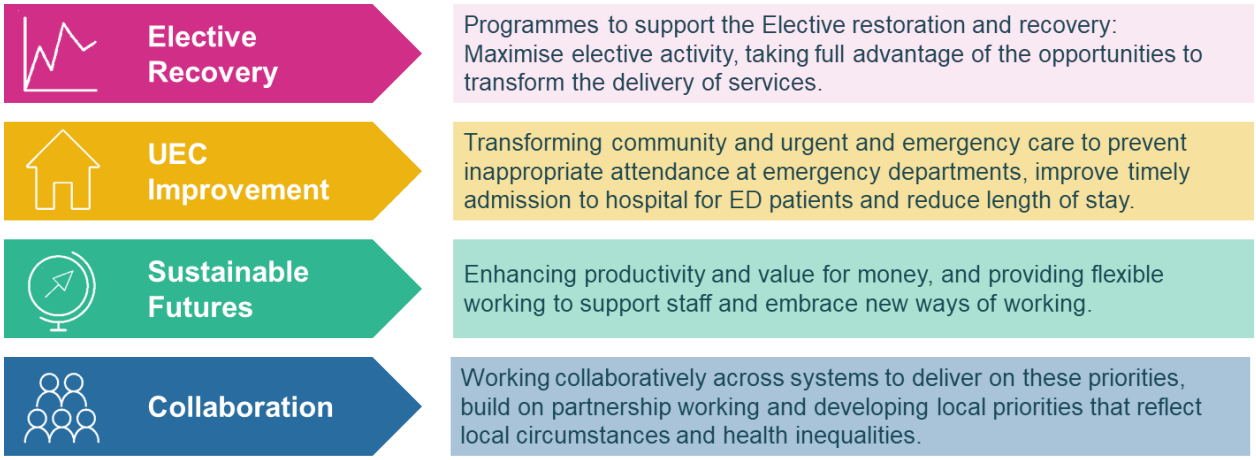
The WWL Transformation Plan contains high priority, large scale programmes of change for the Trust. This sees it include programmes of work that:

- Are key strategic priorities and therefore require Executive leadership to support delivery through having an Executive SRO in place and regular oversight from Executive Directors.
- Are complex, through being cross divisional or pan-organisation and require interdependencies to be visible and managed.
- Are required to deliver sizeable benefits and outcomes and therefore need more robust oversight and governance to manage any delivery risks.
- Will lead to a material change in how the Trust delivers its services in the future.
- The change and overarching approach to achieving a common outcome is applicable to multiple services and therefore a standardised approach through a programme is merited.

An evidence-based approach and degree of objectivity is taken in determining whether an improvement or change scheme is best suited for being placed in the Transformation Plan and subject to this level of programme governance using a locally adapted Programme Complexity Matrix. It is therefore relevant to highlight that the transformation plan does not represent the totality of the improvement work and efforts taking place across the Trust but instead signals the most complex and those requiring transformation expertise to support delivery and more robust governance.

Themes

The Transformation Programmes for 21/22 all contribute to four main themes which align to WWL priority areas and the Operational Planning Guidance 21/22. These are as follows:



Transformation Plan

Within the four identified themes, there are eight individual programmes. Each programme has a Senior Responsible Officer (SRO) at Executive Director level, and each project a lead identified as part of the scoping process. The plan incorporates a spread of programmes to account for the current priorities.

Theme	Programmes	Executive SRO	Projects	Locality
Elective Recovery	Outpatient Reset	Dr Sanjay Arya	• PIFU • Virtual Clinics • Advice & Guidance • Digital Communications • Enhancing Primary & Community Care	✔
	Clinical Service Collaboration	Richard Mundon	• GM Specialist Care Pathways • Wrightington – Elective Recovery Hub	
Urgent & Emergency Care (UEC) Improvement	Protecting the front door	Mary Fleming	• NHS 111 • Crisis Response • CAS • UTC / WIC • MH Pathways	✔
	UEC Streaming		• SDEC / SAEC • Monitor @ Home • CAU • Direct referral	
	Discharge & Flow		• Better @ Home • Community Beds • Discharge 2 Assess	
Sustainable Futures	Agile Working	Ian Boyle	Collaborative project across Workforce, IM&T, E&F, & Transformation	✔
	Productivity	To be confirmed	Divisional schemes to build a culture of improving the efficiency of all services	
Collaboration	GM Collaboration Programmes	Richard Mundon	• GM Integrated PACS • Unified Hospital Pharmacy Supply Chain • GM Pathology Network improvements	

Each programme has a clear aim, with specific outcomes developed in order to ensure that the changes made deliver the intended objectives. For programmes that are already well established, these outcomes have already been defined as part of the WWL 5Ds Improvement Model approach.

The aims, outcomes and measures for the schemes with the Programme Initiation Document process completed are provided in appendix one, alongside an overview of the remaining programmes which are currently being established.

Key highlights and points of escalation

The following provides key highlights and escalations from the reports given to the Transformation Board on the 7th May 2021.

Outpatient Reset

- Virtual clinics remain at 50% of all outpatient activity without a procedure. This proportion of non-face to face activity is above the nationally mandated figure of 40%, which is within the planning guidance and one of the gateway requirements for accessing the Elective Recovery Fund. A stretch target of 60% will be set at the next Outpatient Reset Programme to encourage this percentage to increase during the year.
- Digital appointment letters are now being used in 21 specialities. The pilot of digital letters, which featured three specialities, delivered a reduction in DNAs from 11% to 9% and a reduction in patient cancellations from 4.4% to 3% for patients who accessed their letter digitally. The ongoing productivity improvements, including the expenditure reduction from reduced postal letters, will be included in the outcome metrics in future reports. Patient satisfaction data evidence that the introduction of digital letters is positive for patients, providing better and more convenient access to appointment information.
- Am ambitious schedule for 10 key specialities introducing a Patient Initiated Follow Up (PIFU) pathway in the forthcoming months has now been agreed with Divisions and an associated trajectory in place for the increase in patients on a PIFU waiting list. Each patient added to PIFU waiting list leads to an average reduction of 1.2 follow up appointments per year, which will initially support reducing the follow up backlogs. This will be monitored as the outcome metrics after rollout.

- The outpatient e-prescribing system pilot commenced on the 19th April. This is a key enabler to supporting clinicians to effectively run virtual clinics and reduce the risks associated with posting prescriptions to patients. This is a locally developed solution with WWL the only Trust in GM currently piloting a e-prescribing solution for outpatients.

Urgent and Emergency Care (UEC) Improvement Theme

- Impact of Community Assessment Unit and Same Day Emergency Care - Analysis of admission data from the dates when the Community Assessment Unit admission pathway commenced and Same Day Emergency Care pathways were expanded is beginning to demonstrate correlation with the improvement in A&E performance against the four hour standard. The impact on admissions and bed-days continues to be monitored to evidence the reduced demand on G&A beds as the new models embed.
- Plans are progressing to make alterations to Orrell Ward to improve the facilities available for surgical ambulatory care, which will further see the number of surgery overnight admissions reduce. This is being funded via the Healthier Together business case, which was recently approved by the treasury.
- The Jean Heyes Reablement Unit at Leigh Infirmary project is progressing. The build work is scheduled to be completed for 31st May 2021 and the full clinical pathway and workforce model in development. The business case will be developed in June, therefore allowing plans to proceed to operationalise the service later in the year.
- A risk and exception in this programme is the percentage of patients being discharged from the hospital within 24 hours of 'no longer requiring a bed'. Performance against this standard for WWL patients was 13% for April 2021, which is a significant deterioration from the levels achieved during the initial surge and when the Better @ Home team was created. This is primarily due to a delay in recruiting fully into the Better @ Home team; a plan is however in place to address this.
- The other exception is the implementation of a 'true' Discharge to Assess model, which sees patients ongoing needs assessed in their own home, as opposed to an acute setting. Evidence supports this resulting in a more accurate assessment, leading to more patients remaining at home and therefore a reduction in ongoing care and residential placements. A discharge to assess model has been developed and a pilot commencing on the 3rd May. The expected impact will be a reduction in G&A bed-days and reduction in expenditure on ongoing care for the local authority.

Clinical Service Collaboration

Wrightington Elective Hub – The Specialist Service Divisional leadership team are now engaging actively with the Lancashire and South Cumbria ICS to support their orthopaedic elective recovery plan. Lancashire and South Cumbria have immediate access to elective recovery fund monies due to being one of the 'accelerator' ICS. Principles around supporting this request alongside our role to support GM and international partners have been developed, ensuring we continue to support equity of access to our full patient group whilst furthering our strategic priority around the development of Wrightington.

Conclusion

The Transformation Plan for 2021/22 aims to deliver benefits across a range of areas and many of the established programmes now beginning to deliver their expected and required outcomes. Work

will focus in the next month on setting trajectories for outputs and outcomes in the established programmes and setting up the new programmes to have clear aims, outcomes and delivery plans for the rest of the year.

Appendices

Appendix 1

Aims, Outcomes and measures of transformation programme

Aim	Outcomes	Measure
Outpatient Reset		
To transform the way that secondary care outpatient services are delivered, improving the efficiency and effectiveness of services through increased patient self-management support, making best use of technology, harnessing and embedding innovations used during the pandemic response and working collaboratively with primary and community services to ensure system resources are used.	• Improve productivity and create efficiency savings through new ways of working • Support reduction in follow up waiting list backlogs • Collaborative pathways with primary care to optimise referrals into secondary care • Improve patient experience through shared care and flexible access to services	• Minimum of 40% of all OP clinks are delivered virtually • Increase number of patients on PIFU waiting lists • Increased uptake of Advice and Guidance in primary care • Increase number of patient communication delivered electronically
Protecting the Front Door and UEC streaming		
To transform the way that patients access A&E and Urgent Care pathways by appropriately streaming UEC patients to pathways that support urgent diagnosis and treatment on the same day, and referring patients to Primary Care and alternative providers where appropriate.	• Reduce unnecessary overnight admissions to general and acute beds • Increase the proportion of planning Urgent Care attendances • Stream patients to the correct location based on clinical need • Improve patient experience and quality of care for UEC pathways	• Reduction in A&E attendances, acute admissions and G&A bed demand • Increase in % of patients using NHS111 to access UEC appointment slots • Increase numbers of patients accessing SDEC, CAU, UTC and WIC • Improvement in A&E quality and access standards
Discharge and Flow		
To ensure a 'Better @ Home' approach to discharge resulting in swifter discharge, improved therapeutic and rehabilitation outcomes for patients, and a reduction in long-term residential care packages and hospital readmissions	• Following discharge from hospital, patients are enabled to go home (and stay home) rather than into residential placements • Patients on pathway 1 – 4 are discharged swiftly, releasing hospital bed days and improving flow • Patients and families are better involved in planning and meeting their reablement goals • Meet the agreed GM D2A discharge pathway distribution model	• Increase % of people who are living in their own home 3 months post discharge • 95% of people (pathway 1 – 4) are discharged from hospital within 24 hours of 'no longer requiring a hospital bed' • Decrease in long-term residential and nursing placements • Increase number of patients who have a therapeutic assessment at home as part of their discharge

Summary of new and developing programmes

Clinical Service Collaboration

This new programme to the Transformation Plan in 2021/22 will provide the mechanism to govern projects where there is a vision and benefit for clinical services to collaborate across systems and the region in order to deliver specialist care in a sustainable and streamlined way. Its initial focus is the green sites / pathways work feeding into elective recovery, currently centring on the development of Wrightington as an Elective Recovery Hub. This also directly supports one of the corporate objectives for 2021/22. The very early thinking around clinical collaboration for day case elective surgery at Leigh may emerge and sit within the programme in due course and any other clinical collaborations that emerge during the year.

Agile Working

This programme will focus on developing a considered and sustainable strategy for agile working, driven by the potential benefits that this could deliver for staff and services. Whilst WWL has adapted rapidly to the urgent need to change and embrace working from home, in the longer term, there are many factors we need to be considered to make this a successful model and the right thing for our workforce. The programme will be a collaboration across a number of key areas including workforce, IM&T and E&F with all being critical partners in planning and delivering a benefit focussed strategy and policy for agile working. As this is a new scheme, a scoping exercise will be undertaken in Q1 to inform the design and implementation of changes.

Productivity

The scope and priority areas for this workstream are still to be collectively agreed but it is acknowledged that layering a more strategic overview and direction through the Transformation Board on delivering services more efficiently and therefore making the most of the skills and expertise of our staff is a key priority.

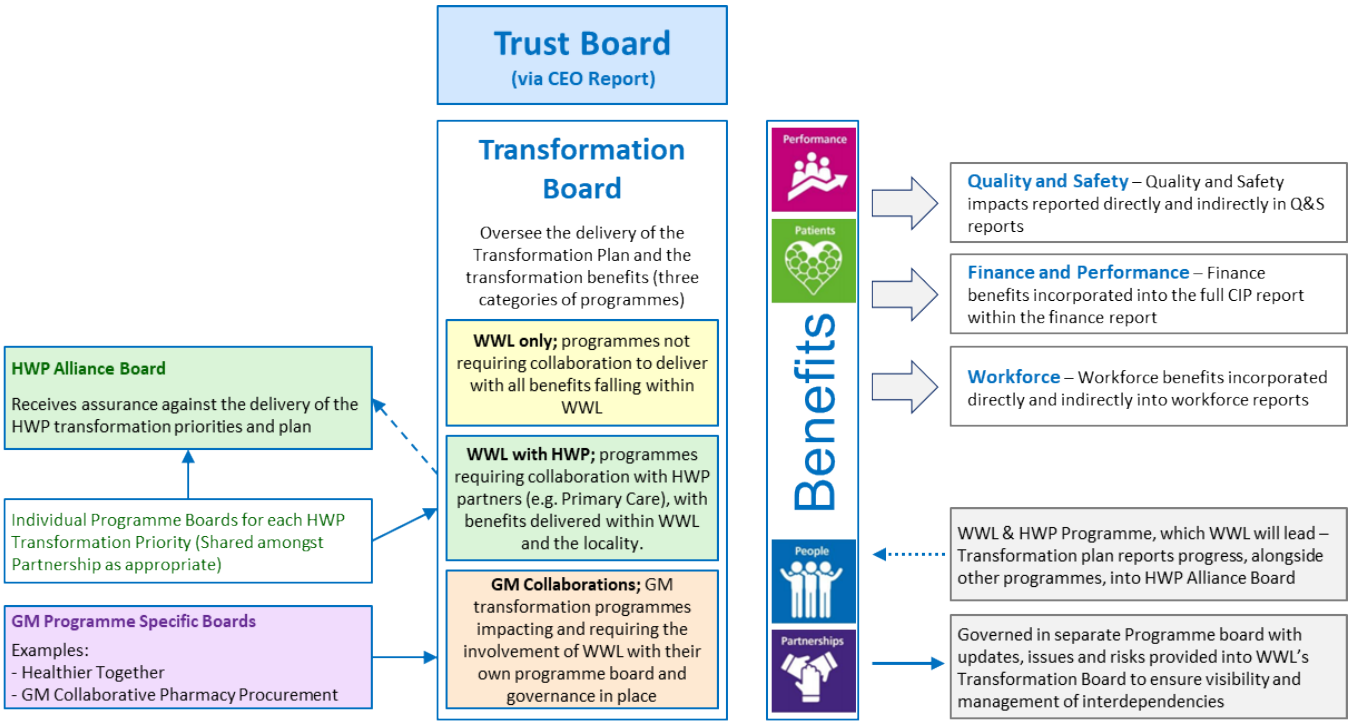
An SRO for the programme will be confirmed in the next month and the initial areas of focus. It is likely that this will be a focus on productivity initiatives and metrics that directly support the corporate objective around elective recovery given this is priority for GM and therefore requirement for WWL.

GM Collaboration Programmes

There are several well-established collaboration transformation programmes within GM, including GM integrated PACS, the unified Hospital Pharmacy Supply Chain and the GM Pathology Network. Any future collaborations would also be brought into this programme as they come on-line. This programme will oversee the delivery of these programmes and provide a link to the wider governance structure, ensuring effective communication flows into and out of WWL. It will govern the internal benefits realisation of these system changes.

Appendix 2

Transformation Board Governance Structure



Title of report:	Research Committee
Presented to:	Trust Board
On:	26th May 2021
Presented by:	Karlyn Forrest, Director of Strategic Transformation
Prepared by:	Karlyn Forrest, Director of Strategic Transformation
Contact details:	E: karlyn.forrest@wwl.nhs.uk

Executive summary

The development and expansion of the research portfolio within the Trust is key and central in delivering key aspects of *Our Strategy 2030,* most notably the strategic ambition to become a University Hospital Teaching Trust. There are numerous benefits of having an active research department; research enhances patient care, brings access to new treatments for residents and is also a critical enabler to any organisation in attracting and then retaining the highest calibre of clinicians.

There is a collective ambition to build on the growth of the research department seen in recent years and further expand the reach and impact of research. This requires the historic lack of status and profile to be addressed and, in doing so, sharpening the governance arrangements to ensure the Trust Board are fully sighted and receiving assurances around the delivery of the Research Strategy and delivery plan.

The current and future governance of research has therefore been considered, engaging and discussing options and their respective benefits with a number of key internal stakeholders.

This has resulted in a proposal for a new Trust Board sub-committee to be created that will focus on research and innovation to provide the required assurances to the Trust Board going forward around this function. The context and rationale for this proposal is outlined in this paper, alongside the work done to fully consider other options to achieve the maximum benefit to the Trust. A draft term of reference is also provided.

Link to strategy

The proposal set out in this paper supports and enables the delivery of the Trust's strategic objective of attaining university hospital trust status.

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 are recommended to support the proposal to create a new Research sub-committee.

Introduction

The Trust has an active and highly regarded Research and Development (R&D) function, which continues to expand and grow its research activity each year on a local and national level. In addition to participation in many portfolio trials (those managed by the National Institute for Health Research), the Trust also participates in commercial trials and over recent years has become increasing involved in working with researchers to develop successful grant applications to deliver 'home grown' research. The department has a proven track record for delivering high quality trials within schedule and meeting recruitment targets with many large commercial partners, such as GSK, Roche, Johnson and Johnson, Astra Zeneca and Pfizer. This places WWL is a strong position to expand on both a national and international platform for the future.

Most recently the Trust has been extremely active in its participation in the RECOVERY COVID-19 study, leading the way in the development of life saving treatments for the disease. The largest global trial in COVID-19 and an exemplar of what trials can do, this has had a positive secondary benefit of attracting new clinicians into research, therefore building our research capability and interest across the Trust for the future.

Research enhances patient care, brings access to new treatments for residents and is also a critical enabler to any organisation in attracting and then retaining the highest calibre of clinicians.

Lastly, the expansion and development of the R&D function will be front and centre in the Trust's journey as it works towards achieving its strategic ambition of becoming a University Teaching Hospital Trust.

Rationale for the proposal

The Research and Development portfolio and function has historically lacked status and profile within the Trust, with this now considered to be inhibiting its future development. This has also led to some of the Trust's key research clinical leaders beginning to feel disenfranchised and, with great ambition for research and the benefits it can deliver, understandably putting forward challenge and ideas about the future of the function.

This is a strategic issue for the Trust to address giving the integral nature of R&D to many aspects of our future strategy and specifically the ambition to achieve University Teaching Hospital Trust status. To achieve and be externally recognised as a Trust with a thriving and embedded research culture, it is proposed that the positioning of R&D needs to be elevated and one that the Trust Board is fully sighted on.

Alongside the ongoing creation of a Research Strategy and delivery plan to describe the key steps in how the department will evolve and increase its impact on patient care, a review of the research governance arrangements up to Trust Board level is also required. The R&D function currently does not report into any of the Trust's sub-board committees and therefore no assurances being received about its plans to develop and the delivery against these.

Consideration of other options

This paper puts forward the proposal to create a new Committee focused on research and innovation.

In putting forward this proposal the handful of other options available have been considered to ensure that the recommended proposal best addresses the issues and future requirements of the Trust. The output of the consideration of the different options is summarised in appendix 1.

Purpose and duties

A draft term of reference for a new Research Committee is provided in appendix 2 to illustrate the purpose and duties of the committee.

In summary it will:

- Provide strategic oversight of research activities at the Trust and to receive assurances around the delivery of the Trust's Research Strategy and delivery plan.
- Promote and encourage the innovation and research ethos and culture, which is integral to the Trust's vision.
- Monitor progress, development, governance and performance of research across the Trust.
- Receive assurances that the Research function is developing and on track to meet the criteria required for University Hospital status.

Conclusion

The Board are recommended to support the proposal to create a new Research sub-committee.

Appendix 1

There were considered three options available to improve the governance of research so fully visible to Trust Board and assurances able to be received. These are:

1. Review the terms of reference of an existing sub-committee to include R&D
2. Create a joint R&D and undergraduate education committee, therefore changing the existing governance arrangements of education.
3. Create a new committee for research and innovation.

The considered implications of each are summarised below:

	Advantages	Disadvantages
1. Review the terms of reference of an existing committee to include R&D		
Finance and Performance Committee	• None	• Research, whilst attracting additional income through commercial trials and grants, is not concerned with the financial performance of the Trust. • Limited synergy and alignment with the principle purpose of this existing committee. • Sitting in an existing committee wouldn't fulfil the need to significantly raise the status and profile of the function and make this more visible to Trust Board.
Workforce Committee	• Research attracts and retains high calibre staff, and makes roles fulfilling. • Undergraduate medical education already sits within this Committee.	• The clinical focus and benefits of research would mean a significant change and stretch in remit and scope of this committee. • Sitting in an existing committee wouldn't fulfil the need to significantly raise the status and profile of the function and make this more visible to Trust Board.
Quality and Safety	• Positive impact of new trials, development of new and effective treatments and access to new treatments for local patients would align with the quality aspect of this meeting	• Large and wide-ranging agenda – would R&D get the focus and time required? • Sitting in an existing committee wouldn't fulfil the need to significantly raise the status and profile of the function and make

		this more visible to Trust Board.
2. Create a joint R&D and undergraduate education committee, therefore changing the existing governance of undergraduate education.		
	• Alignment of plans for University Hospital Status	• Effective governance arrangements already in place for education. • Widening the remit would potentially dilute the impact of the new committee • Wouldn't provide same level of support consultants and clinical staff currently need.
3. Create a new committee for research and innovation.		
	• Achieves the need to raise the profile of research directly to Trust Board • High levels of support from senior clinical colleagues active in research for this proposal. • Creates the required assurance mechanism going forward for the research aspect of university hospital status.	None identified.

Appendix 2

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

TERMS OF REFERENCE

1. AUTHORITY

1.1. The Research Committee ("the Committee") is constituted as a standing committee of the foundation trust's Board of Directors ("the Board"). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board meetings.

1.2. The Committee is authorised by the Board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee.

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

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

2. MAIN PURPOSE

2.1. The Committee will give strategic direction and enable the Board to obtain assurance around the development and delivery of the Research Strategic Plan. This will include receiving assurances that the research department has a plan in place and is delivering against this to meet the membership criteria for the University Hospital Association, a prerequisite of becoming a University Hospital Trust.

2.2. Its key duties are as follows:

(a) To develop, review and update the strategic direction and business plan for research and innovation through:

(i) Approving the Research Strategic plan

(II) Receiving assurances around the implementation of the Research Strategic Plan

(b) Promoting and establishing highly effective collaborative relationships with universities, other organisations (including NHS), research and innovation networks and other key stakeholders.

(c) Identifying and reviewing changes in research-related legislation and national research and / or innovation policy and guidance.

(d) Supporting research and innovation being embedded at every level of the organisation through establishing the conditions for increasing participation in clinical trials.

(e) To establish the conditions for, and promote, a patient-focused and ambitious culture for research and innovation.

(f) To oversee and direct the activities which support the development of a research into action culture, bringing research and clinical application closer.

(g) To promote and see innovation and clinical research working seamlessly together.

(h) To assure high robust management and governance of research and innovation.

(i) To monitor research and development finances, including grant income.

(j) To assure the Board that where there is a research risk that may jeopardise the Trust's ability to deliver its strategic objectives or which have significant reputational, patient or cost impact, that these are being managed in a controlled and timely manner to mitigate the risks.

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

3. MEMBERSHIP

3.1. The membership of the Committee shall consist of:

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

(b) Director of Strategy and Planning;

(c) Medical Director;

(d) Chief Nurse

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

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

4. SECRETARY

4.1. The Director of Corporate Assurance or his/her nominee shall be secretary to the Committee.

5. ATTENDANCE

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

(a) Clinical Director for Research and Development

(b) Head of Research and Development

(c) Divisional Research Champion (on 1 in 4 rotational basis)

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

6. FREQUENCY OF MEETINGS

6.1. Four meetings per year will be scheduled.

7. MINUTES AND REPORTING

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

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

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

7.4. The following group shall report to the Committee:

(a) Research and Development Committee

8. PERFORMANCE EVALUATION

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

9. REVIEW

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

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Register of referrals received by the Clinical Ethics Group
Presented to:	Board of Directors
On:	26 May 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 21 May 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 1 (April 2021)
Presented to:	Finance and Performance Committee
On:	24th May 2021
Presented by:	Ian Boyle [Chief Finance Officer]
Prepared by:	Senior Finance Team
Contact details:	E: ged.murphy@wwl.nhs.uk

Executive summary

	In Month			Year to Date		
	Actual £000's	Plan £000's	Var £000's	Actual £000's	Plan £000's	Var £000's
Income	36,568	36,131	437	36,568	36,131	437
Expenditure	(35,509)	(35,161)	(348)	(35,509)	(35,161)	(348)
Financial Performance	(142)	(221)	79	(142)	(221)	79
Cash Balance	39,998	37,826	2,172	39,998	37,826	2,172
Capital Spend	209	801	592	209	801	592

Key Messages:

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

The WWL Way

- Cash is £40.0m at the end of Month 1.
- Capital spend is £0.2m in month 1.

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

FINANCE AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

1.1. The Finance and Performance Committee ("the Committee") is constituted as a standing committee of the foundation trust's Board of Directors ("the Board"). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board meetings.

1.2. The Committee is authorised by the Board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee.

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

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

2. MAIN PURPOSE

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

2.2. Its key duties are as follows:

Finance

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

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

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

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

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

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

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

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

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

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

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

Performance

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

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

(n) To consider investment or divestment in services;

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

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

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

Risk

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

Business cases

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

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

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

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

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

3. MEMBERSHIP

3.1. The membership of the Committee shall consist of:

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

(b) Chief Finance Officer;

(c) Chief Operating Officer; and

(d) Director of Strategy and Planning.

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

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

4. SECRETARY

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

5. ATTENDANCE

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

(a) Governor; and

(b) Director of Transformation

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

6. FREQUENCY OF MEETINGS

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

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

7. MINUTES AND REPORTING

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

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

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

7.4. The following groups shall report to the Committee:

(a) Site and Service Investment Group

(b) Research and Development Group

8. PERFORMANCE EVALUATION

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

9. REVIEW

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

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

PEOPLE COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

1.1. The People Committee ("the Committee") is constituted as a standing committee of the foundation trust's Board of Directors ("the Board"). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board meetings.

1.2. The Committee is authorised by the Board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee.

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

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

2. MAIN PURPOSE

2.1. The main purpose of the Committee is to be responsible for:

(a) Approve and oversee the implementation of the People Strategy;

(b) Approve of prioritised annual People objectives;

(c) To assure the Trust Board of compliance against key national and statutory workforce requirements;

(d) To develop strategic workforce recommendations for approval by the Board

3. SCOPE OF RESPONSIBILITIES

(a) To monitor the implementation and relevance of the People Strategy and WWL People Promise

(b) To ensure that WWL has thorough and robust implementation plans to deliver against the WWL People Promise Pledges;

- Employment Essentials
- Steps for Wellness
- Your Voice Matters

- Learn and Grow

(c) To provide assurance of improvements and compliance against key statutory and NHS specific workforce equality, diversity and inclusion requirements;

(d) To ensure that a culture of psychological safety and learning is embedded throughout the Trust

(e) To provide assurance to the Board of Directors on workforce issues; taking account of local and national agendas;

(f) Monitor and provide assurance to the Board of the specific workforce risks identified within the Board Assurance Framework or Corporate Risk Register and people related corporate objectives;

(g) To monitor deliver progress of the People Strategy and mandated standards;

(h) Ensure strategic alignment of the WWL People agenda with the NHS Long Term Plan, National People Plan and NHSE/I mandated standards;

(i) Growing the recruitment brand;

(j) Talent management and the expansion of management and leadership opportunities;

(k) Innovation and the development of new clinical and non-clinical roles to meet the needs of our patients and innovation in service delivery models

4. MEMBERSHIP

4.1. The membership of the Committee shall consist of:

(a) Non-Executive Director Chair;

(b) Director of Workforce;

(c) Non-Executive Directors x2

(d) Chief Operating Officer;

(e) Chief Nurse;

(f) Chief Finance Officer Medical Director;

(g) Director of Strategy and Planning;

(h) Director of Communications and Stakeholder Engagement

4.2. The Committee will be deemed quorate with a minimum of 2 non-executive directors, of which 1 will be the non-executive Chair or their nominated deputy, and the Director of Workforce or their nominated deputy.

5. SECRETARY

5.1. The Company Secretary or their nominated deputy shall be secretary to the Committee.

6. ATTENDANCE

6.1. The following participants are required to attend meetings of the Committee;

(a) Deputy Director of HR;

(b) Deputy Director of Staff Engagement & OD;

(c) Divisional Directors of Operations & Performance;

(d) Associate Director of Estates & Facilities;

(e) A staff side representative.

6.2. A representative of the Council of Governors shall also be entitled to attend meetings.

6.3. Other persons may be invited by the Committee to attend a meeting so as to assist in deliberations.

6.4. Any member or non-member, including the secretary to the Committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

7. FREQUENCY OF MEETINGS

7.1. Meetings shall be called as required, but at least quarterly in each financial year.

8. MINUTES AND REPORTING

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

8.2. Once approved by the Committee, the minutes should be circulated to the Board for information.

8.3. The following sub-groups shall report to the People Committee:

(a) Local Negotiating Medical Committee (LNC);

(b) Educational Governance Committee;

(c) Partnership Council;

(d) International Recruitment Governance Group;

(e) Workforce DQEC.

9. PERFORMANCE EVALUATION

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

10. REVIEW

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

Title of report:	Provider licence self-certifications 2020/21
Presented to:	Board of Directors
On:	26 May 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

Each year, NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence and specifically conditions G6, CoS7 and FT4. The deadline for self-certification of conditions G6 and CoS7 is 31 May 2021 and the deadline for self-certification of condition FT4 is 30 June 2021.

Whilst an excel document is provided by NHS Improvement to facilitate this self-certification, the format does not lend itself well to review by the board. The content has therefore been duplicated in this report and it is proposed that, following approval by the board, the content will be inserted into the NHS Improvement template and the relevant signatures applied.

There is no requirement to submit the self-certifications to NHS Improvement. Rather, NHS Improvement will undertake an audit of a sample of FTs to confirm that they have self-certified.

Link to strategy

There is no direct link to the organisational strategy, however compliance with the NHS Provider Licence underpins the organisation's ability to provide services.

Risks associated with this report and proposed mitigations

Self-certification is a mandatory requirement and this report mitigates the risk of non-compliance.

Financial implications

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

There are no people implications to highlight.

Wider implications

There are no wider implications to highlight.

Recommendation(s)

The Board of Directors is recommended to approve the self-declarations as outlined in the attached report.

1. GENERAL CONDITION 6

The declaration for General Condition 6 is given below, and the board is required to respond either "confirmed" or "not confirmed".

"Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution."

The board is recommended to direct that a response of "**CONFIRMED**" is provided. Information in support of this recommendation is contained in annex 1 to this report.

2. CONTINUITY OF SERVICES CONDITION 7

There are three declaration options available to the board and these are given below:

(a) After making enquiries, the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate; or

(b) After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services; or

(c) In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

The board is recommended to respond **"CONFIRMED"** to declaration (a), above and to respond **"NOT CONFIRMED"** to declarations (b) and (c) above. Information in support of this recommendation is contained in annex 1 to this report.

The board is also required to provide a statement of the main factors taken into account when making the above declaration. It is recommended that the content of annex 1 relating to condition CoS7 is provided as the text of this statement.

3. FOUNDATION TRUST CONDITION 4

The board is required to respond to a number of statements in order to self-certify against condition FT4, as well as providing detail of the risks and mitigating actions. The statements, and the proposed responses are provided overleaf:

Statement	Response and detail of risks and mitigating actions
1. The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	**Confirmed** ▪ Compliance with NHS Foundation Trust Code of Governance regularly assessed and reported to the Audit Committee and within the annual report. ▪ The Trust's Standing Orders require that a register of director's and governors' interest is in place and kept up to date (held by the Company Secretary who has accountability for its maintenance). ▪ There are no material conflicts of interest in the Board. ▪ All governors' elections and by-elections are held in accordance with election rules. ▪ Systems and controls assurances are obtained via the Audit Committee. ▪ An independent review of leadership and governance using the well-led framework was completed in 2016/17 with no material concerns having been highlighted. An action plan was developed to ensure that good practice and other recommendations were implemented and embedded within the organisation ▪ The most recent CQC inspection report (published February 2020) rates the foundation trust as "good" in all areas, including well-led ▪ The most recent Use of Resources inspection undertaken by NHS Improvement rated the foundation trust as "good" ▪ More complete explanations about systems of corporate governance are set out in the annual governance statement and the foundation trust's annual report. ▪ The Company Secretary maintains an overview of corporate governance developments within the NHS and across wider sectors, and good practice is shared through established regional and national Company Secretaries Networks ▪ The Audit Committee receives regular updates on good practice from the internal and external auditors.

2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	**Confirmed** ▪ Compliance with NHS Foundation Trust Code of Governance is assessed each year as part of the annual reporting process. ▪ Any guidance requirements are routinely assessed and implemented as necessary - overview of guidance provided by MIAA and Deloitte in updates received at each Audit Committee meeting. Assurance and advice is provided as required by the Audit Committee
3. The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation."	**Confirmed** ▪ Board committees established with clear lines of reporting, and recently reviewed ▪ Terms of Reference in place for Board and all other committees and groups within the Trust which are regularly reviewed and updated where necessary. These set out remit of each type of meeting, membership, attendance by others, quorum requirements and reporting responsibilities. ▪ Chairs report to the board to escalate assurance and concerns in line with reporting structure. ▪ Clear delegation of actions to committees. ▪ Annual Governance Statement in place which identifies areas of potential risk and mitigating actions. ▪ Scheme of Delegation and robust Standing Financial Instructions in place
4. The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality	**Confirmed** ▪ Risk Management Strategy in place and currently subject to review ▪ Board Assurance Framework used extensively at each committee and board meeting ▪ Datix risk management system in place. ▪ Use of internal and external audit services to investigate any areas of concern.

Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	▪ Royal College reviews undertaken where appropriate or necessary. ▪ Contracts for services agreed with clinical commissioning groups. ▪ Finance and Performance Committee considers detailed financial performance report at each meeting ▪ Performance report considered at each Board meeting. Detailed performance discussed at quarterly divisional performance reviews. ▪ Comprehensive agendas for Board meetings circulated to directors in advance of each meeting ▪ Service and Value Improvement Plans in place which are risk assessed for quality ▪ Standing Financial Instructions and Standing Orders in place ▪ Counter Fraud specialist reports to the Audit Committee ▪ In relation to point (f) and (g), the Trust's annual report and operational plan have set out a number of high level risks facing the Trust and ways in which these are being mitigated. ▪ Points as set out in 1), 2) and 3) above apply.
5. The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate,	**Confirmed** ▪ The Medical Director and the Chief Nurse are both appropriately professionally qualified and accountable to their professional body (in addition to the Trust). ▪ NEDs individually bring extensive experience and expertise from many different areas of private and public sector activity including finance, commerce, governance and organisational development. ▪ Collectively, the NED component of the Board is suitably qualified to discharge its functions. ▪ Quarterly Safe, Effective Care (SEC) report presented to Quality & Safety Committee and commissioners and shared with the Board. ▪ Quality and Safety Committee – chaired by a NED – Terms of Reference include reporting from Divisional Quality Executive Committees,

comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Safeguarding Committee, Medicine's Strategy Board and Infection Prevention and Control. ▪ Clinical Audits – the Trust participates in national audits and also local audits. Audit reports are submitted to relevant committees or groups. ▪ Learning from national reports with comparative reports undertaken and action plans devised and implemented. ▪ National reports and benchmarking e.g. NICE guidelines and patient safety alerts. ▪ Monthly leadership safety walk rounds undertaken by Executive directors, Non-Executive Directors and Governors. ▪ Processes in place to escalate and resolve issues - Risk and Environmental Management Group (REMG) ▪ The executive team is supported by a cadre of appropriately-qualified and capable deputies and recruitment to vacant posts is currently underway
6. The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed** ▪ The Medical Director, Chief Nurse and Chief Finance Officer are all appropriately professionally qualified and accountable to their professional body (in addition to the Trust). ▪ All Executive Directors' performance and competencies are reviewed through annual appraisals. ▪ Collective & individual skill-sets reviewed as part of board development ▪ Chairman receives an annual performance appraisal from the Senior Independent Director ▪ NEDs receive an annual performance appraisal from the Chairman who advises the governors ▪ NEDs have been appointed by the Council of Governors as advised by the governors' Nominations and Remunerations Committee ▪ NEDs individually bring extensive experience and expertise from many different areas of

	private and public sector activity including finance, commerce, governance, and, OD. . Collectively, the NED component of the Board is suitably qualified to discharge its functions. ▪ Once in post, each NED undergoes an internal induction to facilitate an understanding of the Trust, its operations and strategic direction. ▪ Thereafter, on-going training to develop existing and new skills relevant to the NED role is undertaken by attendance at external conferences and workshops as required. ▪ NED progress is monitored by the Chair via one to one meetings including a formal annual appraisal session at which achievements against objectives for the preceding year are evaluated and new goals for the forthcoming year and a personal development plan are established. ▪ This is supplemented by a number of Board away days throughout the year to discuss strategy and policy as well as developing the knowledge and skills of the Board on specific issues. ▪ Divisions are led by experienced and capable teams consisting of a Divisional Director of Operations, Divisional Medical Director and Head of Nursing. ▪ Safer staffing levels on wards are reported to Board monthly and are monitored and are included on the wards' quality board.

Annex 1: Information in support of G6 and CoS7 declarations

Condition G6

There is no requirement on the self-certification form to show any evidence or mitigation, however, if required under audit, the following should be taken into consideration:

- The Board and supporting Committees and Groups (Audit Committee, Quality & Safety Committee, People Committee, Finance and Performance Committee and the Risk and Environmental Management Group) receive regular reports and supporting data analysis covering patient safety, clinical quality, patient experience, workforce, performance and finance.

- The CQC undertook a comprehensive inspection of services in 2019 and published their report in February 2020. The foundation trust was rated as "Good" in all domains and there were areas of excellent practice.

- Governors hold Non-Executive Directors (individually and collectively) to account for the performance of our Board of Directors by ensuring that they act so that WWL does not breach its provider licence. Governors receive details of meetings, agendas and approved minutes of each Board of Directors' Meeting and regularly attend to observe directors in action.

Condition CoS7

The board made a going concern declaration in the annual report and accounts 2019/20 (the most recently-approved) and intends, on the recommendation of the Audit Committee, to make the same declaration in the 2020/21 report and accounts following detailed consideration of the content.