Board of Directors held in public

Wed 24 November 2021, 13:30 - 16:00

Microsoft Teams

Agenda

11.
Declarations of Interest

Information

12.
Minutes of Previous Meeting

Decision *Mark Jones*

To follow

Minutes - Public Board - Sep 2021.pdf (8 pages)

13.
Patient Story

Discussion *Rabina Tindale*

14.
Chief Executive's Report

Discussion *Silas Nicholls*

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

15.
Committee Chair's Reports

Information *NED*

Verbal item

16.
Board Assurance Framework

Discussion *Mark Jones*

14. BAF - Nov 2021.pdf (40 pages)

17.

Maternity Reports

Discussion *Rabina Rindale*

17.1.
Maternity Provider Board-level Report

17.1 Maternity provider board-level report.pdf (6 pages)

17.2.
Maternity Dashboard

Discussion *Rabina Tindale*

17.2 Maternity dashboard.pdf (8 pages)

18.
Safe Staffing Report

Discussion *Rabina Rindale*

18. Safe staffing report.pdf (21 pages)

19.
Wellbeing and People Pledges

Discussion *Alison Balson*

19. Wellbeing pledges.pdf (4 pages)

20.
EDI Strategy

Decision *Alison Balson*

20. EDI strategy.pdf (28 pages)

21.
Performance Report

Discussion *Executive Team*

21a. Balanced scorecard.pdf (4 pages)
21b. Performance report.pdf (3 pages)

22.
Consent Agenda:

22.1.
Month 7 finance report

Information

22. Finance report.pdf (2 pages)

22.1.1.
EPRR Core Standards Self-assessment

Information

22b. EPRR core standards report.pdf (11 pages)

23.
Close

Information *Mark Jones*

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

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

HELD ON 29 SEPTEMBER 2021, 1.15PM

BY VIDEOCONFERENCE

Present:	Mr R Armstrong	Chair (in the Chair)
	Prof S Arya	Medical Director
	Mr S Nicholls	Chief Executive
	Prof C Austin	Non-Executive Director
	Mrs A Balson	Director of Workforce
	Mr R Mundon	Director of Strategy & Planning
	Mr M Jones	Chair Designate
	Mr I Boyle	Chief Finance Officer
	Lady R Bradley DL	Non-Executive Director
	Dr S Elliot	Non-Executive Director
	Ms M Fleming	Deputy Chief Executive
	Mrs A Tumilty	Non-Executive Director
	Mr I Haythornthwaite	Non-Executive Director
	Mr P Howard	Director of Corporate Affairs
	Mrs A-M Miller	Director of Communications
	Mrs L Lobley	Non-Executive Director
	Ms R Tindale	Chief Nurse
	Mrs F Thorpe	Non-Executive Director
In attendance:	Mr A Howarth	Public Governor (observer)
	Mr J Murray	Deloitte (observer)
	Mrs J Wilson	Vocational Learning Facilitator (to item 111/21)

The Board reconvened following an adjournment.

The Chair opened by welcoming A Tumilty as a newly appointed Non-Executive Director. The Chair also welcome Mark Jones, current Chair Designate, who will be taking up post as Chair in November 2021.

109/21 Declarations of interest

There were no opening declarations of interest.

110/21 Minutes of the previous meeting

The minutes of the previous meeting held on 28 July 2021 were **APPROVED** as a true and accurate record, subject to an amendment to the attendance record.

111/21 Staff story

Julie Wilson, the foundation trust's Vocational Learning Facilitator, joined the meeting and shared the experiences of young people who had previously been long-term

unemployed and who had been given opportunities within the foundation trust as part of the government-supported Kickstart programme. She outlined the robust process that had been established in partnership with the human resources team, highlighting the positive impact of the programme and noting that four individuals from the first cohort had subsequently secured substantive roles within the organisation.

In response to a question from Mrs Tumilty, Julie outlined the plans moving forward for the Kickstart programme, noting that the last onboarding was scheduled for December 2021 but that more information on the potential extension of the scheme was anticipated during October 2021. Julie also noted that candidates are asked to provide weekly reports outlining their learning with a view to this enhancing job applications after the programme.

The Chief Executive thanked Julie Wilson for her update, recognising the value of her enthusiasm and her obvious passion for the topic. He noted that, depending upon the national decision on the potential extension to the scheme, funding of a local scheme may need to be considered in order to continue the beneficial work within the foundation trust.

In response to a question from Mrs Lobley, Julie highlighted the importance of identifying the impact that individuals in the scheme have on patients and staff in the workplaces they are placed in, suggesting that feedback from questionnaires or directly from management could be incorporated.

The Board was extremely supportive of the work being undertaken via the scheme and thanked Julie for her dedication and leadership in this area.

The Board received and noted the verbal update.

Julie Wilson left the meeting.

112/21 Chief Executive's report

The Chief Executive presented his report which had been circulated with the agenda. He highlighted the fact that the organisation was focused on elective recovery, noting there had been recognition from the regional office regarding the progress that had been made and adding that the foundation trust was one of the best performing organisations against its recovery plan. He highlighted the significant work undertaken to deliver this position, particularly given the pressures staff are facing, and expressed his gratitude to all staff.

The Chief Executive also noted that, in addition to providing the internal COVID-19 vaccination booster programme for staff, work was also being undertaken to deliver the school vaccination programme, led by community staff.

The Chief Finance Officer updated the Board that the Public Finance Awards had taken place the day before the meeting and that the procurement team had won the Outstanding Procurement Initiative Award, as well as the overall Grand Prix award.

The Board received the report and noted the content.

113/21 Committee chairs' reports

Mrs Thorpe summarised the Quality and Safety committee meeting in September 2021, adding that the agenda had been structured around key elements of the Board Assurance Framework. She noted that the new Duty of Candour policy for the organisation had been approved and, in relation to the Board Assurance Framework, highlighted that the committee is yet to be provided with robust assurance on pressure ulcers and the mortality improvement plan, which would be discussed in more detail at its next meeting.

Mrs Lobley summarised the People Committee meeting in September 2021. She highlighted progress with equality, diversity and inclusion and advised that a post had recently been recruited to, in order to enable this work to further develop. Mrs Lobley noted areas where assurance is currently limited, being participation in the Your Voice Matters survey and medical appraisal and revalidation response rates. She highlighted that the People Board Assurance Framework was currently RAG-rated as green.

Mrs Tumilty noted that the Finance and Performance Committee had met in the previous week and advised that it had focussed on the key areas of the Board Assurance Framework in discussions. She highlighted H2 funding as an area of concern due to the lack of clarity regarding the funding regime, noting that allocations for H2 are expected to be finalised by mid-November and that there needs to be a clear strategy going forward in terms of funding permanent recruitment versus temporary recruitment. In relation to performance, she highlighted the two major risks as urgent and emergency care and elective recovery, outlining the steps being implemented to tackle the pressures. Mrs Tumilty commented that it had been reported to the committee that the delivery of the digital strategy will be delayed to allow more time for staff engagement, noting the intention for the Board to approve the strategy in November 2021.

The Director of Strategy and Planning provided an update on partnership working, noting that the shadow arrangements for operating as an ICS and as a locality take effect as of 1 October 2021. He reminded the Board that relationships across provider colleagues and with the CCG and local authority are strong and went on to note that the first Locality Governance Board would be taking place during October 2021.

Prof Austin updated the Board that the first Research Committee meeting had taken place in September 2021, noting that the meeting had been positive with lots of enthusiasm for research. She noted that membership of the committee had been considered and that it had been suggested that the Director of Communications and Stakeholder Engagement be invited to join the committee, adding that communication and engagement is key for research and development.

Mr Haythornthwaite summarised the Audit Committee meeting in September 2021, noting the work that had been done internally to follow-up internal audit recommendations and to ensure timely completion. He highlighted the success of the deep dives in specific areas of risk, adding that the committee intends to continue with deep dives on a cyclical basis.

The Board received the verbal updates and noted the content.

114/21 Board assurance framework

Having taken account of the feedback from committee chairs, the Board **APPROVED** the Board Assurance Framework as presented.

115/21 Maternity/Ockenden report

The Chief Nurse provided an overview of the reports which had been circulated with the agenda to provide the Board with information regarding maternity.

Dr Elliot informed the Board that during the recent Maternity Safety Champions meeting, members were keen that the Board be informed of further developments around the Ockenden report, adding that it is expected that either another interim or the final report will be published shortly. Dr Elliot went on to inform the Board that the local Maternity Voice Partnership meeting had recently taken place in which a service user had shared their experiences. Whilst they had been complimentary about the work of the foundation trust, they had highlighted some issues around performance and Dr Elliot confirmed that he had shared this feedback with the relevant staff members to ensure that they are addressed. In response to a question from the Chair Designate, Dr Elliot commented that additional recommendations from the review may be published before the end of the calendar year.

Lady Bradley queried whether there are any national investigations to explore the impact of COVID-19 on births and pregnancy and how this relates to vaccine uptake. In response, the Chief Executive confirmed that the North West Critical Care Network was exploring this and that an update would be provided once the information is available.

Mrs Tumilty, referencing one of the reports circulated, queried the low breast-feeding rates in Wigan and whether steps are being put in place to support this important activity. In response, Dr Elliot expressed his hope that this might be influenced via the Healthier Wigan Partnership.

The Board received the report and noted the content.

116/21 Infection prevention and control board assurance framework update

The Chief Nurse presented the Infection Prevention and Control Board Assurance Framework update, noting there had not been any significant changes since the last report in July 2021.

The Chief Executive provided an update in relation to the business case to support the new national cleaning standards referenced in the report, advising that the additional investment for clinical areas has been approved but that the investment for non-clinical areas had not yet been confirmed.

The Board received the report and noted the content.

117/21 Safe staffing report

The Chief Nurse presented a report which had been circulated with the agenda to provide the safe staffing report for July 2021.

Dr Elliot declared a potential interest as a member of a GP federation which is involved in delivering the vaccination programme and queried why the 12-15 vaccination programme would significantly impact on the ability to deliver other core service requirements. In response, the Chief Nurse advised that the impact of this additional activity without extra resource that was creating some level of challenge.

In response to a question from Lady Bradley, the Chief Nurse commented that the ward accreditation programme had been paused for some 18 to 24 months, noting that the first step would be to ensure that all wards are at this baseline. The Chief Executive highlighted the fact that ward accreditation involves all staff associated with a ward and is not limited to nursing staff.

The Medical Director reminded the Board of the intention to present a medical safe staffing report with effect from the next meeting in November 2021.

The Board received the report and noted the content.

118/21 Performance report

The Deputy Chief Executive presented a report which had been circulated with the agenda and reminded the Board that the report had been subject to detailed scrutiny by the Finance and Performance Committee earlier in the week. She drew the Board's attention to the scorecard section of the report and provided an overview of the content. Particular note was made of the scale of the challenge around access metrics on a national scale, as well as the steps that are being taken to widen access wherever possible. The Deputy Chief Executive noted the requirement for an additional 50 beds as part of the wider winter plan and that, whilst the beds themselves had been identified, work was ongoing to identify the appropriate staffing to support those beds, with this expected to be confirmed by the end of October 2021.

With regard to the elective recovery programme, the Deputy Chief Executive gave a summary of the work being undertaken, including around the number of patients waiting 104 weeks or more for treatment. She advised that the national focus is on eliminating the number of such patients by the end of March 2022 and confirmed that internal modelling had indicated that there would be c.600 such patients as at the end of March 2022 and that this number had been included as part of the Greater Manchester submission.

The Deputy Chief Executive also summarised the arrangements that had been put in place across Greater Manchester for organisations to buddy other organisations in particular specialties. She also discussed cancer pathways and areas of challenge, noting that the foundation trust had experienced a 30% increase in referrals to the colorectal specialty.

The Chief Executive noted that consultation had taken place on the removal of the 4-hour target for Accident and Emergency attendances, which would be replaced with a new 12-hour standard from the time of arrival to the patient's discharge or admission.

In response to a question from Mrs Thorpe around equality of access and the potential impact for sections of the community arising from the transferring of patients to different organisations where needed, the Deputy Chief Executive provided a summary of the related discussions which had touched on the need to consider providing transport and to consider moving clinical teams rather than patients.

Mrs Lobley noted the development of patient-initiated follow-ups and asked whether any evaluations of the service were being undertaken. In response, the Medical Director clarified that the approach was not new in all areas and confirmed that evaluations would be commencing within rheumatology in the near future. The Chief Executive also advised that data relating to the approach is reviewed on a monthly basis.

The Board received the report and noted the content.

119/21 Finance report

The Chief Finance Officer presented a report which had been circulated with the agenda to summarise the foundation trust's financial position as at month 5 2021/22. He noted that outturn remains in line with the plan and confirmed that he was forecasting remaining in line with the overall plan at the end of H1 2021/22. With regard to the second half of the year, note was made of the fact that national planning assumptions had not yet been released, although he confirmed that block contract arrangements will continue and that £1bn of national funding would be made available to support organisations to recover their elective performance, although there would be challenging trajectories associated with this.

The Board received the report and noted the content.

120/21 Transformation report

The Director of Strategy and Planning presented a report which had been circulated with the agenda to summarise performance against the 2021/22 transformation plan as at the end of August 2021.

In response to a question from Mrs Thorpe around equality of access to services and particularly those using remote technologies, the Director of Strategy and Planning described the suite of metrics that is available to support analysis. The Director of Workforce advised that the Equality, Diversity and Inclusion Strategy was currently under development and would be subject to consultation, part of which would cover the use of virtual outpatient appointments and seeking feedback on the impact and how any inequalities could be addressed. The importance of robust equality impact assessments for any service developments was also iterated, as well as the need to routinely consider 'net zero' implications.

121/21 Update on partnership working with GPs

The Medical Director provided a verbal update on the partnership working with GPs, noting that there are 57 practices in Wigan Borough with a total of 247 GPs. He confirmed that he regularly attends meetings across the borough. Dr Elliot also provided some feedback from across primary care, and noted the work being undertaken to further develop relationships.

The Board received and noted the verbal update and agreed that this would be a welcome topic of discussion for a future away day.

122/21 Consent agenda

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

1. THAT the terms of reference for the Audit Committee and Research Committee be **APPROVED** as presented.

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

3. THAT the Risk Management Strategy be **APPROVED** as presented.

4. THAT the General Medical Council revalidation report be received and noted.

123/21 Date time and venue of the next meeting

The next meeting of the Board of Directors will be held on 24 November 2021 by videoconference.

Action log

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
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Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	24 November 2021
Presented by:	Chief Executive
Prepared by:	Director of Communications and Stakeholder Engagement
Contact details:	T: 01942 822170 E: anne-marie.miller@wwl.nhs.uk

Executive summary

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

Link to strategy

The links to overall strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

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

Legal implications

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

People implications

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

Wider implications

There are no wider implications associated with this report.

Recommendation(s)

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

Chief Executive's Report – November 2021

It has been a period of transition and change for the Trust over the past couple of months, with the departure of a highly respected and long-serving Chairman in Robert Armstrong, who retired down from his position at the end of October. We will be forever indebted to Robert for his service to WWL over the years, but we are now embarking on a new era of leadership with Mark Jones, who began his tenure as the Trust's Chair on 1st November 2021. Mark has been present at WWL since May, shadowing Robert in his duties to ensure a smooth arrival on his first day. Mark's passion for our patients, carers, staff and governors shone through during the recruitment process and he has continued to show all of those qualities. I'm sure Mark is going to continue to make a positive impact on the way we operate and communicate as a Trust.

Over the past two months, our elective recovery programme has been making significant progress, particularly at our Greater Manchester Elective Recovery Hub for Orthopaedic surgery at Wrightington Hospital, with our services consistently performing at the top across the Greater Manchester region. Investment in Wrightington Hospital has contributed significantly to this, with support to recruit new team members, as well as being able to carry out refurbishment work to increase capacity. That said, without the enormous efforts of our staff across the site, we wouldn't be in the position we are currently, and they continue to make a huge difference to people's lives on a daily basis.

Maintaining our stepped-up services is going to be critical during the winter months, which makes our winter planning evermore important. Representatives from WWL, North West Ambulance Service, Greater Manchester Mental Health NHS Foundation Trust, Wigan Borough Clinical Commissioning Group, Primary Care, Community Services, Communications Teams and Wigan Council have developed a joined-up winter plan, working to ensure strong partnership working, outpatient transformation and the correct public messages continue throughout. This whole system approach has been developed to maintain patient flow, provide continuity of services and ensure patients can access the right care, at the right time and in the right place.

At the end of September, I joined Consultant Respiratory Physician and Divisional Medical Director for Medicine, Dr Abdul Ashish in officially inaugurating our Enhanced Respiratory Care Unit on Winstanley Ward. The unit has continued to provide much needed support and forms part of our plans to make sure we are in the strongest position possible ahead of the winter months and beyond. Alongside keeping our staff and patients safe through COVID-19 and flu vaccinations, it is just as important to make sure our facilities are well-equipped to deal with anticipated winter pressures, as this will allow our teams to continue to care for patients in the safest and most effective way. The same can be said for our Surgical Ambulatory Emergency Care Unit on Orrell Ward, which was opened by outgoing Chairman Robert Armstrong and our Chair, Mark Jones at the end of October. The unit plays an important role in WWL's continuous aim to improve patient care and experience and provides a safe and flexible alternative for surgical patients to be assessed and receive treatment without the need to be admitted to a hospital bed; significantly enhancing the patient journey.

Our COVID-19 and flu vaccinations programmes continue to gather pace in order to help protect our staff from infection, in turn helping to protect our patients, but importantly ensuring continuity within teams to be able to provide the care our patients need in all areas. Our first and second dose percentages are above 90%, with our booster dose percentages steadily increasing as we work through appointments for our staff across a number of sites.

Our staff are the backbone of the NHS, and we continue to work with all of our people to make WWL a thriving and safe environment to work in. A number of programmes are underway to continually achieve this, including the introduction of the independent Guardian Service which launched at the beginning of October – this service provides staff with a safe and confidential space to discuss any work-related matters or concerns that they may have.

We continue to have reasons to celebrate our people, and I have been delighted to see the support given to Allied Health Professionals, Occupational Therapists and Radiology colleagues on appreciation days over the past couple of months. In addition, we've had more award recognition on national and regional scales, with the Trust named as winner of the Best Not-for-Profit Project at the Digital Technology Leaders Awards for the work carried out during the COVID-19 pandemic. WWL will also had 12 representatives at the National Institute for Health Research Clinical Research Network's Greater Manchester Evening of Excellence, highlighting the extraordinary efforts from across a wide range of WWL teams to not only provide critical COVID-19 research projects, but also to keep our non-COVID-19 projects on track.

Finally, as we now approach winter and what I anticipate to be one of the most challenging and pressured times for our services, I would like to thank our staff, patients and our community for their continued support for WWL.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Board Assurance Framework update
Presented to:	Board of Directors
On:	24 November 2021
Presented by:	Director of Corporate Affairs
Prepared by:	John Harrop, Head of Risk Paul Howard, Director of Corporate Affairs
Contact details:	T: 01942 822027 E: paul.howard@wwl.nhs.uk

Executive summary

The latest assessment of the trust's key strategic risks is presented here for the Board's review and approval.

Link to strategy

The risks identified within this report relate to the achievement of strategic objectives.

Risks associated with this report and proposed mitigations

This report identifies proposed mitigation to control the trust's key strategic risks.

Financial implications

There are no financial implications associated with this report.

Legal implications

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

People implications

The report invites the Board to consider accepting and de-escalating four people related risks from the Board Assurance Framework in November 2021.

Wider implications

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

Recommendation(s)

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

1. Introduction

1.1 Our Board Assurance Framework provides a robust foundation to support our understanding and management of the risks that may impact the delivery of Our Strategy 2030 and the annual corporate objectives. This report considers those risks that are most likely to materialise and those that are likely to have the greatest adverse impact on delivering the strategy.

1.2 The Board of Directors has overall responsibility for ensuring that the trust's risk management system is sufficiently robust to mitigate any significant risks that may threaten achievement of the trust's agreed strategic objectives. Assurance on the effectiveness of this system is gained through audit and other independent inspection or accreditation, and systematic collection and scrutiny of performance data. We work with our staff, through our governance structure and committees, to ensure that we are responding to these changes, identifying risks as they emerge and developing effective plans to manage them.

1.2 The Board Assurance Framework sets out the current key risks to achievement of the trust's strategic objectives and any gaps in controls and assurances on which the Board relies.

1.3 The Board of Directors is responsible for reviewing the Board Assurance Framework to ensure that there is an appropriate spread of strategic objectives and that the main risks have been identified. The Board reviews the Board Assurance Framework on a bi-monthly basis.

1.4 Each risk within the Board Assurance Framework has a designated Executive Director lead, whose role includes routinely reviewing and updating the risks:

- Testing the accuracy of the current risk score based on the available assurances and/or gaps in assurance
- Monitoring progress against action plans designed to mitigate the risk
- Identifying any risks for addition or deletion
- Where necessary, commissioning a more detailed review or 'deep dive' into specific risks

2. Strategic Objectives

2.1 The trust's strategy is focused on the delivery of four strategic objectives:

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

3. Risk Rating Matrix

3.1 Each risk in the Board Assurance Framework is rated at an initial, current and target risk level using the following matrix:

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

3.2 The initial, or inherent, risk level indicates the level of risk prior to the application of control measures or if current controls fail. The current risk indicates the current level of risk considering the application of controls, assurances and progress made since the last review. The target risk indicates the Trust's appetite for an individual risk – i.e., the level of risk that the Trust is aiming to accept in pursuit of its strategic objectives – and also how the risk should be managed (the risk 'response'). There are five categories of response – terminate, transfer, treat, tolerate or take the opportunity.

4. Board Assurance Framework Review

4.1 The latest assessment of the Trust's key strategic risks is presented here for the Board's review and approval. The Board Assurance Framework report is provided in Section 7 with detailed drill-down reports into all individual risks.

4.2 In November 2021, all the trust's strategic risks were inputted electronically into the Datix Risk Register module and new risk identification codes (risk IDs) have been applied. The new risk IDs enable the linking of strategic risks with associated corporate risks from the wider Corporate Risk Register within Datix. Previous risk references are still included in the report to support a clear audit trail.

4.3 The current risk assessment incorporates the outcomes of Lead Executive reviews of their designated risks, which took place in November 2021.

5. New Risks Recommended for Inclusion in the Board Assurance Framework and Updates to Existing Risk Assessments

5.1 No new risks are recommended for inclusion in the Board Assurance Framework as of November 2021.

5.2 Risk 1.2 (3267) SHMI - Primary and Secondary Care Pathway, has been updated to reference that the Community AKI pathway is now live. Risk 1.3 (3267) SHMI - Discharge and return to hospital has been updated to include the completion of recent audits.

5.3 The Director of Workforce has provided an update to the actions planned section for all risks where she is the designated Risk Lead.

5.4 Horizon Scan – Risk relating to CO3 Harm Free Care, pressure ulcers are being reviewed and an update will be provided in the next Board Assurance Report in January 2022.

6. Risks Recommended for Acceptance and De-escalation from the Board Assurance Framework

6.1 The current risk scores for the following risks have been reduced to the same score as their target risk scores:

- Risks 6.3 (3280) Organisational commitment to wellbeing.
- Risk 8.2 (3285) Culture - funding for the leadership development programmes and behaviour based 360 feedback.
- Risk 9.1 (3286) Fairness and compassion – Person-centred employment policies.
- Risk 9.2 (3287) Fairness and compassion - workforce EDI expertise and supporting infrastructure.

6.2 The Board are invited to consider accepting and de-escalating these risks from the Board Assurance Framework in November 2021.

7. Review Date

7.1 The date of the next scheduled review of all risks on the Board Assurance Framework is January 2022.

8. Recommendation

8.1 The Board of Directors are asked to:

- Review the risks and confirm that they are an accurate representation of the current significant risks to the delivery of the Trust's strategic objectives
- Confirm that the target risk score for each score, once achieved and sustainable, can be withstood
- Approve the recommendation to reduce the risk scores, tolerate and de-escalate from the Board Assurance Framework Risk 6.3 (3280) Organisational commitment to wellbeing; Risk 8.2 (3285) Culture - funding for the leadership development programmes and behaviour based 360 feedback; Risk 9.1 (3286) Fairness and Compassion – Person-centred employment policies and Risk 9.2 (3287) Fairness and compassion - workforce EDI expertise and supporting infrastructure.

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Board assurance framework

November 2021

The content of this report was last reviewed as follows:

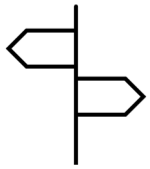
Quality and Safety Committee:	17 Nov 2021
Finance and Performance Committee:	22 Nov 2021
People Committee:	22 Sep 2021
Audit Committee:	7 Jun 2021
Executive Team:	16 Nov 2021

“ **assurance** (/əˈʃɔːrəns/) *noun*

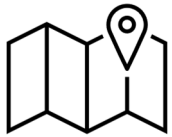
(In relation to board assurance) Providing confidence, evidence or certainty that what needs to be happening is actually happening in practice ”

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:	4WARD THINKING · WORKING TOGETHER · ACCOUNTABLE · RESPECTFUL · DEMONSTRATE COMPASSION 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

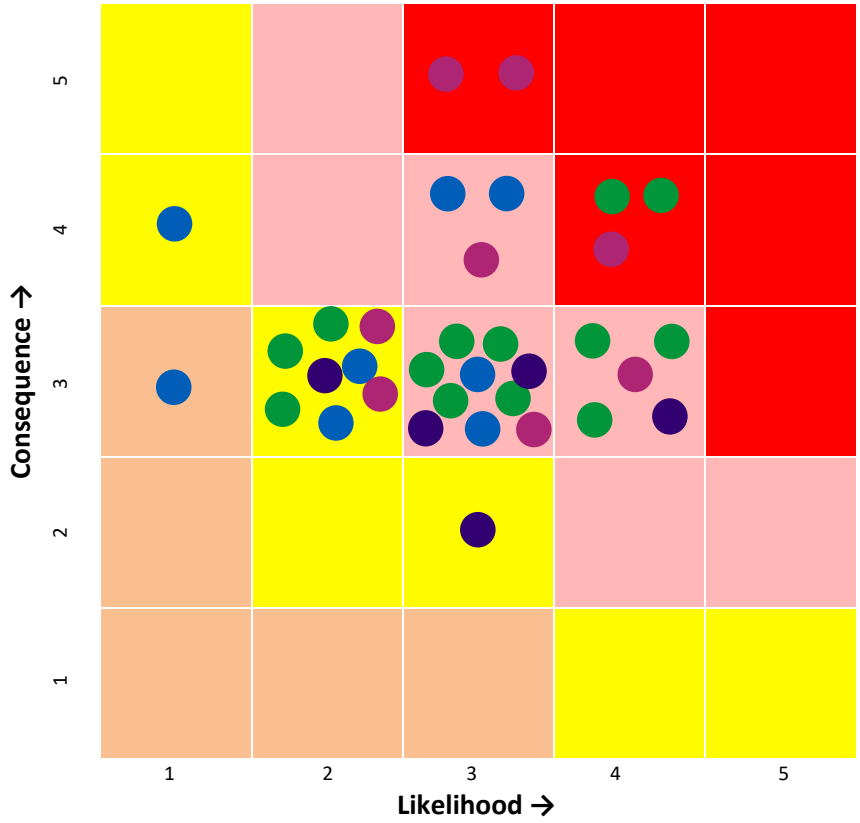
Risk management

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

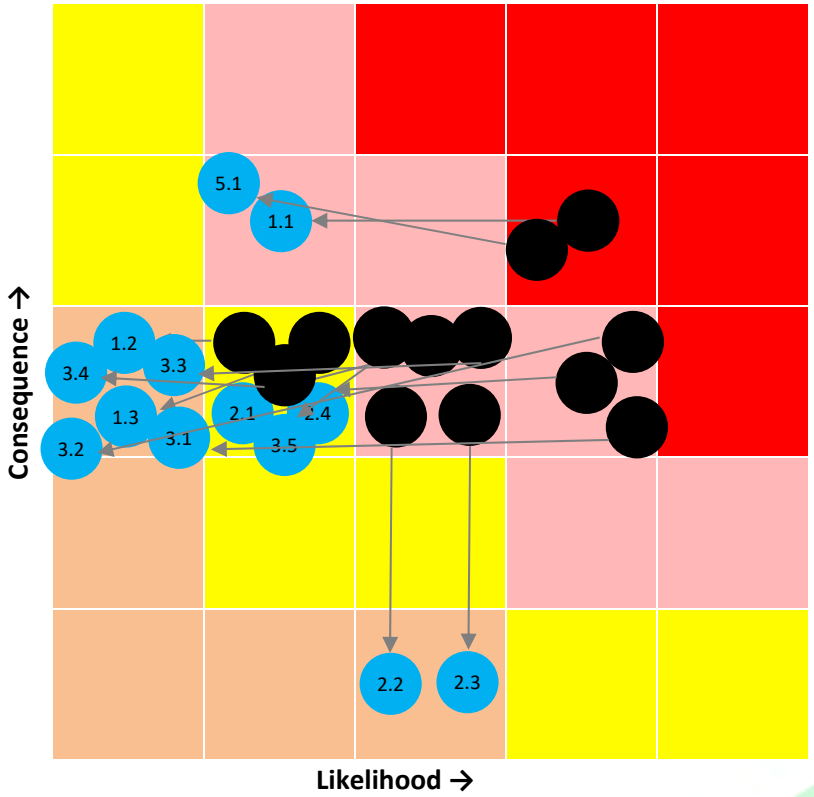
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

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 (ID 3265) Our bed base is the second lowest in GM and lower than the average general and acute beds per 100,000 population. As SHMI calculations are based on percentages derived from bed figures, there is a risk that this artificially inflates our SHMI.	L4 x C4 16 Significant	L4 x C4 16 Significant	L2 x C4 8 High	Additional beds are available on Bryn Ward (51 beds) and Jean Heyes Reablement Unit (20 beds). Community Assessment Unit now open which will increase bed capacity (21 beds) for medically optimised patients.	Jun 2021 Jun 2021	Staffing model for permanent beds on Bryn Ward not funded, therefore the beds cannot be included in our bed base. Retrospective planning permission for Bryn Ward not yet obtained.	A business case to permanently fund the medical and nursing staffing model to be developed and presented to the Business Case Oversight Group.

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
1.2 (ID 3266) There is a risk that patients will present late or be readmitted following discharge due to the lack of a joined-up pathway between primary and secondary care.	L2 x C3 6 Moderate	L2 x C3 6 Moderate	L1 x C3 3 Low	Dedicated resource now in post to provide a link between primary and secondary care and working on a joint Mortality Improvement Plan. Monthly meetings with BI/Dr Foster in place to review data Mortality Board in place Mortality mandatory agenda item at Divisional Clinical Cabinet	Jun 2021 Jun 2021 Jun 2021 Jun 2021	A pathway for common conditions with high mortality needs to be developed and monitored through the Mortality Board	Community AKI pathway devised; further training requirement identified for community staff before launch. Community AKI pathway now live (16/11/21 Community sepsis pathway currently under development and will be discussed initially at Deteriorating Patient Improvement group, lead nurse identified

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?)
1.3 (ID 3267) There is a risk that patients will return to hospital following a period of admission as a result of being discharged prematurely.	L2 x C3 6 Moderate	L2 x C3 6 Moderate	L1 x C 3 3 Low	Dedicated resource now in post to provide a link between primary and secondary care and working on a joint Mortality Improvement Plan. Monthly meetings with BI/Dr Foster in place to review data Mortality Board in place Mortality mandatory agenda item at Divisional Clinical Cabinet	Jun 2021 Jun 2021 Jun 2021 Jun 2021	Review of deaths in community to be undertaken to identify those which have adversely impacted on SHMI.	Audit completed and further workstreams identified to include linking with the discharge letter audit, upskilling in palliative care needs for A&E and education around completion of a comprehensive discharge letter. Oct 21 – Audit of Deaths 30 Days Post Discharge completed – 98% patients discharged appropriately Further audit completed in September to explore link between length of stay and sepsis - pulling report together

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 (ID 3268) There is a lack of recognition, screening and treatment of the deteriorating patient across the foundation trust	L3 x C3 9 High	L3 x C3 9 High	L2 x C3 6 Moderate	This is a dedicated corporate objective for FY2021/22 Rapid Improvement Group Sepsis QI group Sepsis Improvement Plan Visibility of AKI and Sepsis Nurse in clinical areas AKI and sepsis audits undertaken	Jun 2021 Jun 2021 Jun 2021 Jun 2021 Jun 2021 Jun 2021	Workload demands for AKI and Sepsis nurses AKI Improvement Plan needs to be developed	Deteriorating Patient Improvement Group continues to meet monthly, themed SIRI to take place on 23 Sept 2021 focusing on improvement work. Sepsis in HIS now live
2.2 (ID 3269) 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	In addition to monthly AIMS sessions there is a plan in place for AIMS to be added to Clinical induction programmes once training returns to face to face. Plan agreed for blood culture train the trainer role in A&E, training to commence September.

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?)
2.3 (ID 3270) 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.
2.4 (ID 3271) The AKI and sepsis services are currently single nurse led over a 5-day working week.	L4 x C3 12 High	L4 x C3 12 High	L2 x C3 6 Moderate	Separate clinical leads in place Support is provided by the Critical Care Outreach Team Information is cascaded through attendance at corporate and divisional meetings There is a policy and SOP in place	N/A N/A Jun 2021 Jun 2021	No cover is in place during annual leave, Bank Holidays or other absence. There is no contingency plan in place for patient safety nurses.	AKI and sepsis nurse to work collaboratively to provide cross-cover and ensure that work plans are more aligned. Business case for Harm Free Care Services had initial review – further information requested. This team will include additional resources to support both Sepsis and AKI

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 (ID 3272) 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 (ID 3273) 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 (ID 3274) 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

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?)
3.4 (ID 3275) 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.
3.5 (ID 3276) 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 (ID 3277) 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

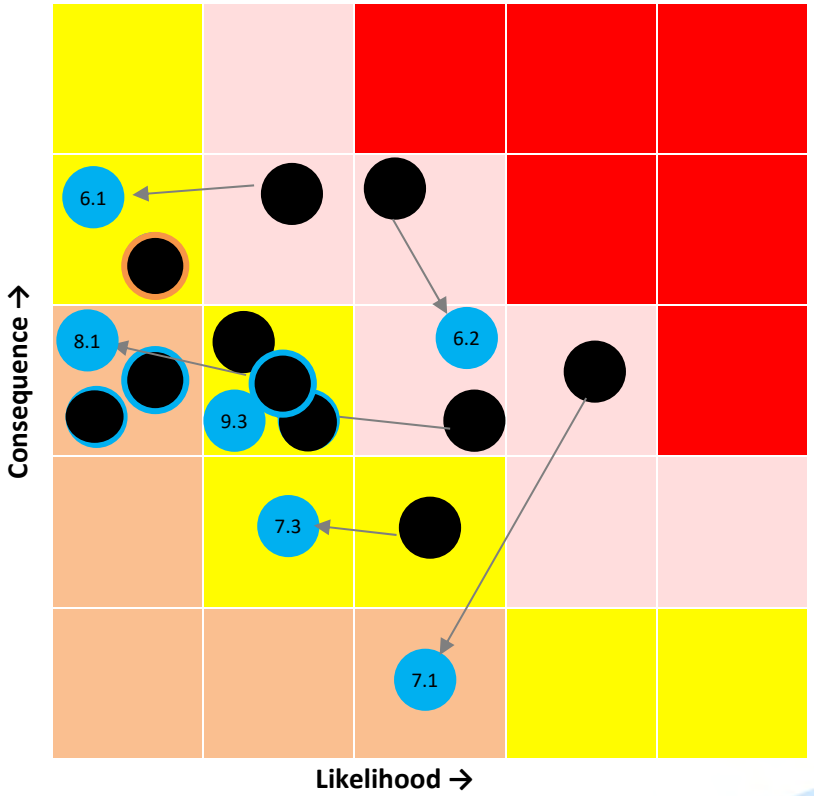
To create an inclusive and people-centred experience at work that enables our WWL family to flourish

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:	Impact measures around well-being interventions very positive. 12-month proof of concept expectations exceeded regarding stress related absence levels. Business case to continue and expand the services categorised as A/B by BCOG. Full business case now to be considered to deliver full stepped care model in a sustainable way for physical and mental health.		

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 (ID 3278) There is a risk that the necessary funding to deliver the stepped care model for physical and mental may not be prioritised, meaning that the service cannot be provided.	L2 x C4 8 High	L2 x C4 8 High	L1 x C4 4 Moderate	Business case drafted and subject to review prior to submission to BCOG Working with GM Resilience Hub where appropriate Transferred OHD MSK and counselling services into Steps 4 Wellness function for better resource efficiency Outline Business Case submitted to BCOG (August 2021) – categorisation awaited	Apr 2021 August 2021	Key roles to provide full stepped care model (included in business case)	Steps 4 Wellness to prioritise and recruit to required structures, following business case decision Business case is being considered at the November 2021 Trust Board meeting. Access to services is currently restricted and waiting times are increasing due to vacancies arising from a lack of job security.

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 (ID 3279) 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 Demand for services is outstripping capacity. Evaluation data provided to People Committee and recruitment activity is reducing the vacancy gap. Well-being measures included in Your Voice Survey, includes knowledge of and accessibility of services	Jun 2021 Jun 2021 Jul 2021 September 2021 September 2021	Commitment to roster time for people to be released as needed.	Divisional leadership teams Colleagues do currently appear to be supported to engage with activities - DNA rates are low and there has been positive engagement with the Theatres stress management team pilot
6.3 (ID 3280) There is a risk that organisational commitment to wellbeing reduces as operational pressures and expectations increase.	L3 x C3 9 High	L2 x C3 6 Moderate *(Score lowered from L3 x C3 = 9 Nov 2021)*	L2 x C3 6 Moderate	Executive team focused on this issue at the moment NW workshop for Chairs, CEOs and Well-Being Guardians – pledge to ensure prioritisation in action	Jun 2021 September 2021		Mandatory well-being training for all leaders (October 2021) Well-being remains a high priority and is recognised in all divisions through their operational and business plans. A well-being plan to support winter pressures has been developed with support from the Divisions

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:	Vacancy rates are decreasing. Interim arrangements in place to provide vacancy information and PID approved to implement ESR self-service and ESR establishment control – 9-month programme of work from commencement. International recruitment pipeline opened again. Targeted recruitment and social media campaigns ongoing.		

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?)
7.1 (ID 3281) We do not currently have a robust process which provides a single version of the truth about vacancies, which hinders effective decision making	L5 x C3 15 Significant	L4 x C3 12 High	L1 x C3 3 Low	Currently using finance spreadsheets to understand vacancy position and for reporting purposes (not real time) PID agreed at ETM (shared at People Committee) to implement ESR manager self service and establishment control	Jun 2021 August & September 2021	Full establishment control arrangements in ESR Process changes required for recruiting managers as we transition	ESR programme of work – recruitment commencing September 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?)
7.2 (ID 3282) International recruitment a) National pause of recruitment from India due to Covid travel restrictions Funding risk for any IR requirements in excess of 40 that have been budgeted for in 2021/22	L5 x C3 15 Significant	L2 x C3 6 Moderate	L2 x C3 6 Moderate	National pause has ended and recruitment pipelines are open again Recruitment & Retention report to People Committee	July 2021 September 2021		Modelling 5 year profile requirements (Deputy CNO and Deputy HRD) – business case to be developed
7.3 (ID 3283) LNA requirements may not meet the funding criteria set by HEE resulting in gap in funding	L3 x C2 6 Moderate	L3 x C2 6 Moderate	L2 x C2 4 Moderate	Full LNA analysis from Divisions being compiled – to be reviewed against available funding sources and provision methods. Update provided to Education Governance Group LNA reports at Education Governance Committee and People Committee reports	May 2021 September 2021	Ability to roll forward HEE funding allocations (3 year funding, may not be equally distributed over the 3 years)	Full detailed review to be completed (CNO, DCNO, DW and education leads) November 2021

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. Culture pilot (under Our FFF) has commenced. Leadership development framework proposals to be taken to ETM in September and additional clinical leadership framework under development. Forums for various clinical groups established. FAME network operational and others for additional protected groups to be established. EDI lead recruited to support team integration associated with international recruitment.		

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 (ID 3284) 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	L1 x C3 3 Low	L1 x C3 3 Low	"Our family – Our future – Our focus" engagement reset programme under DCE leadership Board visibility of programme Launch events for Our FFF and associated programmes of work	Jul 2021 September 2021	Metrics to be reported via Board	Workforce team There has been good engagement in the pilot teams so far. Escalation has been needed to ensure medical staff are engaged

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?)
8.2 (ID 3285) 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	L1 x C4 4 Moderate *(Score lowered from L2 x C4 = 8 Nov 2021)*	L1 x C4 4 Moderate	Leadership development framework discussion paper – Education Governance Leadership development proposals submitted to ETM for consideration – in house delivery	September 2021		Workforce team The leadership for all framework and additional clinical leadership development was approved through ETM and supported by Trust Board in November 2021. This includes provision of the behaviour based 360 on a rolling programme. Funding has been identified to support this for the coming 12 months. Leadership development will use HEE upskilling and apprenticeship levy funding in the first instance. Only where this is not possible will the central training budget be used, aligned to divisional and profession learning needs analysis review

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:	Key policies have been reviewed and work to develop new policy handbook on track. Exec triage working well to determine conduct cases that should progress formally. Fast track process operational and well-received. New FTSU service starting 1st October. Just & learning culture session planned as part of Board development. EDI strategy framework and priorities agreed at ETM and submitted to People Committee in September.		

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 (ID 3286) 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	L1 x C3 3 Low *(Score lowered from L2 x C3 = 6 Nov 2021)*	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 Well-being policy change is being discussed as part of the NW pledges at Board in November 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?)
9.2 (ID 3287) 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 *(Score raised from L1 x C3 = 3 Nov 2021)*	L1 x C3 3 Low	Workforce EDI specialist recruited (fixed term contract) EDI strategy update and governance proposal – ETM & People Committee	July 2021 August & September 2021	No ongoing funding commitment	EDI strategy to be approved at Board November 2021. Staff network remit to be expanded (FAME network) and additional networks launched in January 2022 for disability / long term conditions and LGBTQIA. This was supported at Trust Management Board in November. No substantive EDI workforce resource to support delivery against strategic aims set out in the strategy.
9.3 (ID 3288) 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	Proposed EDI governance structures that include links to HWP	September 2021	HWP commitment on shared agenda	Discussions around locality-wide approach required at HWP (Chief Executive and Deputy Chief Executive) Engagement is still needed with locality partners through Healthy Wigan Partnership

Performance

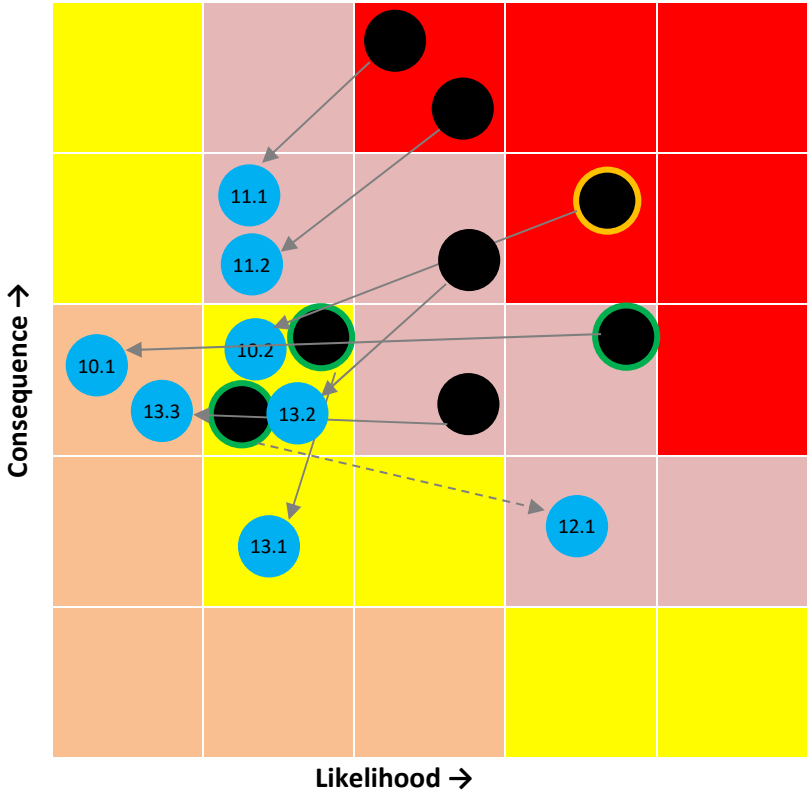
Our ambition is to consistently deliver efficient, effective and equitable patient care

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 (ID 3289) There is a risk that because the overall waiting list is growing due to increased numbers of referrals, the waiting list is growing more quickly than we are able to address the backlog which would lead to us not being able to reduce the backlog in a timely way across all three indicators	L5 x C3 15 Significant	L4 x C3 12 Significant	L1 x C3 3 Low	Regular reviews of risk stratification are undertaken according to clinical priority WWL manages patient lists in accordance with risk stratification National communications being issued around how patients will be contacted for review (Ext)	Jul 2021 Jul 2021 ---	Lack of capacity to undertake reviews of allocated risk stratification across all specialties. Patients to be given mechanism for getting in contact with GP or WWL if deteriorating.	Currently being reviewed by senior leadership teams. Joint correspondence from WWL and CCG being sent to every patient to update them and provide contact information.

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
10.2 (ID 3290) There is a risk that the value of core (or core +) activity exceeds the funding available because we have to use additional bank/agency or independent sector provision, or we are unable to access ERF funding if we exceed our trajectory, meaning that all work cannot be undertaken.	L5 x C4 20 Significant	L4 x C4 16 Significant	L2 x C3 6 Moderate	Work is ongoing to value the plan that we have submitted and to triangulate that with the activity plan. GM Elective Recovery Reform Group in place with two programmes of work; (1) capacity and demand across GM and (2) reform. Deputy Chief Executive attends for WWL. (Ext.) Reviewing how we can address the issue by activating elective recovery fund at GM level. (Ext) Continue to access independent provider capacity.	Jul 2021 Jul 2021 Jul 2021 Jul 2021	Nil at present; final submission is due in June. The next phase is then to describe the additional capacity available, the costs of doing so and what using that capacity will mean.	---

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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
11.1 (ID 3291) There is a risk that efficiency targets will not be achieved, resulting in a significant overspend	L3 x C5 15 Significant	L3 x C5 15 Significant	L2 x C4 8 High	Monitored via Executive Team, Finance and Performance Committee and Board of Directors Expenditure is flexed in line with the emerging position Work ongoing across the system on a joint approach to productivity (Ext)	May 2021 May 2021 May 2021	SAVI Programme Board to be reinstated	This is currently subject to discussion and a verbal update will be provided to the meeting
11.2 (ID 3292) Allocations and efficiencies for H2 unknown meaning that we cannot plan appropriately	L3 x C5 15 Significant	L3 x C5 15 Significant	L2 x C4 8 High	Lobbying via Greater Manchester (Ext)	May 2021	SAVI Programme Board to be reinstated to identify a range of schemes	This is currently subject to discussion and a verbal update will be provided to the meeting

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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
12.1 (ID 3293) No funding is available to deliver the bullets above as the capital application was rejected on the basis of CDEL being allocated to business critical or existing commitments.	L4 x C3 12 High	L2 x C3 6 Moderate	L4 x C2 8 High	Lobbying via GM (Ext) Preparing business cases to submit in the event of capital slippage MS Teams roll-out undertaken Telephony business case approved Sepsis pathway being input into HIS	Jul 2021 Jul 2021 Jul 2021 Jul 2021 Jul 2021	Alternative funding for digital developments to be explored sought	Chief Information Officer to monitor availability

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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
13.1 (ID 3294) There is a risk that because the clinical strategies are still under development the estates strategy may not address all elements of intended future delivery	L3 x C3 9 High	L2 x C3 6 Moderate	L2 x C2 4 Moderate	Capital prioritisation exercise undertaken which will inform the estate strategy and therefore link to the future development of clinical strategies.	Jul 2021	Group to discuss the development of the estates strategy alongside clinical strategy development	Director of Strategy and Planning and Director of Estates and Facilities to coordinate
13.2 (ID 3295) There is a risk that because of uncertainties around capital funding arrangements the strategy may assume that more investment can be made than is available	L3 x C4 12 High	L3 x C4 12 High	L2 x C3 6 Moderate	Lobbying via Greater Manchester (Ext)	May 2021	---	---
13.3 (ID 3296) There is a risk that the estates strategy will not fully address the net carbon zero requirements	L3 x C3 9 High	L3 x C3 9 High	L1 x C3 3 Low	Sustainability Officer in place who can provide expert input Net Zero Champion appointed	Jul 2021 Jul 2021	Need to develop Green Strategy for WWL	Director of Estates and Facilities working with external company to undertake this work

Partnerships

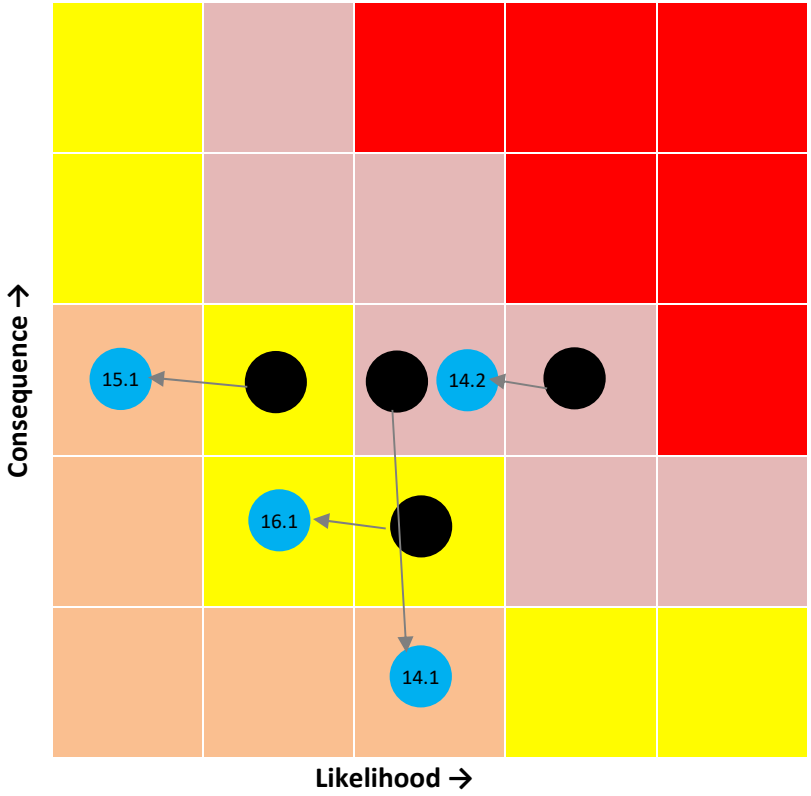
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

Monitoring: Board of Directors

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

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

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



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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
14.1 (ID 3297) There is a risk that there will be insufficient staff available to undertake the levels of additional activity	L4 x C4 16 Significant	L3 x C3 9 High	L3 x C1 3 Low	Discussions relating to the use of a third party sub contractor at advanced stages	Jul 2021	Contract yet to be finalised	CFO appointed as WWL's point of contact
14.2 (ID 3298) There is a risk that WWL may be restricted in the amount of capital it is able to spend	L4 x C3 12 High	L4 x C3 12 High	L3 x C3 9 High	Submission made to Greater Manchester	May 2021	---	---

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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
15.1 (ID 3299) There is a risk that the organisation will not generate sufficient research funding in 2021/22 to qualify for University Hospital Association membership	L2 x C3 6 Moderate	L2 x C3 6 Moderate	L1 x C3 3 Low	Monitoring of research funding	May 2021	Research Committee	Proposal to establish on May board agenda.

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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
16.1 (ID 3300) There is a risk that staff with local knowledge and understanding may be lost given the changes anticipated with CCGs	L3 x C2 6 Moderate	L3 x C2 6 Moderate	L2 x C2 4 Moderate	Locality meeting structures in place to support lasting corporate knowledge	May 2021	---	---
16.2 (ID 3301) There is a risk that the ambiguity around the future structure, governance and financial flows within the locality slows down decision making and decisions on investments	L3 x C2 6 Moderate	L3 x C2 6 Moderate	L3 x C2 6 Moderate	Locality meeting structures in place	Sep 2021	---	---

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Maternity Provider Board Level report
Presented to:	Board of Directors
On:	24 November 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 Board provider template provides oversight at provider level of safety metrics within the maternity service and aims to provide timely escalation of any concerns or deterioration within the service and any support that may be needed. Since 2017 all Trust Boards have been required to have a board-level safety champion, whose remit it is to bring together a range of internal sources of insight to provide strategic oversight and leadership for perinatal safety which links to the regional and national oversight and strengthening of safety measures within maternity services.

For October there have been no concerning incidents to report or concise investigations to provide oversight on.

Incident exception reporting.

At this time no babies diagnosed with HIE 2 or 3, No cases met the criteria for referral to HSIB.
0 Steis reportable incidents have occurred, and no Maternity Diverts

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

- The Trust has had 0 maternal deaths in Q2 2021-22, and 0 neonatal death.
- No stillbirths have occurred in October and the overall rate remains low

Recommendation(s)

The board are asked to review the provider template for October 2021

Ockenden Exception Report to Board

CNST

Year 3 CNST compliance confirmation and refund is expected in December 21. Year 4 standards are being worked towards and a full quarterly update will be provided in January 2022.

There are currently no major areas of concern, although training compliance remains on track with the exception of Registrar attendance; all are booked to attend in the coming months but due to limited numbers for face-to-face training this is proving to be difficult to get enough through the training.

Additional sessions are being planned to address the shortfalls and skills training sessions are now offered on 2 days per month which will increase capacity and boost compliance going forward.

Ockenden Update

Feedback has been received from the National team in the form of a rag rating against the evidence submission. Non-compliance was noted against some standards however the Trust can challenge this and clarify, (the team assessing the evidence are not clinical so for example where it asked for a SOP and a guideline was sent this was marked as non-compliant), However this can be challenged and amended.

Initial RAG rating currently stands at 80% and it is expected that this may reach approx. 90% with amendments agreed.

There is no indication what the expected % is to be but the action plan will need to be updated as required to achieve any outstanding actions to gain full compliance against all the 7 Immediate and Essential Actions as recommend.

A meeting has been arranged with the Regional Chief Midwife on 19 November to review the evidence and make any challenges which has to be agreed and re-submitted via the regional team.

Maternity Staffing

Maternity services are undergoing a national staffing crisis, and this is also a problem here at Wrightington Wigan and Leigh Maternity services. We currently have vacancies we are unable to recruit to, due to the low numbers of staff available within the system and we have been greatly affected by staff sickness due to covid isolations and viral infections. Staff have been working most shifts not staffed to the appropriate ratios and they are generally becoming burned out by the continual pressure and levels of activity and acuity we are seeing within maternity services at present.

The service has been out to recruitment continually since we received funding from the Ockenden Bid to increase our establishment due to the shortfall we had in staffing at the time the bid was submitted. We were unable to fully recruit to all the vacancies at that time and have since accrued several more.

A staffing paper is currently in progress and due to be presented to Board in December

Continuity of Carer update.

Meadows and Daisy teams are the two Maternity Continuity of carer (MCoC) teams within WWL, but in addition they were also utilised as part of the escalation process for when the unit was at full capacity or had a shortfall in numbers, and this was having a knock-on effect to their workloads.

Meadows team has had staff leave and staff due to go on maternity leave in addition to long term sickness, and intrapartum care could not be safely sustained with the current staffing numbers.

Given the current staffing pressures the difficult decision to pause the intra-partum element of continuity in the interests of safety and staff wellbeing has been made. This was agreed within the Trust and plans were put in place to pause from 1st November. Letters were sent to the local maternity System lead, Regional Chief Midwife and MVP Chair and the CCG informing them of this pause. In recent months other Trusts within GM have also had to make this decision at various points.

The continuity midwives are currently providing antenatal and postnatal continuity within Daisy and Meadows teams as far as possible, and women will attend the unit for birth to be facilitated by a delivery suite midwife. Women who are due to birth during the paused period have been informed face to face of the need to do this.

It is planned that as soon as Meadows can be fully staffed, we will resume full CoC again with the two existing teams, we gave an initial date of February 1st to resume but this will be fully dependant on having the staff to be able to provide the service.

As set out in the NHS Operational Planning Guidance for 2021/2022 The Trust is required to submit a local implementation plan by 31 January 2022 to the Local maternity System (LMS) having first being presented and discussed at board on the 14 December.

By March 2022 The LMS are then required to put in place the building blocks for MCoC to be the default model of care offered to all women .

CNST also requires that we submit the MCoC action plan to the Board level Safety Champions by March 2022. Should staffing levels not allow full MCoC by March 2023 the guidance does state where it is clear full staffing cannot be achieved alternative timescales will be assessed and agreed.

Maternity Risks

There are no maternity risks scoring 15 or above.

The highest scoring maternity risks are:

- CTG misinterpretation. The concern is that Cardiotocograph (CTG) misinterpretation will result in a serious adverse outcome for a mother and baby. It is vital to determine whether a fetus is showing a normal physiological response to the stress of labour or if the fetus is exposed to intrapartum hypoxia to ensure timely and appropriate management.

All mitigations are in place with training compliance for all staff groups above the 90% rate. There is a centralised CTG monitoring system to provide additional surveillance of all CTG traces within the delivery rooms, allowing a helicopter view and timely intervention if required.

- Delivery Suite coordinators should be supernumerary at all times. NICE (2015)

Average compliance is usually above 99%, however this has been reduced slightly for the last 4 months due to the ongoing staffing issues. No direct harm events have been identified during any period where the coordinator was not able to remain supernumerary.

When this has not been possible it is reported as a Maternity Red Flag incident and is also captured monthly on the maternity and provider dashboards. (3 reported in month related to coordinator unable to remain supernumerary)

Maternity staffing and pause of continuity risks are due to be presented at the next Governance and Risk meeting within the Division.

Conclusion

A robust training programme remains in place to meet the requirements of CNST and Saving Babies Lives recommendations with monthly review in progress and actions taken where recommendations are not being met.

All incidents continue to be reviewed and escalated appropriating through ESG, with additional local and regional oversight of all moderate and above incidents through the Greater Manchester Serious Incidents Group (GMSIG)

Staffing levels remain a challenge however the number of vacancies is slowly reducing. Short term sickness remained a problem throughout October.

A robust workforce plan is required to address the ongoing attrition of the aging workforce and the reduced number of Student midwives that will qualify in 2022, scoping is in place to identify possible number of staff who plan to retire or reduce hours in the next 5 years to ensure that shortfalls in the establishment do not reach the same high levels of 2021. A staffing paper will be provided in December 2021 outlining the current state and what plans are in place to maintain safe staffing levels.

Wrightington, Wigan And Leigh NHS Foundation Trust

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

	2021									
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct
Findings of review of all perinatal deaths using the real time data monitoring tool (quarterly reports)		See attached Appendix 1 in Board Report			Q1 report to be presented at June Meeting		Presented in CNST complaince report		See narrative in Exception 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	Draft report recieved from HSIB will be presented once finalised.	Finalised report received. No concerns or recommendations highlighted.	No cases for HSIB	No cases for HSIB	No cases for HSIB	No cases for HSIB
The number of incidents logged graded as moderate or above	7	6	5	6	6	7	9	2	4	
Training compliance for all staff groups in maternity as per CNST requirments (need 90% compliance rate for all staff groups by July 2021) Attendance = Midwives = 10-15 per month Consultant = 1 per month Registrars = 2 per month To maintain % over 95%										
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%	Midwives 98% Consultant 92% Registrars 100%	**New Training Year(June - May) commenced.** *Rolling% Midwives 7 * 95% Consultant 0 *92 % Registrars 1 *100%	Midwives 9 *96.7% Consultant 0 * 92% Registrars 1 *100%	No Training In August	*Rolling% Midwives 11 * 97% Consultant 0 *100 % **Registrars 1 *67%**	*Rolling% Midwives 13 * 95% Consultant 0 *100 % **Registrars 4 *89%**
Practical Obstetric Multi-Professional Training (PROMPT) (emergency Skills Drills Training)	Midwives 42% HCA's 21% Consultant 18% Registrars 24% Anaesthetists 18% Anaesthetic Staff 0%	Midwives 62% HCA's 42% Consultant 81% Registrars 90% Anaesthetists 81% Anaesthetic Staff 0%	Midwives 78% HCA's 53% Consultant 90% Registrars 100% Anaesthetists 81% Anaesthetic Staff 0%	Midwives 88% HCA's 67% Consultant 90% Registrars 100% Anaesthetists 88% Anaesthetic Staff 3	Midwives 98% HCA's 81% Consultant 99% Registrars 100% Anaesthetists 93% Anaesthetic Staff 3	Midwives 4.82% *96% HCA's 0% *90% **Consultant 0% *83%** Registrars 9% *100% Anaesthetists 0% *93%	Midwives 6.2% *95% HCA's 6 % *90% **Consultant 0% *83%** Registrars 9% *100% Anaesthetists 7% *93%	No Training In August	Midwives 6.8% *97% HCA's 10 % *94% **Consultant 0% *83%** **Registrars 12% *47%** Anaesthetists 7% *100%	Midwives 8.6 % *90% HCA's 0% *75% **Consultant 8.3% *83%** **Registrars 12% *47%** Anaesthetists 7% *100%
Prospective Consultant Delivery Suite Cover (60 as standard for WWL)	60	60	60	60	60	60	60	60	60	60
1:1 care in labour	99.40%	100%	99.42%	99.38%	99.32%	99.48%	99.44%	100%	100%	100%
Supernumeray Shift Co-ordinator	100%	100%	100%	100%	95.20%	100%	98.50%	95.20%	93.30%	95.20%
Number of Datix submitted when shift co-ordinator not supernumerary	0	0	0	0	3	0	4	5	6	3
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 15 Steps Walkabout.	Meetings have taken place with regards to revamping the maternity pages of the trust website. Ongoing recruitment by MVP chair continues	Meetings with Comms Team and MVP chair have taken place and plan agreed on way forward.	Work ongoing with Comms Team with a view to initial go-live in August 2021	Work ongoing with Comms Team with a view to initial go-live in August 2021	New web pages are almost complete and currently being tested.	**Maternity Voice Partnership Feedback** Very helpful supportive staff . Excelent support provided in community settings . Some issues with Breasfeeding support. Buzzers not always answered in a timely manner. Pain relief delayed . Communication issues . feeling lonely and isolated	**Maternity Voice Partnership Feedback** Helpful supportive staff but some issues identified with pain relief and buzzers not being answered in a timely manner. Still some issues reported with breastfeeding support however initiation of BF has increased in October.
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 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.	Safety Walkabout to take place on 21 May 2021	Safety Walkabout took place where staff mainly raised concerns regarding Continuity of Carer. Webinars continue for staff.	Safety Walkabout will take place on 12 August 2021		Staff reported frustrations with the printers continually going offline and this causing delays in discharges and patient flow across the maternity floor as discharge paper work could not be generated. Staffing shortages across the service due to staff isolations having an increased impact , causing low morale as continually working without breaks and shorfalls in numbers, during an especially busy period.	Next Scheduled Safety Walkabout October 21	Unable to shedule walkabout due to staffing issues. , planned for November
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	0	0	0	0	0	0
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	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	9 Safety Actions compliant. On track to achive remaining 1 by July 15 deadline . See Board Report	10 Safety Actions compliant. Board Assurance report presented to board for sign off	Awaiting outcome of submission	Awaiting outcome of submission. Year 4 standards published.	Awaiting outcome of submission. Year 4 standards published.	Outcome of Year 3 submission expcted in Dec, work ongoing with year 4
Number of StEIS Reportable Incidents/HSIB case	1	0	1	0	0	0	0	0	2	0
Number of Stillbirths	1	1	0	0	0	0	0	1	0	0
Number of Neonatal Deaths	0	1	0	0	0	0	0	0	0	0
Number of Maternal Deaths	0	0	0	0	0	0	0	0	0	0

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Maternity Dashboard Report
Presented to:	Board of Directors
On:	24 November 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

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.

Recommendation(s)

The board are asked to note the October 2021 dashboard and overview of indicators as outlined below.

Maternity Dashboard October 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

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.

October 2021 Exception report

Summary.

Octobers Maternity dashboard remains predominantly green or amber with several improving metrics demonstrated .

- There have been no cases reported to the Healthcare Safety Investigation Branch (HSIB) or babies diagnosed with HIE 2 or 3.
- There were 3 midwifery red flags reported due to the shift coordinator being unable to remain supernumerary however 1-2-1 care in labour has been maintained at 100%.
- 2 Maternity complaints were received in October (1 which dates to care received in 2020) however the service continues to receive positive feedback letters and messages from Women regarding the excellent care they have received.

Steis reportable Incidents

There were no Stillbirths or Neonatal Deaths, and the overall stillbirth rate remains very low to date. No maternity diverts occurred.

Hospital Name	19 Q1	19 Q2	19 Q3	19 Q4	20 Q1	20 Q2	20 Q3	20 Q4	21 Q1	21 Q2	21 Q3
Bolton	2.09	4.93	3.35	5.02	4.14	7.35	2.78	3.60	3.51	3.62	2.70
East Cheshire	2.96	2.74	0.00	2.62	8.09						
MFT - North Manchester	1.09	2.19	6.28	1.14	6.82	1.18	2.14	3.49	5.35	3.67	6.66
MFT - Oxford Road	4.55	5.33	5.63	3.65	4.80	4.74	5.22	3.96	4.45	4.06	5.69
MFT - Wythenshawe	5.35	5.90	0.91	1.90	1.96	6.26	2.66	1.71	2.56	4.08	6.19
Pennine O	4.03	3.88	3.83	5.31	8.17	8.14	7.35	6.27	4.38	3.98	3.83
Stockport	0.00	2.65	0.00	1.29	1.32	3.53	3.45	4.51	5.92	3.58	2.21
Tameside	3.62	3.42	8.33	5.49	0.00	1.81	3.45	10.79	3.78	9.06	4.99
WWL	5.02	3.25	4.54	3.30	12.24	3.60	1.69	1.57	3.44	1.68	1.43
MEDIAN	3.62	3.42	3.83	3.30	4.80	4.17	3.11	3.78	4.08	3.82	4.41

Green

The Midwife to Birth ratio is currently at 1:28. However this does not factor in the acuity of women and despite the ongoing challenges with staffing and high levels of activity and acuity the service has been able to maintain good standards of care.

- Women booked by 12.6 weeks remains above the National target rate.
- Births are increased month on month with a projected increase of 150-180 on 2020 births.

Smoking at the time of Delivery (SATOD)

Again, this month there has been a considerable reduction in the number of women smoking at the time of delivery

Whilst WWL still has the highest rate across the GM the Gap is beginning to close and this has been noted at regional meetings were WWL rates have been recognised as showing a marked improvement.

Re-admissions of babies within 30 days has remained at normal levels with increased Jaundiced levels and feeding issues within the early days being the main reason for readmission.

All infants with Apgar's less than 7 . This has remained at low levels and will be closely monitored for any further spikes.

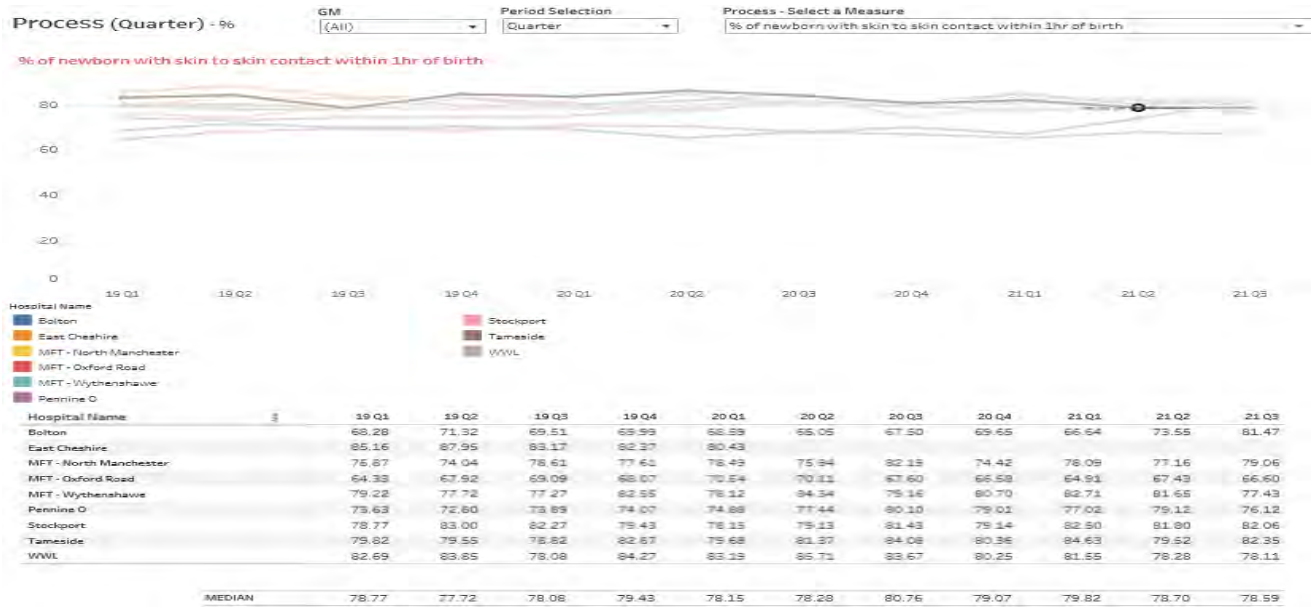
Women readmitted within 28 days of Delivery. Has reduced and is within expected rates.

The number of mothers who have opted to breastfeed has seen a significant improvement in October with an increase of nearly 8%

Amber

The overall Caesarean section rate has remained amber for the last 6 months however there is now a slight upward trend and as a direct consequence, the normal birth rate remains just below the 60% National average. Currently 2 rooms are being refurbished as low risk birth rooms and work to promote normality and optimise birth outcomes continues across the maternity service.

Skin -Skin . The percentage of babies receiving skin to skin within 1 hour of birth has fallen for 2 consecutive months from a normally complaint rate of above 75-80%. staff will be reminded about the importance of initiating this wherever possible.



Hospital Name	19 Q1	19 Q2	19 Q3	19 Q4	20 Q1	20 Q2	20 Q3	20 Q4	21 Q1	21 Q2	21 Q3
Bolton	68.28	71.32	69.51	69.99	68.59	66.05	67.50	69.65	66.64	73.55	81.47
East Cheshire	85.16	87.95	83.17	82.37	80.43						
MFT - North Manchester	75.87	74.04	78.61	77.61	78.49	75.84	82.13	74.42	78.09	77.16	79.06
MFT - Oxford Road	64.33	67.92	69.09	68.07	70.54	70.11	67.60	66.58	64.91	67.43	66.60
MFT - Wythenshawe	79.22	77.72	77.27	82.55	78.12	84.34	79.16	80.70	82.71	81.65	77.43
Pennine O	73.63	72.80	73.89	74.07	74.88	77.44	80.10	79.01	77.02	79.12	76.12
Stockport	78.77	83.00	82.27	79.43	78.15	79.13	81.43	79.14	82.50	81.80	82.06
Tameside	79.82	79.55	78.82	82.67	79.68	81.37	84.08	80.36	84.63	79.52	82.35
WWL	82.69	83.85	78.08	84.27	83.19	85.71	83.67	80.25	81.55	78.28	78.11
MEDIAN	78.77	77.72	78.08	79.43	78.15	78.28	80.76	79.07	79.82	78.70	78.59

Red

Term admissions to NNU. Whilst remining within the GM average for most quarters there can be seen a clear upward trajectory. The term admission audit ATAIN (avoiding term admissions into neonatal units) has commenced and is currently looking at Q1 admissions which will be followed by Q2 in December , the findings of these audits will be fed back to staff and submitted to Regional and National teams and action plans developed where necessary

Hospital Name	19 Q1	19 Q2	19 Q3	19 Q4	20 Q1	20 Q2	20 Q3	20 Q4	21 Q1	21 Q2	21 Q3
Bolton	21.49	24.29	24.41	20.12	20.56	16.18	18.63	17.23	14.72	15.81	13.30
East Cheshire	52.80	34.68	25.77	48.99	44.25						
MFT - North Manchester	28.74	14.39	18.20	17.07	17.37	12.87	12.85	25.28	30.75	6.52	7.23
MFT - Oxford Road	53.27	73.15	64.87	83.67	75.33	75.70	87.89	99.95	101.88	102.65	82.06
MFT - Wythenshawe	32.79	50.59	45.68	52.58	50.54	41.67	53.78	51.74	56.64	42.55	28.01
Pennine O	23.52	18.80	23.00	18.80	16.44	25.02	23.49	13.13	20.55	24.02	20.83
Stockport	55.81	27.10	36.99	34.53	31.75	43.69	38.94	52.76	46.63	44.50	26.70
Tameside	41.92	31.54	29.74	38.78	56.09	57.31	38.96	45.91	32.59	39.92	27.47
WWL	51.66	34.72	38.21	37.43	55.34	42.64	40.74	23.89	34.29	36.83	38.76
MEDIAN	41.92	31.54	29.74	37.43	44.25	42.15	38.95	35.60	33.44	38.38	27.09

Maternal steroids are given to mature the fetal lungs when premature labour is suspected, or early delivery is required.
There were 3 eligible singleton births, and 66% compliance was achieved. 2 babies received a full course. 1 mother delivered prior to the second dose being administered. No lapses in care were identified

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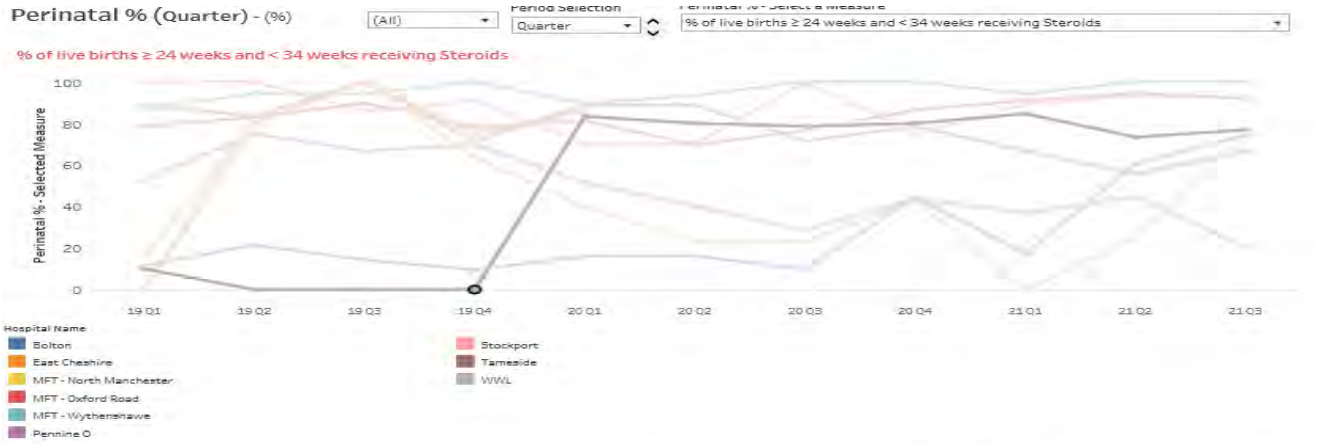


Hospital Name	19 Q1	19 Q2	19 Q3	19 Q4	20 Q1	20 Q2	20 Q3	20 Q4	21 Q1	21 Q2	21 Q3
Bolton	11.4	21.4	14.3	9.5	16.1	16.2	9.7	44.4	17.2	50.6	74.4
East Cheshire	0.0	80.0	100.0	75.0	85.7						
MFT - North Manchester	15.4	80.0	100.0	63.6	40.0	23.1	23.1	42.9	0.0	25.0	75.0
MFT - Oxford Road	78.6	83.0	89.7	78.2	81.3	69.6	76.5	86.5	90.9	94.6	91.8
MFT - Wythenshawe	86.7	94.4	94.1	100.0	89.7	93.3	100.0	100.0	94.1	100.0	100.0
Pennine O	52.6	75.0	66.7	69.7	51.4	40.0	28.6	43.8	36.7	44.8	20.6
Stockport	100.0	100.0	85.7	90.9	70.0	70.0	100.0	75.0	88.9	93.3	92.3
Tameside	88.9	83.3	100.0	71.4	88.9	88.9	71.4	78.6	66.7	55.6	66.7
WWL	10.0	0.0	0.0	0.0	83.3	60.0	78.6	80.0	84.6	73.3	76.9
MEDIAN	52.63	80.00	89.66	71.43	81.25	69.82	73.95	76.79	75.64	66.97	75.96

Induction of Labour (IOL) has seen an increase this month from steady rates for the last 6 months. All cases are reviewed for appropriate medical reasons, gestations and outcomes. WWL rate is not an outlier within GM

Hospital Name	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Bolton	38.60	39.07	39.71	37.10	37.69	36.27	44.31	35.93	38.51	33.46	39.20	35.71
East Cheshire												
MFT - North Manchester	37.27	46.28	37.81	47.10	39.09	40.46	37.55	47.33	45.76	37.79	40.48	
MFT - Oxford Road	30.81	32.60	36.24	33.44	29.36	30.47	32.44	34.14	35.50	27.67	28.85	28.26
MFT - Wythenshawe	34.35	36.29	37.22	29.97	35.71	32.85	33.66	36.45		18.14	34.37	29.98
Pennine O	37.61	39.41	36.90	41.65	36.63	39.95	35.84	35.38	32.87	34.01	36.70	31.07
Stockport	43.41	41.99	39.15	36.40	44.61	38.36	43.23	42.44	37.93	39.13	45.08	38.84
Tameside	39.58	43.50	46.33	40.78	36.47	43.75	39.66	44.89	42.25	40.80	40.74	39.22
WWL	38.24	41.00	41.58	43.92	41.44	46.08	38.12	40.00	42.54	34.93	41.49	35.71
MEDIAN	37.92	40.20	39.02	38.94	37.16	39.15	37.83	37.96	38.51	34.47	39.84	35.71

Supernumerary Shift coordinator compliance has been reduced again due to ongoing staffing issues and increased activity and acuity, however the number of occasions when this has occurred has reduced due to some increase in staffing levels from the last round of recruitment.
The service strives to maintain safe staffing levels, and any shortfalls are covered by NHSP whenever possible. Short-term sickness due to Covid isolations and viral infections impacting on staffing levels have reduced which has positively impacted the ratios . Recruitment to vacancies remains an ongoing priority.

Conclusion
No concerning metrics noted outside of normal variation and fluctuations. Many positive factors have been sustained.
The increase in term admission to NNU will be fully explored and any themes or trends identified.
Two complaints received in month, but the total number of complaints received to date is 3 for 2021 which is the lowest number the service has had, which is in part due to the sustained effort by the maternity team to deal with any issues as they arise.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Maternity Dashboard 2021

		Goal	Red Flag	Measure	2020 Data Aug	Sept	Oct	Nov	Dec	2021 Data Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD	Trend
Activity	Number of Registerable Births	>200	<180	2020 Births	167	220	241	202	193	192	182	208	181	182	232	229	241	229	242			582	595	699	242	2118	
	Number of Bookings(retrospective 1 month)	≥240	≤200	2020 Bookings	216	247	233	226	246	238	252	285	231	214	222	205	222	242	227			775	667	669	227	2338	
	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%	61.5%	56.9%	57.2%	56.8%	55.5%	59.1%			56.9%	58.8%	56.5%	59.1%	57.6%	
	% 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%	0.0%	1.7%	0.8%	0.9%	0.4%			2.7%	1.5%	1.1%	0.4%	1.6%	
	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%	8.8%	13.8%	13.1%	12.0%	11.4%	7.9%			12.9%	12.6%	12.2%	7.9%	12.0%	
	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%	29.7%	29.3%	29.7%	31.1%	33.2%	33.1%			30.2%	28.6%	31.3%	33.1%	30.5%	
	% Emergency Caesaean Sections				17.4%	23.2%	14.5%	18.3%	17.6%	20.8%	18.7%	17.8%	14.4%	15.4%	19.0%	14.0%	14.9%	15.7%	23.6%			19.1%	16.5%	14.9%	23.6%	17.5%	
	% Elective Caesarean Sections				10.8%	12.3%	13.7%	13.9%	12.4%	10.9%	11.0%	11.5%	12.2%	14.3%	10.3%	15.7%	16.2%	17.5%	9.5%			11.2%	12.1%	16.5%	9.5%	13.0%	
	Number of successful VBAC deliveries			Births/month	2	3	2	7	3	8	6	3	5	8	9	7	6	7	5	.	.	17	22	20	5	64	
	%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%	7.4%	7.4%	1.5%	2.7%	5.3%	8.8%			6.3%	7.6%	3.2%	8.8%	5.9%	
	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%	39.6%	41.8%	34.9%	41.5%	34.9%	44.2%			43.1%	40.0%	37.2%	44.2%	40.4%	
	% 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%	1.1%	0.4%	0.4%	1.7%	1.3%	0.0%			1.4%	0.8%	1.1%	0.0%	1.0%	
	% of women induced for Suspected SGA				7.8%	6.8%	6.2%	6.4%	7.3%	6.8%	12.1%	12.0%	7.7%	11.0%	6.0%	11.4%	6.6%	12.2%	11.2%			10.3%	8.1%	10.0%	11.2%	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	1.6	1.3	1.5	1.2	1.3	1.4			1.5	1.5	1.3	1.4	1.4	
	Number of In-utero transfers in from other units				2	1	0	1	1	1	0	0	0	0	0	3	1	3	1			1	0	7	1	9	
	Number of In-utero transfers out to other units				1	1	6	0	0	0	4	1	0	5	0	0	0	0	2			5	5		2	12	
	%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%	7.9%	13.5%	13.1%	11.2%	13.8%	13.0%			11.4%	11.0%	12.7%	4.3%	9.9%	
	% 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%	10.0%	11.8%	14.9%	8.6%	12.5%	9.2%			14.0%	12.3%	12.0%	3.1%	10.3%	
	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%	79.7%	75.3%	80.3%	80.0%	74.2%	75.6%			81.6%	78.3%	78.2%			
	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%	51.1%	54.1%	51.1%	47.5%	48.0%	55.4%			55.3%	52.4%	48.9%			
	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%	90.2%	91.0%	97.6%	89.2%	94.2%	90.7%			91.0%	90.7%	93.6%	90.7%	91.6%	
Workforce	Prospective Consultant hours on Delivery Suite	60 hours	< 60 hours	Nat Standard	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60			180	180	180	60	600	
	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	1.25	1.25	1.26	1.28	1.28	01:28			1.74	1.74	1.82	1.28	3.58	
	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%	99.32%	99.48%	99.44%	100	100	100			99.6%	99.4%	6699.8%	########	3069.6%	
	Percentage of shifts where shift Co-ordinator able to remain supernumerary	100%	<100%	Nat Standard	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.2%	100.0%	98.5%	95.2%	93.3%	95.2%			100.0%	98.4%	95.6%	95.2%	97.7%	
	Diverts: Number of occasions unit unable to accept admissions				0	0	0	0	0	0	0	0	0	0	0	1	0	1	0			0	0	2	0	2	
	Diverts: Number of women during period affected by unit closure				0	0	0	0	0	0	0	0	0	0	0	0	0	1	0			0	0	1	0	1	
	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%	7.3%	6.3%	6.3%	8.3%	8.3%	9.0%			13.6%	8.4%	7.6%	9.0%	9.7%	
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%	2.8%	3.5%	3.9%	1.2%	1.8%	2.1%			3.1%	3.4%	2.3%	2.1%	2.8%	
	with unassisted births (normal)			2020 Births	1.2%	0.5%	1.7%	2.0%	1.6%	2.6%	1.7%	1.5%	1.1%	2.2%	2.2%	1.3%	0.8%	0.4%	1.3%			1.9%	1.9%	0.9%	1.3%	1.5%	
	with assisted births (Instrumental)			2020 Births	0.0%	0.9%	1.7%	1.0%	0.0%	0.5%	1.7%	1.5%	2.8%	0.6%	1.3%	2.6%	0.4%	1.3%	0.8%			1.2%	1.5%	1.4%	0.8%	1.3%	
	% 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%	8.0%	6.8%	3.1%	7.3%	3.9%	7.0%			7.3%	7.4%	4.8%	7.0%	6.5%	
	Episiotomies with Episcissors				92.6%	84.6%	85.1%	85.7%	90.5%	75.0%	84.0%	77.8%	75.9%	88.0%	85.3%	70.4%	86.5%	86.7%	77.8%			78.9%	83.1%	81.2%	77.8%	80.7%	
	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%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%			0.3%	0.2%	0.0%		8.8%	
	Number of Blood Transfusions ≥ 4 Units			Births/month	1	0	1	1	1	1	0	1	0	4	0	0	0	0	1			2	4		1	7	
	Number of Women Requiring Level 2 Critical Care			Births/month	4	4	0	2	2	2	3	1	1	0	1	1	4	0	0			6	2	5		13	
	Number of Women Requiring Level 3 Critical Care			Births/month	1	0	0	0	0	0	0	1	0	0	1	0	1	0	0			1	1	1		3	
	Maternal Deaths			Nat rate per 1000	0	0	0	0	0	0	0	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	3	5	1	1	3	1			5	9	5	1	20	

Neonatal Morbidity & Mortality	Stillbirths **			Nat rate 3.5 per 1000 births	1	1	0	1	0	1	1	0	0	0	1	0	1	0	0			2	1	1		4	
	Early Neonatal Deaths (before 7 days)			Nat rate per 1000 births	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0			1	0			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	2	5	1	3	1	1			3	10	5	1	19	
	HIE 2 &3 > 37 weeks (reported retrospectively)			GM av 1.95 per 1000	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0			1	0			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%	1.6%	1.7%	0.9%	0.4%	1.7%	0.4%			1.0%	1.8%	1.0%	0.4%	1.2%	
	Singleton Babies born <30 weeks gestation			Births/month	3	1	0	1	1	0	2	1	0	0	1	2	1	0	0			3	1	3		7	
	% whose mother received magnesium sulphate	100%	90%	Rolling% of eligible babies	100.0%	100.0%	0	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	0.0%	100.0%	100.0%	100.0%	n/a	n/a			66.7%	33.3%	100.0%			
	Singleton Babies born <34 weeks gestation			Births/month	8	3	7	2	2	4	4	3	3	4	1	2	5	3	6			3	1	3		7	
	% 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%	50.0%	100.0%	60.0%	60.0%	66.7%	66.7%			63.6%	81.8%	61.5%	66.7%	68.3%	
	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%	1.8%	4.3%	2.4%	4.5%	4.7%	5.6%			3.4%	3.7%	3.9%	5.6%	3.9%	
	Number of babies re-admitted with 28 days of birth	<16	>20	194 in 2020	12	15	18	14	12	21	9	14	17	14	18	15	28	18	12			44	49	61	12	166	
Risk Management	Number of indicents reported				53	57	91	42	53	67	58	51	61	70	86	60	65	46	74			176	217	171	74	638	
	Number of Concise Investigations				0	0	0	0	0	0	1	2	0	0	0	0	0	1	1			3	0	1	1	5	
	Number of StEIS Reported Incidents				0	0	0	0	0	1	0	1	0	0	0	0	0	2	0			2	0	2	0	4	
	Number of Midwifery Red Flags Reported				0	0	0	0	0	0	0	0	0	4	0	2	3	4	3			0	4	9	3	16	
	Number of Complaints				0	0	0	1	0	0	1	0	0	0	0	0	0	0	2			1	0	0	2	3	
	Number of Letters of Claim Received				0	0	0	0	0	0	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:	September Safe Staffing Report
Presented to:	Board of Directors
On:	24 November 2021
Presented by:	Chief Nurse
Prepared by:	Deputy Chief Nurse and Divisional Directors of Nursing and Allied Health Professionals
Contact details:	T: 01942 82 2176 E: allison.luxon@wwl.nhs.uk

Executive summary

The purpose of this report is to provide the Board to provide assurance of the ongoing monitoring of nurse staffing levels and the triangulation of staffing levels with quality, safety and patient experience 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 ratio of registered nurses to unregistered remains 55:45 as agreed by Trust Board in 2018 with the exception of the assessment areas which are staff at a ratio of 60:40. This ratio remains out with national recommendations of 70:30 and the Trust flags as an outlier in this regard on every publication of the CQC Insight Report as presented to Quality and Safety Committee.

- There continue to be a number of additional clinical areas escalated within month in order to staff these areas there has been a need to reduce staffing ratios on some inpatient ward. The lack of ability to flex the workforce to meet increased pressures associated with capacity and demand is related to the escalation of areas in the Emergency Village to support patient flow and appropriate segregation of patients, and an escalated unfunded ward area, as well as vacancy factors and a lack of appropriate staffing uplift.

- The RCN (2015) also recommended that Ward Leaders posts should be fully supervisory to clinical practice in order to ensure adequate time for leadership, management and quality improvement. The Trust position in regard to this metric remains 50%, however, a business case was recently approved by Trust Board.

- Appendix 1 has been modified to include more metrics relating to community services and to support the Board to have visibility of the OPEL status of services that are being provided.

- There has been an increase in District Nurses caseloads in month associated with staffing shortfalls. This has resulted in 4 occasions in September where staff have provided face to face visits for Priority 1 patients only. No harm was reported when the reduced service was in place. The division continues to actively recruit to vacancies. Work is being undertaken across the community adult services team to ascertain which treatments can be delivered differently to assist in reducing demand on caseloads. This will include providing education and support to patients to move towards self-care. Proposed changes and a quality impact assessment are expected to be presented for approval by November 2021.

- The Community division is continuing to work with partners across the system to provide a response to the 12–15-year-old vaccination programme whilst assessing the impact on safeguarding and public health contracted work. The Community Childrens Nursing Service will support this programme in Month 8 across special school settings.

- 2 Falls occurred in month on CAU, 1 of which resulted in severe harm to the patient. There has been an increase in the number of falls reported on the unit. The Division has increased the number of unregistered staff within the area to provide enhanced observations for patients at risk of falls.

- There remain considerable pressures across the workforce in the Trust Operating theatres which has resulted in the cancellation of some surgical procedures. All patients have been offered and have accepted alternative dates for surgery. The Divisions continue to work collaboratively with GTEC to support the transfer and placement of staff as part of the Earn, Learn and Return Programme.

- Capacity pressures continue to be experienced across all areas of the Division of Medicine, including the Emergency Floor. Recruitment continues to the fixed term posts funded as part of winter planning, however, there remain ongoing shortfalls in staffing which negatively impact on patient experience and flow with increasing numbers of patients requiring care on beds in the area especially overnight.

- Additional inpatient areas have been escalated in month to accommodate the requirement for additional beds and to relieve congestion in ED. This has resulted in the requirement to reduce nurse to patient ratios on several occasions throughout the course of the month and further demonstrates the lack of resilience within the nursing workforce to respond to increasing pressures.

- ICU continues to face workforce challenges associated with the fragility of the team should escalation be required. Workforce plans for winter preparedness highlight a 25% turnover within the team, and that 52% of the workforce have less than 18 months experience.

- The Paediatric RSV surge plan continues to be developed in collaboration with colleagues in the Trust to provide assurance of resilience for service delivery.

- There remain workforce pressures across Maternity service associated with vacancies and other unplanned leave. The service continues to risk assess staffing requirements and mitigates most

risk by the deployment of staff from other areas of the service to support the high-risk areas i.e. delivery suite.

- Across the organisation 3 CDT have been reported in month, all of which have been subject to RCA to identify whether lapses in care occurred.

- There were 2 falls reported in September, one of which resulted in severe harm to the patient on CAU. There has been an increase in the number of falls reported on the unit and as such te Division has increased the number of unregistered staff within the area to provide enhanced observations for patients at risk of falls. The second fall occurred on Pemberton resulting in significant harm.

- No Category 3 and 4 pressures ulcers were escalated to StEIS within the reporting period.

- All clinical divisions continue to progress work to improve roster compliance and advance notice of unfilled shifts to NHSP. Lead in times for September on average exceeded the 42-day target at the time of roster production, however this reduces to 26 days when adjusted for short notice absence.

- Nationally there continues to be a shortfall of Registered Nurses, and the impact of the increase in nursing and midwifery training placements has yet to be felt. Work has been completed to identify staffing risks associated with the age profile of registered nurses and midwives and turnover rates and identify emergent and potential staffing and skills shortfalls up to and including financial year 2025/26. The business case for additional international nurses has been has been approved and GTEC are actively recruiting.

- CHPPD comparable data is no longer being provided via the Model Hospital and this will be removed from future reports.

- **Link to strategy**

Delivery of safe care

Risks associated with this report and proposed mitigations

- Registered and unregistered nurse recruitment is being proactively managed.
- Registered staff vacancies within theatres, district nursing services and maternity present risk to patient safety and experience and the overall Trust Covid recovery plan
- The report highlights improvements required to deliver effective staff rostering and use of Safe Care.
- The report identifies risks relating to the ability to sustain safe staffing levels as a consequence of the increased escalation of areas/unfunded areas, a reduced uplift in staffing when benchmarked against National Quality Board (NQB) standards, vacancy rates and a reliance on temporary staffing

Financial implications

- Temporary staffing costs related to sickness/absence and vacancy levels, and backfill requirements, and to support additional staffing to support patient flow within ED, the

escalation ward, and the acuity of patients on the CPAP medical area. This has been further compounded in month with the required escalation of smaller inpatient areas to mitigate overcrowding in the Emergency village and to meet the demand for inpatient services.

Legal implications

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

People implications

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

Wider implications

- Increased scrutiny from Commissioners and Regulators

Recommendation(s)

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

1. INTRODUCTION

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

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

1.3 The report also includes exception reports relating to nurse staffing levels, related incidents and red flags which are then triangulated with a range of quality indicators.

2 SAFER STAFFING EXCEPTION REPORT

2.1 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. CURRENT POSITION – September 2021

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

3.2 The ratio of registered nurses to unregistered remains 55:45 as agreed by Trust Board in 2018 with the exception of the assessment areas which are staff at a ratio of 60:40. This ratio remains out with national recommendations of 70:30, with SNCT recommended levels of no less than 65:35 within inpatient areas. The Trust flags as an outlier in this regard on each publication of the CQC Insight Report as presented to Quality and Safety Committee.

3.3 The Trust also remains an outlier for the uplift of nursing and midwifery establishment levels. The Trust agreed uplift is 20% against an advised 25%, and a SNCT minimum recommended level of 23%.

3.4 The RCN (2015) also recommended that Ward Leaders posts should be fully supervisory to clinical practice to ensure adequate time for leadership, management, patient safety and experience, and quality improvement. The Trust position regarding this metric remains 50%, however a business case has been approved to address this.

3.5 Appendix 1 has been expanded in month to represent more broadly Community Services and includes the OPEL status of services which provides a better indicator of safety and responsiveness for the Board.

4 FILL RATES

4.1 OPEL levels, (provided in Appendix 1), are a broader indicator of staffing pressures within the Community Division and the impact on services than fill rates.

4.2 In September there were 3 services that were OPEL level 3 for staffing within District Nursing Services (DNS), and 1 service at OPEL level 4 within Professional Practice.

4.3 Due to the specialist nature of some services within the community division it has not been possible to back fill with temporary staff and this is impacting on access times for 18 of the 51 services provided by the Division.

4.4 Of particular concern is the impact on caseloads within District nursing services which have increased from 15-17 patients per WTE in August to 16-20 patients in September. This increase in caseload numbers has occurred despite the 85% uptake in temporary staffing provided to support activity.

4.5 Bryn North has reported underfill rates of registered staff against funded establishment in month. This is attributed to the deployment of staff to supported escalated areas at night.

4.6 Across the Emergency Floor there continues to be a reported overfill rate against funded establishment of both registered and unregistered staff associated with the escalated areas required to maintain the segregation of patient flow and social distancing during the COVID-19 pandemic.

4.7 In month the Medical Division has noted overfill against funded establishment on ASU, Astley, Shevington and Standish wards. This is attributed to a higher number of patients requiring enhanced observations and increased usage of NHSP to augment the team and ensure patient safety. It should also be noted that recurrent funding for Standish Ward remains outstanding and this negatively impacts on fill rates.

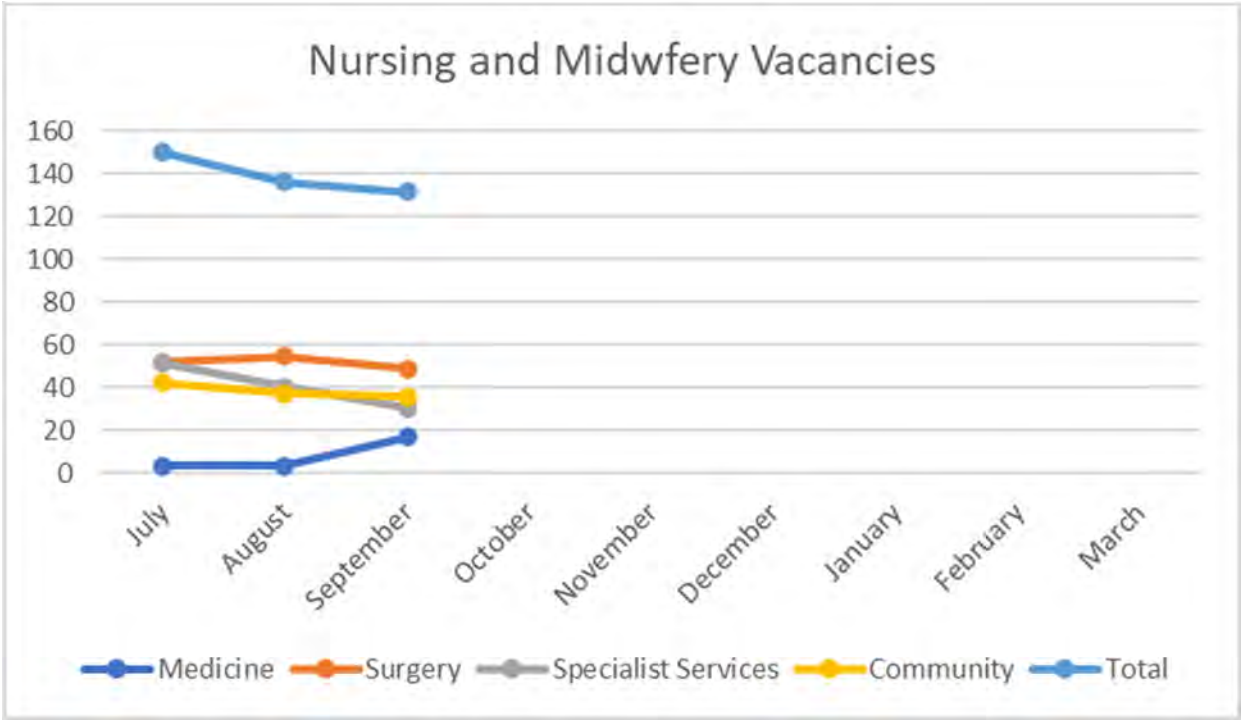
4.8 Fill rates within Critical Care, Orrell and Swinley have been achieved in month, however there is an expectation that fill rates would be higher within Critical Care to cover the supernumerary shift leader requirements.

4.9 Fill rates on Langtree ward for registered day staff remain low, however this position does not accurately reflect the staffing levels as 2 substantive staff on a phased return were not counted within the numbers.

4.10 Fill rates for theatres in the surgical division have been below 90%. This has resulted in the cancellation of planned activity due to lack of staffing.

4.11 Within Maternity Services average fill rates were not achieved on nights on the post-natal ward or across the Delivery Suite during September. This was because of vacancies, short term sickness and maternity leave. Staff were moved from the community and continuity teams to assist in the mitigation of risk.

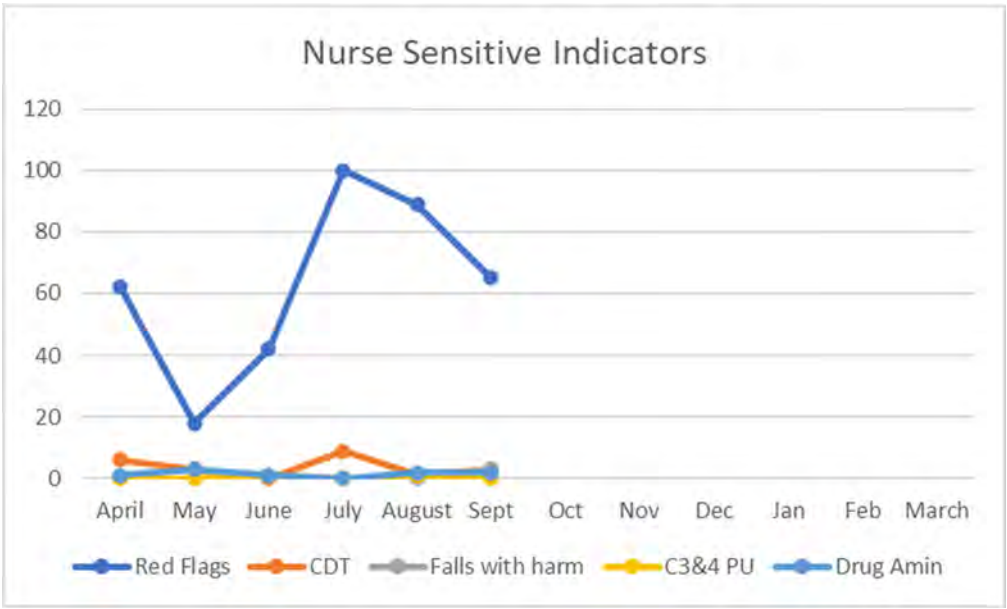
5 VACANCIES



5.1 The Trust finance data currently indicates that WWL has 125.5 WTE nursing and midwifery vacancies against funded posts a reduction of 2.62 WTE from the position reported in August.

5.2 Areas of particular concern remain District Nursing Services, ED, Theatres and Maternity Services. As indicated in section 4 of the report the vacancies within these services are impacting in care delivery resulting in the requirement to increase caseload, reduce services, and the cancellation of surgery for patients to mitigate risk and maintain core essential services.

6 NURSE SENSITIVE INDICATORS (NSI'S)



6.1 There were 4 occasions in month when DNS were required to restrict visits to Priority 1 patients only due to staffing pressures. All appropriate action was taken to support patients via telephone following the cancellation of visits. There were no identified harms reported at these times.

6.2 A Total of 63 Nursing red flags were raised during September. This is a decrease on the number reported in August, however when triangulated with the staffing SBAR's undertaken daily by Matrons, it is felt that shortfalls in registered nursing staff has been under-reported due to the requirement to deploy staff to support the Emergency Department and to staff escalated inpatient areas in response to patient need. Risk was mitigated, where possible by the redeployment of staff, however nurse to patient ratios fell below the Trust required standards throughout the month, particularly on night shifts. Further work is required within SafeCare to capture the deployment of staff to escalated areas in order to accurately measure the impact of this across the Trust.

6.3 In addition several Datix incident reports were submitted from Theatres on the Royal Albert Edward Infirmary and Leigh site relating to shortfalls in staff. Whilst no physical harms have been reported within this area, there have been a number of cancellations of patients which have the potential to impact psychologically and physically. All decisions to cancel were discussed with the patients concerned and alternative theatre dates have been offered and accepted.

6.4 There were 6 Maternity Red Flags reported in September relating to reduced staffing levels and the Supernumerary shift co-ordinator unable to remain supernumerary. No harm events were reported in relation to these shifts and 1-2-1 care was provide to women all women in established labour. The unit went on divert on one occasion in month relating to capacity issues on the labour ward. Although there was the possibility of further diverts in month, these were mitigated by the movement of staff from community and continuity of carer teams to support the clinical area.

6.5 In September there were 2 reported falls with harm to patients. 1 fall resulted in severe harm to a patient who sustained a fracture requiring surgical intervention on the Community Assessment Unit (CAU). Contributing factors to the incidents include the layout of the unit and the lean staffing model. The staffing model will be further reviewed as part of the bi-annual staffing review. The second reported fall with significant harm occurred on Pemberton Ward. This incident has been reported on Steis and there is an ongoing concise investigation. There were no staffing concerns raised at the time of the fall.

6.6 There were 5 falls with no physical harm reported across Wards A and B on the Wrightington site. At the time the falls occurred there were no associated staffing issues and risks assessments for patients had been appropriately completed. A further 6 no harm falls were reported by the division of Surgery, 3 on ICU and 3 on Orrell Ward. The 3 falls on Orrell ward are attributed to a higher volume of confused medical outliers admitted to the clinical area. The falls occurred despite risk assessments being completed and additional staffing support where enhanced observation was required.

6.7 One community acquired pressure ulcer was reported in September. The patient already had some profiling equipment within their home but had declined a specialist mattress. 1 Category 2 pressure ulcer was reported on MAU. A causative factor is believed to be a failure to

reconnect the pressure relieving device to a power source once the patient had been moved. An improvement plan has been developed and is being monitored divisionally.

6.8 Three CDT's were reported in month across the following wards, Aspull, Shevington and Astley. All are subject to investigation and are due to be presented to Executive Panel in October. This is the 3rd CDT attributed to Aspull in the financial year and the area continues to be on a 3-month improvement plan. The Board are asked to note that the 3-month improvement plan remains in place on Orrell ward following CDT reported in the August update to Board.

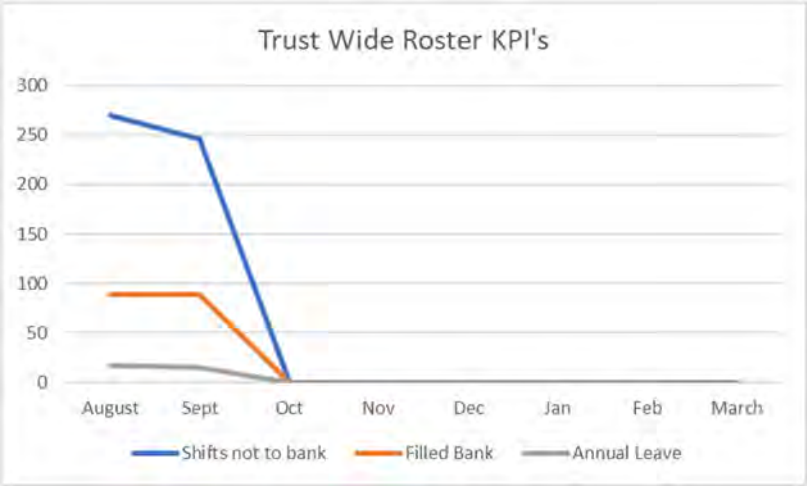
6.9 There was 1 reported medication incident with harm reported on ASU. This involved the early administration of insulin when a patient was being commenced on artificial feeding. The division is undertaking a review of insulin related errors and is planning additional education of ward-based staff.

6.10 In September there were 31 medicine administration errors reported across the divisions where there was no harm reported to the patients. There were no reported shortfalls in staffing at the time the incidents occurred. Staff involved in the incidents have received support and additional training where this is required. A multi-professional approach to staff education has been adopted in the Division of Surgery aimed at improving practice and reducing the risk of the recurrence of errors.

6.11 One case was reported to the Healthcare Safety Investigation Branch (HSIB) as the baby received therapeutic cooling due suspected Hypoxic Ischaemic Encephalopathy (HIE), however this did not meet the criteria for HSIB investigation as MRI was subsequently normal.

6.12 There was one StEIS reportable incident relating to a retained object following Surgery for Elective Caesarean Section which is being jointly investigated by general surgery and Maternity.

7 EFFECTIVE ROSTERING



7.1 The clinical divisions now receive a monthly report on the roster period to be worked to provide oversight of unavailability, roster approval and the safety and fairness of the rosters.

7.2 Work continues with Matrons and Ward Leaders to improve roster compliance and to provide assurances that future rosters are safe and effective and are produced in a timely manner. Roster production remains challenging due to the reduction in management time available to Ward Leaders when they are required to work clinically.

7.3 Further work is required to ensure that unfilled shifts are sent to NHSP for management within Critical Care and Theatres within the surgical division.

7.4 Within month there has been continued focus on ensuring the roster templates reflect the budgets aligned to the clinical areas. It is expected that this work will be concluded by the end of October 2021. There is evidence to suggest that the increase in the requirement for ward managers to work clinically in response to staffing shortfalls/supervision of staff has negatively impacted on their ability to maintain administration. For the divisions to move to Auto-roster, the staffing templates and flexible working rules within the system will have to be cleansed prior to the system being launched.

7.5 67% of unfilled shifts from available substantive staff had already been picked up via NHSP at the time the roster was released to be worked.

8 INTERNATIONAL RECRUITMENT

8.1 Nationally there continues to be a shortfall of Registered Nurses, and the impact of the increase in nursing and midwifery training placements has yet to be felt. Work has been completed to identify staffing risks associated with the age profile of registered nurses and midwives and turnover rates and identify emergent and potential staffing and skills shortfalls up to and including financial year 2025/26. The business case for additional international nurses has been updated to reflect these requirements and is to be forwarded for approval via the approved trust Governance Processes.

8.2 The International Nursing (IN) recruitment flow chart has also been amended. The changes suggested will improve information about the services provided by the Trust, and ensure a placement is agreed for the IN earlier in the recruitment process linked to their skills and

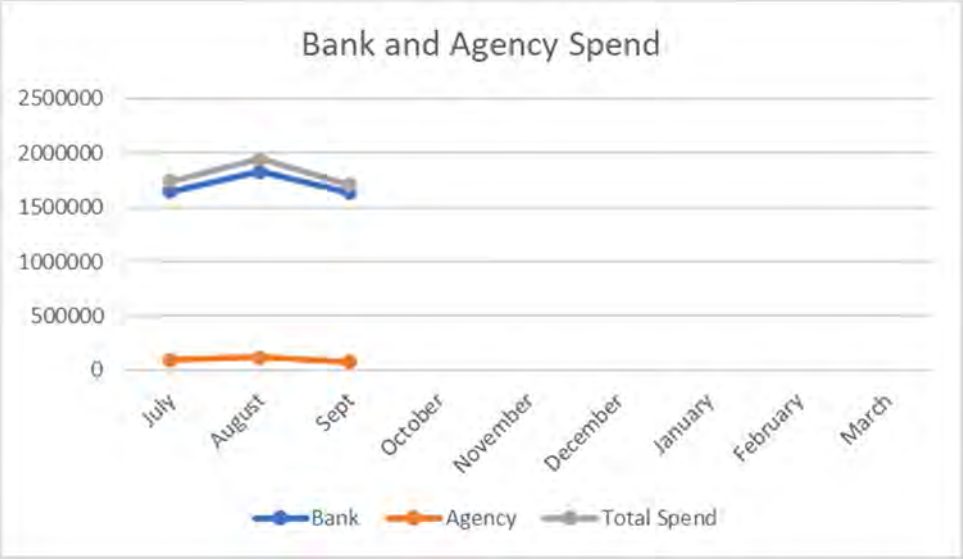
knowledge base. This will greatly assist in improving the well-being of our IN's and in making them feel part of the community prior to their arrival from Crewe.

8.3 A proposal is scheduled to be presented to the senior professional team articulating the process for rotation for educational purposes of the GTEC nurses who are in years 3 and 2 of the programme. This paper will also ensure equity of access to opportunities for domestic recruits to the service with the intention of utilising the Transfer Policy to facilitate movement of staff.

8.4 The Deputy Chief Nurse has also instigated a series of engagement events, in collaboration with the GTEC team, with the IN's to facilitate discussion and advise on potential transfers to support personal growth and development which have been well attended and well received.

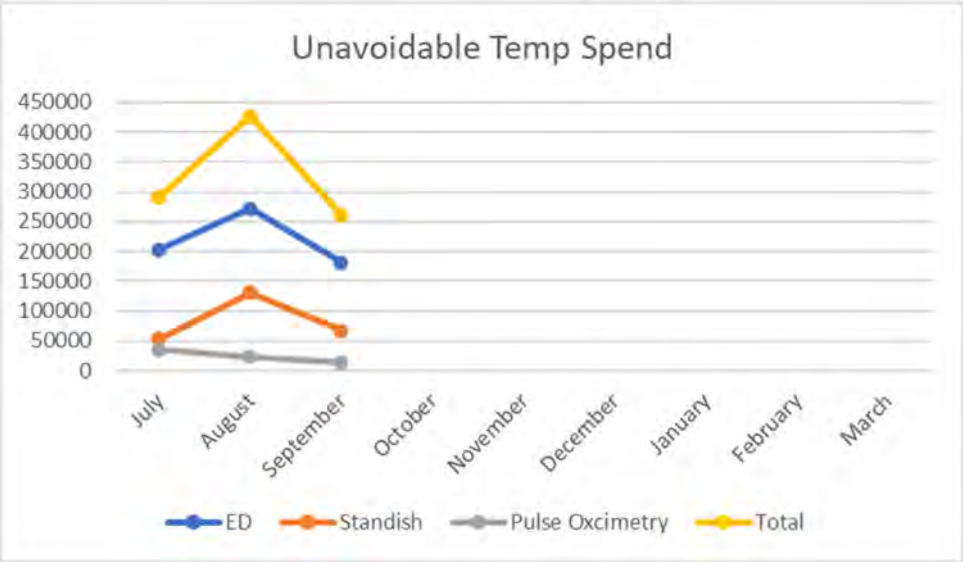
8.5 A business case detailing the skills shortfall and recruitment needs of the Trust is scheduled to be presented to Board for consideration. If accepted, this will build on the 40 IN's funded in the current financial year and increase the numbers of recruits to 109 before the end of the financial year.

9 BANK AND AGENCY UTILISATION



9.1 Bank and agency utilisation has reduced from August to September of 1.9% (27.5k hours). The total spend for Nursing and Midwifery (N&M) in month is provided below.

9.2 The Trust continues to have additional escalated areas on A&E, to support the segregation of patients, on Standish ward, and with the Pulse Oximetry @Home service. The additional temporary spend associated with the escalated areas is provided in the table overleaf.



9.3 From the information above £261,320 of temporary spend is unavoidable as this is required to maintain IPCC patient flows and the provision of safe patient care.

9.4 Overall fill rate marginally decreased by 1% to 92.1% in month.

9.5 There was an increase in demand for registered nurse shifts in September of 0.6% with a total of 2983 shifts being requested. Of these 481were unfilled by either Bank or Agency Staff. Agency usage was 4.5% within the reporting period.

9.6 Healthcare Assistant shift requests reduced by 5.9% to 4501 shifts, 206 of which not were filled. These requests are associated with an increased requirement for 1:1 nursing and improvements in the utilisation of enhanced observation to reduce falls for those identified as being at risk.

9.7 The average lead in time for releasing shifts to NHSP was 49 days, an improvement of 17.4 days at the point of roster production which represents a significant improvement from the previous and is above the trajectory of 42 days. The lead time decreases to 26.5 days when short notice absence is taken into consideration as the roster is worked.

9.8 The top 3 reasons for requesting temporary staff remain vacancy, and long and short-term sickness

9.9 NHSP have continued the programme of work across all sites to recruit both substantive and multi-post holders to the bank; 101 additional workers were recruited in month. The success of this campaign has been the collaborative work undertaken between NHSP and the Ward/Departmental Leaders.

9.10 The Trust continues to provide an enhanced rate of pay for NHSP staff in Critical Care, Maternity, District Nursing Services, the Emergency Department and across Theatres where there are shortfalls and a lack of resilience in the staffing models.

10 STAFF REDEPLOYMENT

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

10.2 With regards to data on SafeCare there have been 164 staff redeployments to other areas in response to patient acuity, short notice absence and the escalation of additional inpatient areas for overnight stay patients. This represents an increase of 27 redeployments to mitigate patient safety risks from the previous report received. The table below provides further divisional detail with regards to redeployment.

Division	Number of staff redeployed	Areas redeployed to
Specialist Services	38	8 to acute medical areas 30 within the division
Surgical Division	11	10 to acute medicine 1 within the surgical division
Medical Division	115	6 to surgical wards 2 to CAU 107 across the medical division
Community Division	0	0
	164	

11 STAFFING RISKS

11.1 There remain risks associated with staffing levels in DNS and the increase in caseloads described in 4.1.4. Whilst this is currently not reflected in harms to patients this will need to be monitored closely and mitigation considered. The Divisional Director of Nursing is currently working in close collaboration with GTEC to improve opportunities for placement and career progression within the service.

11.2 School Nurses continue to deliver the 12-15 Covid-19 vaccination programme. This is impacting on the ability to deliver core service specifications and there continues to be a lack of available support from the GM lead provider service to assist risk mitigation.

11.3 The skill mix in DNS is diluted due to the number of new starters and the requirement for these staff to complete preceptorship.

11.4 There are shortfalls within the Health Visiting (HV) due to vacancies which have been challenging to fill. Backfill of roles is not always feasible due to the lack of available workforce with the required SPQ via temporary staffing. There have currently been no patient harms reported as a consequence of the workforce gaps.

11.5 There remain vulnerabilities in Theatre staffing associated with vacancies and unplanned absence despite recruitment of staff and the placement of international nurses within the workforce. In addition there is a risk to the ability for staff within theatres accessing the Specialist Qualifications (SPQ's) required due to the lack of availability of courses; this is particularly problematic with access to anaesthetic courses.

11.6 Long term sickness within the Increased Dependency Area (IDA) on the Wrightington site has resulted in a decision to reduce the operating times of the service to ensure patient safety.

This has adversely impacted on patient flow across the site and placed additional pressures within other inpatient areas. There continue to be pressures on staffing across the emergency floor and within inpatient areas associated increased attendances in ED and additional escalated inpatient and ED areas to support segregation of patients and patient flow. Pressures are further exacerbated by increased demands on colleagues in social care which is reflected in delays to discharges.

11.7 Although funded vacancies are low within the Medical Division, there remains the requirement to staff unfunded areas associated with escalation of additional inpatient beds. This is impacting on the ability to maintain safe nurse to patient ratios overnight, and further impacting on staff wellbeing.

11.8 Although there are minimal vacancies on the Medical Assessment Areas, there are 3 WTE due to commence maternity leave, and skill mix issues associated with a lack of experience of substantive staff.

11.9 ICU continues to face workforce challenges associated with the fragility of the team should escalation be required. Workforce plans for winter preparedness highlight a 25% turnover within the team, and that 52% of the workforce have less than 18 months experience.

11.10 Theatre staffing remains vulnerable and has resulted in the cancellation of patients to maintain safety across the theatre complexes. Risk to patients have been mitigated following the inclusion in decision making and the provision and agreement of alternative dates for surgery.

11.11 Paediatric Services continue to prepare for a potential RSV surge as part of their winter preparedness plans. These plans include the upskilling of staff outside of the paediatric inpatient environment, collaboration with colleagues in the Community Division, and identification of staff and services via a risk stratification process to support deployment of additional staff should this be required. These plans are being developed following agreed national principles that will offer indemnity to staff working outside of their usual scope of practice.

11.2 Due to the lower numbers of student midwives qualifying in 2022 there is a high likelihood that there will be a shortfall of qualified Midwives in 2022, assuming attrition follows the same upward trajectory, as it is known that 43% of the Midwifery workforce is aged 50+. There is an opportunity to mitigate this risk via International Recruitment following the allocation of the contract to GTEC, however the impact of this is unlikely to be felt until the new financial year. The service continues to risk stratify services to support the delivery of care in high risk areas of the service.

12 SUMMARY AND NEXT STEPS

12.1 In September there were 3 services that were OPEL level 3 for staffing within District Nursing Services (DNS), and 1 service at OPEL level 4 within Professional Practice. This has impacted on caseload numbers in month and resulted the service seeing Priority 1 patients on 4 occasions. The Division continues work to proactively recruit to vacancies and is currently exploring alternative workforce models to reduce the burden on the registered staff.

12.2 There were 2 reported falls with harm in month, CAU and Pemberton Ward Falls occurred in month on CAU, 1 of which resulted in severe harm to the patient. There has been an increase in the number of falls reported on CAU. The Division has increased the number of unregistered staff within the area to provide enhanced observations to patients at risk of falls.

12.3 Work is being undertaken across the Community adult services team in October to ascertain which treatments can be delivered differently to assist in reducing demand on caseloads. This will include providing education and support to patients to move towards self-care.

12.4 The community division will continue to work with partners across the system to provide a response to the 12–15-year-old vaccination programme whilst assessing the impact on safeguarding and public health contracted work. The Community Childrens Nursing Service will support this programme in Month 8 across special school settings.

12.5 The Trust continues to experience staffing challenges across theatres despite ongoing recruitment campaigns and there are additional pressures associated with skill mix and access to accredited training due to lack of training places. Clinical Divisions are continuing to explore the direct recruitment of International Nurses to augment the workforce and provide additional training required from the GTEC process.

12.6 The Clinical Divisions continue undertake improvement work with rostering compliance and roster practices, with particular focus on final approval within 6 weeks, E Roster master classes to improve housekeeping, and roster approval meetings which are scheduled to commence in October.

12.7 Overall funded B5 vacancies for registered staff remain low, however this does not reflect the actual requirement to staff additional escalated areas and the negative impact on nurse to patient ratios particularly overnight and staff wellbeing. Business cases are being developed to support substantive recruitment to unfunded areas to assist in the mitigation of this risk. The previously reported overfill of B5 registered nurses in the Division of Medicine has now reduced to 1.19 WTE.

12.8 Recruitment continues to the additional posts approved in the ED to support Winter Planning. In addition, the Division is working in collaboration with colleagues in the professional practice team and GTEC to offer placements to International Nurses in years 3 and 3 of the programme within this clinical area.

12.9 The Paediatric RSV surge plan continues to be developed in collaboration with colleagues in the Trust to provide assurance of resilience for service delivery.

12.10 Within Maternity Services there remain workforce pressures associated with vacancies and other unplanned leave. The service continues to risk assess staffing requirements and mitigates most risk by the deployment of staff from other areas of the service to support the high-risk areas i.e., delivery suite. WWL have been successful in securing an additional International Midwife through the LMS/ GTEC allocation process and have also submitted bids for further recruits going forward.

12.11 The Neonatal unit is currently having a full staffing review to provide supernumerary shift coordinators at the appropriate banding, to enable 24/7 oversight of each shift whilst

providing support and guidance to staff in line with the British Association of Perinatal Medicine (BAPM) recommendations. The review will also incorporate the requirements of the Neonatal Outreach Service. Consideration will be given within the review of the SPQ requirements of the team to ensure staff have the right skills and knowledge to deliver safe, supportive care within the unit.

12.12 Divisions continue to undertake workforce review in preparation for the Bi-annual staffing reviews. This includes consideration of service changes and succession planning for single handed nurse specialists where single points of failure have been identified.

12.13 A programme of work to ensure effective rostering and utilisation of staff is being progressed. This is being overseen by the Workforce Efficiencies Workstream.

13 RECOMMENDATION

13.1 The Board is asked to receive the paper for information, to be sighted on the workforce challenges and to provide assurance that appropriate mitigation is in place.

Appendices

Appendix 1 Safe Staffing Exception Reports
September 2021

Division of Medicine – Scheduled Care

	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Vacancies (%) - Registered Nursing Band 5-8	Datix Incidents - related to staffing/Red Flags	CDT	Falls (Harm / No Harm)	PU (Grade 1&2 / Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the hospital staff did everything they could do to control your pain?	Have you been given the care you felt you required when you needed it most?
Acute Stroke Unit	112.6%	100.0%	4.1	121.9%	132.6%	5.8	5.70%	0.00%	0.00%		1	0/3		1/2		
Astley	107.8%	98.8%	3.4	137.6%	202.1%	7.0	7.50%	5.23%	0.00%			0/2				
Bryn North	127.7%	64.3%	3.3	114.0%	144.3%	5.0	Unable to report as this cost centre is not recorded on FBI or ESR					1/6		0/1		
Bryn South	0.0%	0.0%	0.0	0.0%	0.0%	0.0	Unable to report as this cost centre is not recorded on FBI or ESR					0/4				
Coronary Care Unit	188.5%	138.2%	10.2	313.3%		3.9	4.50%	2.03%	6.27%					0/2		
Highfield	0.0%	0.0%	0.0	0.0%	0.0%	0.0	Unable to report as this cost centre is not recorded on FBI or ESR									
Ince	132.4%	63.3%	3.4	134.5%	167.1%	5.1	6.77%	6.71%	11.72%	2		0/2		0/4		
Pemberton	116.3%	98.3%	5.8	121.7%	142.0%	5.6	9.10%	0.00%	0.00%			1/4		0/1		
Shevington	97.3%	92.3%	2.9	188.0%	153.6%	5.9	5.68%	4.03%	17.92%	11	1	0/3		0/2		
Standish	105.6%	94.8%	3.7	152.5%	221.0%	8.5	4.41%	12.49%	13.47%	4		0/7		0/1		
Winstanley	172.8%	175.3%	7.8	88.1%	153.4%	7.3	14.31%	0.00%	0.00%	1		0/2				

Division of Surgery

	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Vacancies (%) - Registered Nursing Band 5-8	Datix Incidents - related to staffing/Red Flags	CDT	Falls (Harm / No Harm)	PU (Grade 1&2 / Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the hospital staff did everything they could do to control your pain?	Have you been given the care you felt you required when you needed it most?
ICU/HDU	101.6%	99.7%	34.5	88.7%		6.1	4.78%	0.00%	0.00%			0/1				
Langtree	81.2%	95.1%	2.5	126.3%	182.4%	3.3	9.89%	3.35%	15.32%	4		0/3		0/1		
Orrell	90.8%	81.1%	25.7	82.4%	144.5%	41.9	7.50%	12.06%	8.80%	20				0/3		
Swinley	105.9%	101.4%	3.1	111.1%	183.8%	3.2	4.51%	0.00%	2.65%	4						
Maternity Critical Care / Delivery	88.8%	88.7%	5110.7	0.0%	0.0%	0.0	6.89%	0.52%	2.71%	3						
Maternity Ward	120.4%	79.9%	2.4	105.8%	100.9%	3.3	27.95%	0.00%	0.00%					0/1		
Neonatal Unit	109.3%	114.2%	17.0	92.1%		2.1	1.46%	1.06%	0.00%	1						
Rainbow	99.1%	99.2%	8.3	120.4%	95.0%	3.4	1.41%	7.06%	9.64%							

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	100.2%	95.9%	3.2	122.1%	155.8%	5.48	7.81%	12.86%	11.37%	10	1			0/1		
Ward A	100.8%	81.1%	3.6	88.9%	112.3%	3.97	11.82%	7.60%	0.00%	1		0/2		0/1		
Ward B	114.2%	100.0%	3.8	88.9%	117.4%	3.95	12.94%	8.14%	0.00%			0/3		0/1		
JCW	123.1%	98.6%	8.4	97.7%	134.9%	4.89	1.51%	2.57%	5.35%					0/1		

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	124.0%	125.9%		173.8%	286.4%		6.01%	8.28%	16.27%	1		0/2		0/3		
A&E Paeds	113.7%	101.5%					1.41%	0.00%	0.00%							
A&E NP's	76.9%	0.0%		28.3%			0.00%	31.05%	19.28%							
CDW	84.2%	75.2%		85.1%	100.0%		1.38%	12.04%	19.57%					0/3		
Lowton	97.8%	97.9%		100.1%	162.6%		4.65%	12.39%	10.21%	1		0/8		0/5		
Medical Assessment Unit	83.0%	92.1%		91.9%	163.2%		9.87%	3.90%	2.61%	11		0/8	1/0	1/1		

Community Division

	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)		Average OPEL Scores			
	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?	Staffing	Access to Service	Resources	Total score
Community Assessment Unit: RAEI	191.0%	96.7%	5.3	101.1%	93.5%	4.3	8.8%	0%	0.00%			1/4	1/0				1.05	1.05	1	1.05

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

	Total staffing			Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience		Average OPEL Scores			
Service	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?	Staffing	Access to Service	Resources	Total score
Adult SLT	51.12%	N/A		11.89%	28.09%	21.93%								2.29	1.41	1.06	1.85
Better at Home - AHPs and nursing	No data available	N/A		No data available		No data available								No OPEL data submitted in September 2021			
Cardiology - AHPs	85.51%	N/A		8.22%	0.00%	0.00%								1.93	1.21	1	1.60
Cardiology - nursing	93.04%	N/A		0.85%	7.71%	8.41%								1.18	1.06	1	1.12
CCNT	89.31%	N/A		2.33%	3.04%	0.86%								1.32	1	1	1.16
CFS/ME	103.60%	N/A		0.00%	0.00%	0.00%								2.24	2.24	1	2.24
Children's Audiology	93.60%	N/A		0.69%	0.00%	0.00%								1.91	2.91	1.18	2.41
New Born Hearing Screening	65.18%	N/A		0.00%	15.96%	0.00%								1	1	1	1.00
Children's Occupational Therapy	80.21%	N/A		3.88%	15.94%	18.50%								1	1	1	1.00
Children's Physiotherapy	94.27%	N/A		1.26%	7.01%	9.47%								1	1	1	1.00
Children's SLT	94.75%	N/A		2.97%	1.38%	1.66%								1	1	1	1.00
CIC Team	96.88%	N/A		2.11%	1.57%	0.00%								1	1	1	1.00
Community Health Development	87.37%	N/A		4.96%	0.00%	0.00%								1.27	1.27	1.13	1.27
Community Matrons	90.17%	N/A		1.51%	6.97%	7.83%								1	1	1	1.00
Community Therapy	86.62%	N/A		0.30%	9.77%	9.05%								1	1	1	1.00
Continence	96.54%	N/A		2.22%	0.00%	0.00%								1.21	1.11	1	1.18
Counselling	96.00%	N/A		1.95%	1.80%	1.80%								1	1	1	1.00
CRT AHPs including Clinical Triage, CRT ANPs, Hospital @	86.00%	N/A		0.33%	13.17%	13.31%								1.21	1.21	1	1.21
CRT Nursing including: Clinical Triage, CRT ANPs ,	87.80%	N/A		3.79%	13.79%	16.34%								2.05	2.05	1.05	2.05
Dermatology	49.38%	N/A		87.47%	0.00%	0.00%								2	2	1	2.00
Diabetes Nurses	94.44%	N/A		0.00%	2.22%	2.61%								1.89	1.61	1	1.75
Dietetics	64.82%	N/A		14.80%	20.79%	28.21%								2.31	2.47	1.07	2.38
District Nursing Hindley Golborne	79.37%	Dataset being developed		10.80%	6.31%	7.99%								2.95	2	1	2.48
District Nursing Leigh	116.20%	Dataset being developed		6.29%	2.94%	2.71%								2.86	2.09	1	2.48
District Nursing SWAN	53.84%	Dataset being developed		21.62%	24.44%	29.94%	4			1 / 62	0 / 5			3.4	2.25	1	2.83
District Nursing TABA	99.12%	Dataset being developed		0.00%	18.46%	20.25%								3.5	2	1.06	2.75
District Nursing Wigan North & Central	73.91%	Dataset being developed		13.18%	7.75%	7.37%								3.06	2	1	2.53
Early Years	97.89%	N/A		1.24%	0.00%	0.00%								1	1	1	1.00
Falls & Fracture Liaison - AHPs	75.47%	N/A		21.30%	0.00%	0.00%								1.67	1.67	1	1.67
Falls & Fracture Liaison - nursing	0.00%	N/A		100.00%	0.00%	0.00%								2.33	2	1	2.17
Health Visiting	65.71%	N/A		10.62%	7.60%	6.95%								1.47	1	1	1.23
Learning Disabilities - AHPs	85.58%	N/A		0.00%	0.00%	0.00%								1.32	1.05	1	1.18
Learning Disabilities - nursing	82.25%	N/A		8.40%	5.23%	1.09%								1.62	1.24	1.05	1.43
Lymphoedema	67.68%	N/A		No data available	29.77%	0.00%								2.33	3	2.33	2.67
MacMillan AHP's	97.87%	N/A		2.48%	0.00%	0.00%								1.89	1.67	1	1.79
Neuro - AHPS	75.18%	N/A		6.41%	15.32%	12.65%								1.95	1	1.86	1.48
Neuro - nursing	106.06%	N/A		0.00%	0.00%	0.00%								1.3	1	1.6	1.15
Podiatry - Ashton	81.28%	N/A		15.49%	4.30%	4.30%								2	1.62	1	1.81
Podiatry - Leigh	92.54%	N/A		3.10%	2.64%	3.80%								1.26	1.05	1	1.16
Podiatry - Wigan	85.02%	N/A		5.75%	10.64%	12.61%								1.18	1.05	1	1.11
Practice Development	13.95%	N/A		No data available	84.52%	73.96%								4.00	1.63	0.83	2.76
School Nursing	89.80%	N/A		1.89%	12.23%	7.19%								1.07	1	1	1.04
Stroke - AHPs	66.05%	N/A		5.07%	21.79%	21.36%								2	1.95	1.95	1.97
Stroke - nursing	20.00%	N/A		0.00%	0.00%	0.00%								2	1.5	2	1.75
Treatment Rooms	No data available	N/A		No data available	No data available	No data available								No OPEL data submitted in September 2021			
Wheelchair	95.55%	N/A		3.89%	0.00%	0.00%								1.95	1	1.84	1.47

Appendix 2

	August 2021		September 2021	
• No of areas	• Red Metrics Registered Staff Days	• Red Metrics Registered Staff Nights	• Red Metrics Registered Staff Days	• Red Metrics Registered Staff Nights
• 24	• **1**	• **0**	• **3**	• **6**

- *Table 1. Red Metrics in Inpatient Areas August/September 2021*

Month	Registered WTE	Unregistered WTE
July	122.66	23.39
August	95	33.12
September	85.74	39.76

Table 2. Nurse Vacancies July- September 2021 Trust Wide)

Red Flag Category	**No. of incidents May 2021**	**No. of incidents June 2021**	**No. of incidents July 2021**	**No. of incidents August 2021**	**No. of incidents September 2021**
Shortfall of more than 8 hours or 25% of registered nurses in a shift	13	34	83	63	49
Delay of 30 minutes or more for the administration of pain relief	5	6	6	10	7
Delay or omission of intentional rounding		2	8	3	5
Less than 2 registered nurses on shift	2	8	8	10	9
Vital signs not assessed or recorded as planned					0
Unplanned omission of medication				1	0
Total	**20**	**50**	**105**	**87**	**70**

Table 3. Nursing Red Flags May -September 2021

Red Flag Category	No. of Incidents May 2021	No. of Incidents June 2021	No. of Incidents July 2021	No. of Incidents August 2021	No. of Incidents September 2021
Unit on Divert			1		1
Co-Ordinator Unable to Remain Super-numerary	3			3	5
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)			1		
Delay of 30 or more between presentation and triage					
Delay of 2 hours or more between admission for induction and beginning of process					
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour					
Total	**3**		**2**	**3**	**6**

Table 4. Maternity Red Flags May-September 2021.

Title of report:	Well-being pledges
Presented to:	Board of Directors
On:	24 November 2021
Presented by:	Director of Workforce
Prepared by:	Director of Workforce
Contact details:	Alison.balson@wwl.nhs.uk

Executive summary

The NW HR Directors network ran a workshop on 21st September 2021 for Chairs, CEOs, Well-Being Guardians and Staff Side Chairs. The session included a presentation from Chris van Stolk, Senior Researcher at RAND Europe, setting out the well-being evidence base. This indicates the need to place more focus on prevention and presenteeism and to ensure that well-being is considered and managed in a holistic manner, with flexibility to consider individual circumstances and needs. We believe that this will also be recommended in a national well-being report that is due to be published in the coming months.

This requires a shift in approach, where we focus as much on keeping those who are in work well as we do in managing sickness absence. The NW has had the highest sickness rates in the NHS (and also in other sectors) and this has remained the case for many years, despite our approaches to attendance management and occupational health services being broadly aligned nationally. We know from evidence-based research that health inequalities are pronounced in many areas of the NW and with most of our colleagues live in the area, therefore this must play a part and we need to adopt a different approach if we are to improve and for this to be sustainable.

Trusts are being asked, by the end of November 2021, to discuss at their Board their reflections on the event and the pledges that we would like organisations to commit to:

1. Having holistic well-being services that support all our colleagues
2. Supporting the development and implementation of person centred, flexible attendance management policies that take account of individual circumstances
3. Supporting the development of our leaders to be comfortable and confident in managing well-being in this new way

To achieve this, the Board needs to:

- Understand the evidence base that demonstrates why a focus on presenteeism is of at least equal importance to sickness absence
- Consider the ethical and equality aspects of moving away from standardised rigid trigger-based escalation policy. Equality means meeting the needs of individuals, not treating everyone the same
- Associate this new approach to well-being with our work on embedding a just and learning culture. This will include us highlighting and addressing behaviours and cultures that may have been normalised. This aligns to the programmes of work under Our Family - Our Future - Our Focus
- Ensure that the Board hears the lived experience of our WWL colleagues and how that impacts on them personally and professionally
- Ensure that a well-being lens is applied to all decisions

Link to strategy

Well-Being (Steps 4 Wellness) is one of our pledges under the People Strategy. Nationally, there is an expectation that the well-being of our colleagues is prioritised. This is referenced in the NHS People Plan and the operational planning guidance. Shifting the focus to holistic and person centred well-being should support a culture of psychological safety in the organisation, which is essential and recognised as the bedrock of safety and innovation in the 2030 strategy.

Risks associated with this report and proposed mitigations

There is a risk that Trust management and external stakeholders continue to solely focus attention on sickness absence, rather than where the more significant productivity and patient safety risks lie (presenteeism). The NW HR Directors are working with NHSEI and NHS Employers colleagues to develop the three enabling frameworks consistently across the region. This, along with the anticipated national well-being report, which we believe will support this approach, should help to mitigate this risk.

During the pandemic, temporary resources were put in place to support an enhanced 12-month proof of concept psychological support programme, based on a stepped care model (health promotion and self help resources right through to supporting those with complex psychological needs). This has been extended to the end of the financial year, but due to a lack of job security and high demand, this service is currently having to restrict access and is seeing increasing waiting times. Continuation of this service would be essential in providing holistic well-being services in a timely manner.

Financial implications

There are no direct financial implications associated with this report, though the Steps 4 Wellness business case would require support to effectively deliver holistic well-being services to meet demand.

Research complied by Deloitte indicates that for every £1 invested in employee heath & well-being, there is a £5 return. Additionally, the evidence highlights that productivity and safety would be improved through a focus on addressing presenteeism, both of which result in costs to the Trust.

Legal implications

The Health & Safety at Work Act requires employers to ensure the health and safety of their employees.

People implications

Well-being is one of the priorities under Our Family – Our Future – Our Focus and is known to be a driver of engagement. The evidence also tells us that our people often experience issues (stress and MSK primarily) that drive work impairment or presenteeism well in advance of them actively seeking help or support. Our your voice surveys indicate that colleagues don't always feel they are treated fairly and often cite the attendance management policy as a reason for this. By taking forward the three pledges, we should see improvements in engagement.

Wider implications

NW HR Directors will be working collaboratively with well-being and occupational health professionals, staff side colleagues, NHS Employers, NHSEI, NW Leadership Academy and subject matter experts to develop the three frameworks to support the three pledges.

Recommendation(s)

The Trust Board is asked to reflect on the evidence base and pledges and support the programme of work. This will be communicated as part of Our Family – Our Future – Our Focus as a you said we did action and confirmed to NHS Employers, who are co-ordinating the work programme on behalf of the HRD network.

Assuming the Board agrees with these pledges, an enabling action plan will be shared at People Committee in December for approval at the December Board workshop.

Our pledge for the **wellbeing of our NHS people**

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Signed.....

Name.....

We pledge to shifting the focus from sickness absence (the 5%) to holistic wellbeing for everyone:

- **preparing our board for the change** to take a more holistic, person-centred individual and flexible approach, which is driven through policy and aligns with embedding a just culture.
- **evidencing that wellbeing is a priority with our board by** understanding the wellbeing of our people, giving them a voice, making sure all decisions have a wellbeing lens applied and addressing any issues.
- **committing to the three North West's themes of enabling work**
  - Holistic wellbeing services that support all of our colleagues
  - a new person-centred wellbeing approach and an attendance management policy framework
  - leadership development that supports managers in our new approach.

NHS Employers in association with NHS RAND EUROPE social partnership forum

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Equality, Diversity & Inclusion Strategy
Presented to:	Board of Directors
On:	24th November 2021
Presented by:	Director of Workforce
Prepared by:	Equality, Diversity & Inclusion leads
Contact details:	Toria.king@wwl.nhs.uk / Debbie.jones@wwl.nhs.uk

Executive summary

WWL is required to publish an approved Equality, Diversity and Inclusion (EDI) Strategy and annual objectives. Due to the Covid-19 pandemic, our strategy has expired and the Trust Board agreed to delay the development and publication of our new strategy to ensure that the inequalities exposed by the pandemic could be addressed in our strategic approach.

Consultation processes have taken place with relevant stakeholders, patient representation groups and our colleagues to ensure that our strategy is relevant and addresses the inequalities experienced by residents, patients and colleagues with protected characteristics. Feedback from these stakeholders has been reflected in the strategy.

The strategy has been supported by the Executive Team and key elements have been socialised with wider Trust leadership and networks.

The governance structure ensures that there is equal emphasis on service and employment, with reporting through the Quality & Safety Committee and People Committee respectively. It also recognises the need for partnership working within the Borough if we are to achieve maximum impact and benefit. For this reason, the governance arrangements include links with Healthy Wigan Partnership.

The strategy is based around 3 aims:

- Increasing diversity & accessibility
- Eliminating inequality
- Improving the experience for protected groups

If approved by the Trust Board, we intend to produce a fully designed strategy document that will be used in the new year for formal launch activities, including the expansion of staff networks as key influencers in decision making and in supporting awareness raising through the sharing of lived experiences.

The WWL Way

Link to strategy

The EDI strategy is an integral part of the Trust's People Strategy and is an intrinsic requirement in understanding our local population and their health needs, ensuring that we can provide the best possible services for our patients.

Risks associated with this report and proposed mitigations

This strategy reduces risk to the Trust, as it addresses our statutory obligation under the Equality Act. However, EDI must live and breathe in WWL if we are to truly be an inclusive employer and provider of health services. It is therefore proposed that all senior leaders within WWL have an EDI related objective agreed in their annual appraisal.

Financial implications

There are no direct financial implications associated with this strategy.

Legal implications

Under the Equality Act and the Public Sector Equality Duty, WWL has a statutory requirement to publish an approved EDI strategy and objectives. Objectives will be agreed annually with key performance indicators that support an improvement trajectory.

People implications

Staff networks will form a crucial means to provide colleagues with a safe space, to build awareness and help the Trust management identify actions that will improve services for patients and make WWL a more inclusive employer.

Wider implications

Covid-19 exposed health inequalities that need to be addressed through partnership working across the Borough. Additionally, collaboration with locality partners will be essential as we look to eliminate inequality and promote social mobility.

Recommendation(s)

The Trust Board is asked to:

1. Approve the EDI strategy for publication, with a designed version to follow in the new year
2. Support the development and expansion of our staff networks
3. Promote EDI collaboration with partners in the borough
4. Delegate the development and monitoring of the annual EDI objectives, with performance measures, to the relevant sub-committee
5. Support the cascade of EDI objectives for all leaders (including senior medical staff) in the 2022-23 appraisal year

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Equality, Diversity and Inclusion Strategy 2022-2026

The WWL Way

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Executive Summary

Strategy development process

A communications and engagement framework was developed in September 2021 to enable us to gather thoughts, feedback and ideas from key internal and external stakeholders on our proposed strategy themes and aims. A consultation period was undertaken during October 2021, as we wanted our strategy to reflect the priorities of our colleagues and patients, as well as aligning with our local and national people and service priorities.

What is Equality, Diversity, and Inclusion (EDI) to WWL?

Although we use the term equality throughout this strategy, we acknowledge that what equality means for WWL is true equity and this may mean not treating everybody in the same way, because their needs may differ. Taking positive action to address structural and unconscious bias is the way to achieve real inclusion.

Why an EDI strategy?

We care

WWL wants to be an inclusive employer and service provider and recognises that it has improvements to make. Equality, diversity, and inclusion are the right thing to pursue. They impact on wellbeing, feelings of value and belonging and if we get it right, we can boost morale and confidence. Setting out our EDI strategy lays the pathway for us to focus on the inclusion work that matters most to our patients and our colleagues. We want all our patients and colleagues to know that we are here for them, no matter who they are. Our strategy sets out how we will get to that inclusion goal.

It makes good business sense and improves quality of care

In these challenging times, using the talents of the whole workforce is more important than ever. Considering the diversity of our workforce and ensuring that WWL is an inclusive place to work will enable our people to work with less stress and help enable the psychological safety required for innovative ideas to flourish. This ultimately leads to better patient care.

Making the most of everyone's skills, working patterns and potential is vital for success. Respecting the diversity of Greater Manchester and our local areas will help us to have access to the widest possible pool of talent and competitive advantages that come with it. Fostering an inclusive culture at WWL will help us to retain these valuable people.

As the diversity of our community evolves, we need to ensure that we can understand, reflect on, and deliver services that meet their needs as they develop. We commit to working with patients, local residents and groups representing patients and protected groups in the design, review and delivery of our services. This should also result in better informed decision-making and policy development, leading to services that are more appropriate for our residents and patients, and services that are more effective and cost-effective.

We have legal duties

There are several equality-based national laws and guidelines which mandate and guide how NHS organisations should demonstrate equality. The principal equality drivers include:

Legislation	**Requirement**
The Human Rights Act 1998	The Human Rights Act is underpinned by the core values of Fairness, Respect, Equality, Dignity and Autonomy for all. All public bodies must comply with the convention rights.
The Equality Act 2010	Protection from discrimination based on 9 protected characteristics - Age - Disability - Ethnicity - Gender reassignment - Marriage & Civil Partnership - Pregnancy & Maternity - Religion or Belief - Sex - Sexual Orientation

General Equality Duty	To eliminate unlawful discrimination, harassment, and victimisation. Advance equality of opportunity. Foster good relations.
Public Sector Equality Duty From 5 April 2010	To Publish relevant, proportionate information demonstrating compliance with the Equality Duty To analyse effect of policies and practices on equality. Set specific, measurable Equality Objectives.
Accessible Information Standards	DCB1605 Accessible Information (formerly SCCI1605 Accessible Information) – the 'Accessible Information Standard' – directs and defines a specific, consistent approach to identifying, recording, flagging, sharing, and meeting the information and communication support needs of patients, service users, carers, and parents, where those needs relate to a disability, impairment, or sensory loss.
Gender Recognition Act 2004	The GRA legislation provides a mechanism to allow trans people to obtain recognition for all legal purposes to their preferred gender role.
Workforce Disability Equality Scheme (WDES) **From April 2019**	The Workforce Disability Equality Standards (WDES) is a set of specific measures that will enable NHS Organisations to compare the experiences of disabled colleagues to non-disabled colleagues, this will then be sued to develop any required actions
Workforce Race Equality Standard (WRES) From 1 April 2015	Must demonstrate through the nine-point Workforce Race Equality Standard (WRES) metric how we are addressing race equality issues in a range of staffing areas. Must demonstrate progress against several indicators of workforce equality, including a specific indicator to address the levels of BAME Board representation. This will be included in the Standard NHS Contract.

We have a role as an anchor institution

WWL, as an anchor institution in the Wigan Borough, has a responsibility to advance the welfare of the population we serve. We have sizeable assets that can be used to support local community wealth building and development, through procurement and spending power, workforce and training, and buildings and land. By working and engaging with our community, we should develop strategies to increase opportunities and narrow the inequality gaps that exist within the Borough. This has never been so important, given the health inequalities that the COVID-19 pandemic has exposed.

Links to national & local strategies

The NHS People Plan talks about the NHS needing more people, working differently in a compassionate and inclusive culture. What WWL aims to deliver with its EDI Strategy will help to achieve that goal.

WWL's 2030 Strategy is based around our 4Ps (Patients, People, Performance and Partnerships).

WWL's 2030 Strategy	How we can deliver this through the EDI Strategy.
Patients	Understanding the needs of our population and working with them to design and deliver services that meet the needs of all our patients.
People	Providing good employment opportunities for people who understand and represent the community we serve and creating a caring, inclusive, respectful working environment where everyone can flourish.
Performance	We strive to be ambitious in our aims and will measure how we perform against key equality, diversity and inclusion measures.
Partnerships	Whilst there are things we can take forward on our own, there's more we can achieve by working together with our system partners in the Borough.

The EDI Strategy also aligns with each pledge in WWL's People Strategy (People Promise) 2020-2025:

WWL's People Promise pledges	How we will deliver this through the EDI Strategy
Employment Essentials - Uphold and protect your employment rights	• Pursue inclusive recruitment and selection processes • Eliminate inequality in employment/HR processes
Your Voice Matters – Do our best to make your working life enjoyable	• Amplify diverse voices • Eliminate Bullying, Harassment, Discrimination and Violence
Learn and Grow – Help you to be the best you can be	• Widen participation in personal and professional development
Steps 4 Wellness – Look after your health	• Improving inclusion will reduce stress and will benefit the mental health of our colleagues.

Who we serve

Our local community

Based on recent research and LGBT inequalities data it is estimated that there are **15,000 Lesbian, Gay or Bisexual Wigan Residents 2,500 People who identify as trans in Wigan**

21.5% of Wigan residents are living with a limiting long-term illness, health problem or disability which limits daily activities or work (Census, 2011). **Higher than the national average at 17.9%.**

The Royal National Institute for Deaf People (RNID) estimates that:

60,500 residents in **Wigan** were living with hearing loss in 2019. (RNID, 2020a)

Hearing Loss affects more than **12 million** people across the **UK**. (RNID, 2020b)

The Royal National Institute of Blind People (RNIB) estimates that:

10,200 residents in **Wigan are living with sight loss in 2021.** (1,340 are living with severe sight loss). It is estimated this number will increase to **11,300 in 2025.**

(RNIB, 2021)

Although Wigan is the least ethnically diverse borough in the County, **migration has significantly changed the wealth of diversity in Wigan** since the last census and there has been significant demographic change within Wigan Borough.

Wigan CCG (2019) report that **patients with disabilities often report barriers to using health services: transport; distance; support; poor communication** - All being reviewed within Wigan Borough Locality Plan.

ONS estimate that:

19.1% of the Wigan population were aged over 65 mid 2019. (ONS, 2020)

The number of residents in the Wigan Borough aged 65 and over is projected to increase to 24.9%. by 2037. (ONS, 2013)

The age of patients accessing hospital services is bias towards the older population, reflecting greater healthcare needs.

Dementia is projected to rise – 1 in 6 people aged over 80 years have dementia. (Alzheimer's Society)

People with **learning disabilities are more than 3 times as likely to die of preventable causes.** (LeDeR Annual Report, 2020)

Higher % of Black and Minority Ethnic Groups using maternity services (12%) than overall out-patient/ in-patient activity (4%).

Health Inequalities

Levels of deprivation are significantly worse than the England average. Wigan has a registered population of 320,000. Nearly 100,000 of these are part of the most deprived 20% in the country. (Wigan CCG, 2018)

Life expectancy for both men and women is lower than the England average. Life expectancy is 11.1 years lower for men and 8.8 years lower for women in the most deprived areas of Wigan than in the least deprived areas. (PHE Local Authority Health Profile, 2019)

Almost a quarter of Wigan residents have long term illnesses. Emergency hospital admissions for self-harm, depression and dementia are higher than they should be.

Our Workforce

88.5% of colleagues are of White Ethnicity. This figure remains lower than the **Wigan borough figure of 97.3%.**

57% of colleagues who have disclosed their religion and belief describe themselves as **Christian** compared to a Wigan borough figure of 78%.

Workforce profile remains predominantly **female at 81%** whereas the local population is 50.3% female.

2.6% of the Trust's workforce declared having a **disability**. This figure remains lower than the **Wigan borough figure of 21.5%.**

75% of colleagues describe themselves as heterosexual.

WRES (Workforce Race Equality Standard)
The Trust's Black, Asian and Minority Ethnic (BAME) representation is currently 10% compared to 3% BAME for the Wigan Borough. A large percentage of BAME employees are within clinical colleague groups and in particular the Medical & Dental colleague group. Data highlights that BAME colleagues compare negatively to White colleagues in areas of formal disciplinary, Bullying & Harassment.

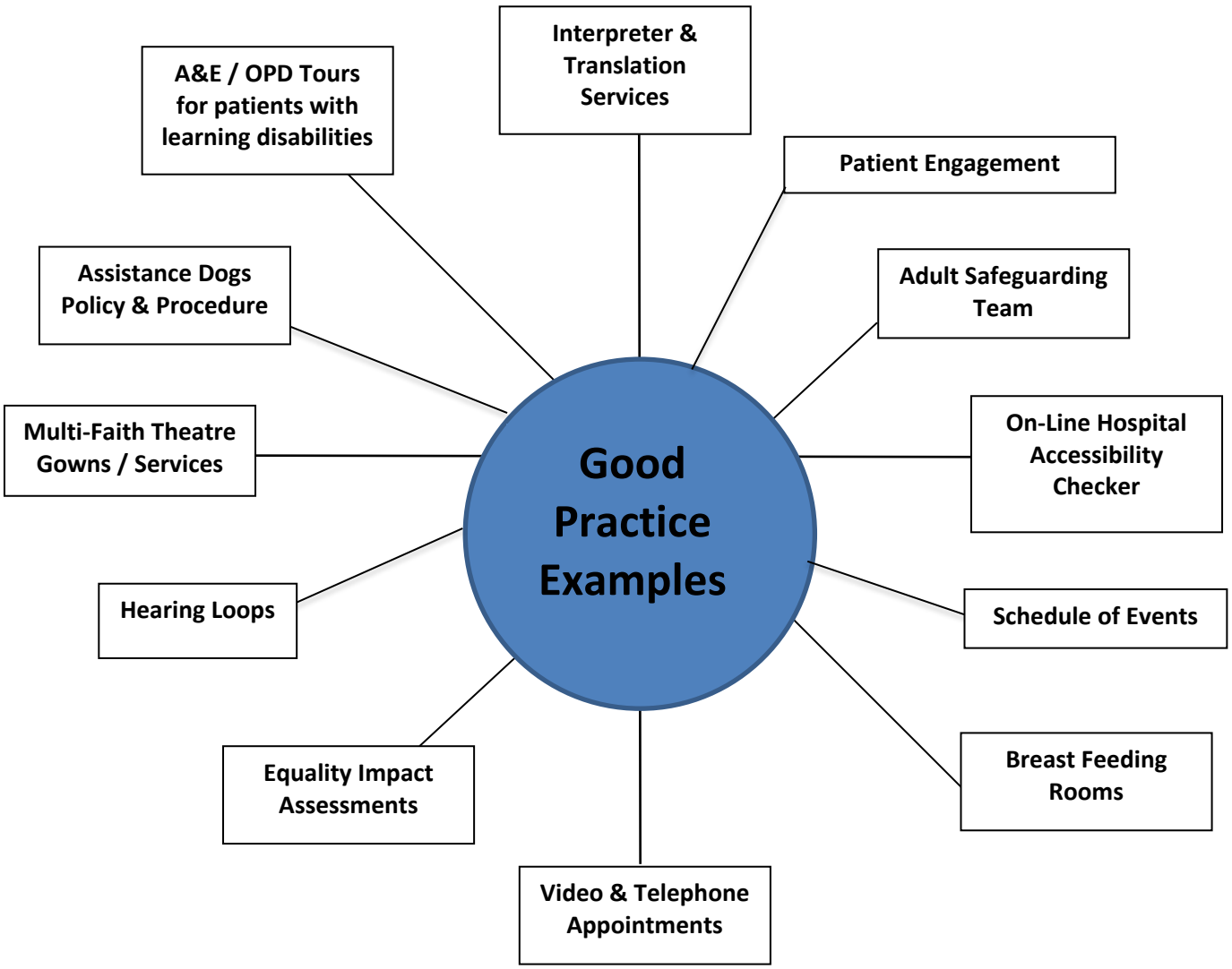
WDES (Workforce Disability Equality Standard)
Disability declaration rates within the trust are currently at 2.6%. Data highlights that disabled colleagues compared negatively to non-disabled colleagues in areas of Career Progression & Promotion, Bullying & Harassment and feeling their work is valued by the Trust.

Gender Pay Gap
The data highlights as of 31 March 2020 the Trust has a 31.46% mean average gender pay gap with females earning £6.86 an hour less than males. As at March 2020 the Trust has a 15.14% median hourly rate gender pay gap with females earning £2.35 an hour less than males.

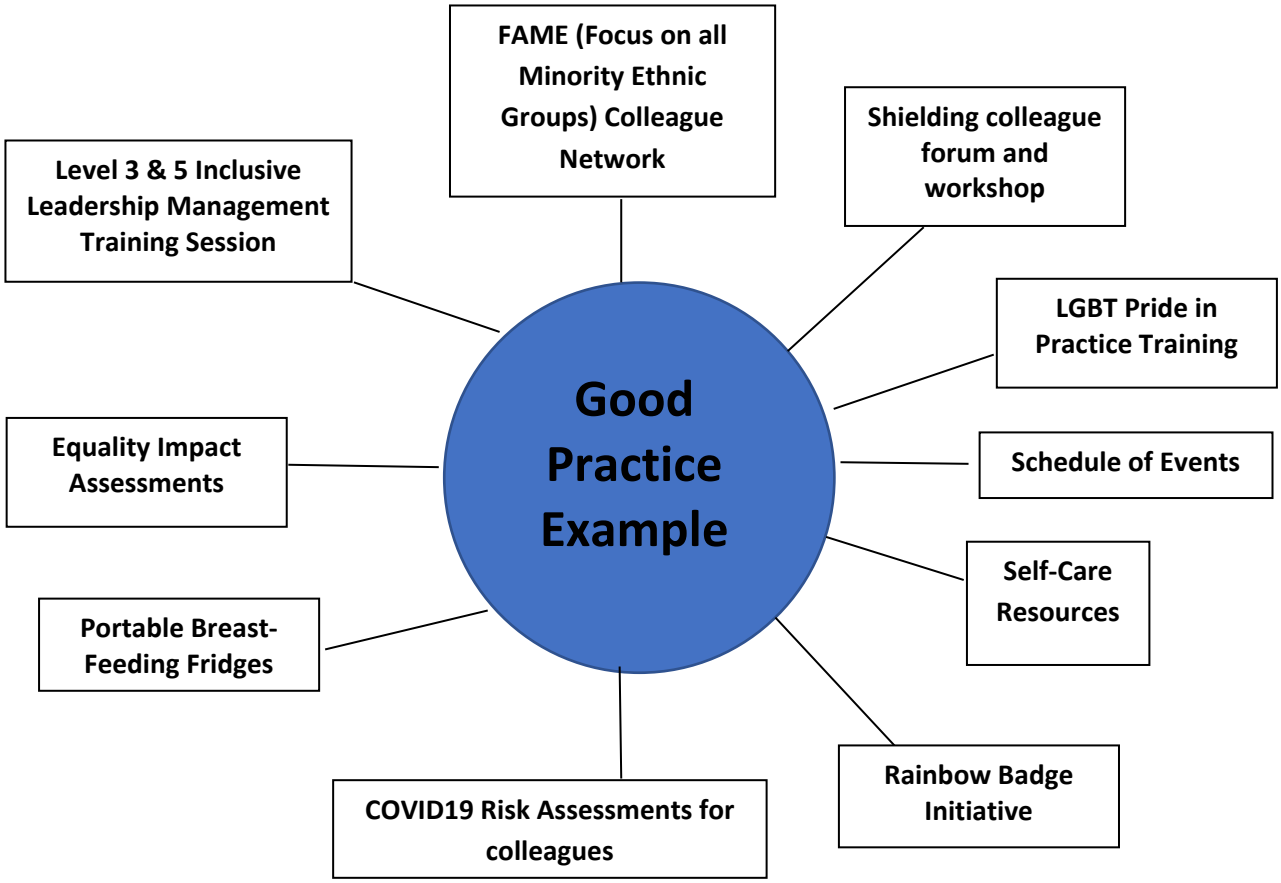
Where we are now

The Trust recognises the importance of equality, diversity and inclusion and the value that it adds.
Our Annual EDI Report provides an update on the achievements, progress, and developments in relation to the EDI agenda at WWL. This report highlights our good practice, some of which are illustrated in the two diagrams below:

Our Patients



Our People


Good Practice Example
FAME (Focus on all Minority Ethnic Groups) Colleague Network
Shielding colleague forum and workshop
Level 3 & 5 Inclusive Leadership Management Training Session
LGBT Pride in Practice Training
Equality Impact Assessments
Schedule of Events
Self-Care Resources
Portable Breast-Feeding Fridges
Rainbow Badge Initiative
COVID19 Risk Assessments for colleagues

Covid Health Inequalities

COVID-19 has exposed some of the health and wider inequalities that continue in our society. It has become increasingly clear that COVID-19 has had a disproportionate impact on many who already face disadvantage and discrimination. The impact of the virus has been particularly harmful on people living in areas of high deprivation, on people from Black, Asian and minority ethnic (BAME) communities, on older people, men, those with a learning disability and others with protected characteristics:

- Covid-19 vaccine hesitancy is around five times higher among Black or Black British adults compared with White adults (ONS, 2021a).
- Mortality rates due to Covid-19 were significantly higher for men than women across all age groups. (ONS, 2021b).
- During the second wave South Asian ethnic groups, especially Pakistani and Bangladeshi groups, were at the greatest risk of death from Covid-19. (ONS, 2021b).

To respond to COVID-19 and begin to restore services, there is a need to increase the scale and pace of NHS action to tackle health inequalities to protect those at greatest risk.

Where we want to be & how we will get there

There are broadly three main aims in this EDI strategy, under which our Patient and People objectives lie. These are:

Increase diversity and accessibility:

Our Patients

We fully recognise that people access services in a range of different ways and may encounter different barriers in doing so. Our aim is to effectively engage with our local communities and organisation representing protected groups to understand their diverse needs, and then to provide services which meet these local needs. The impact of COVID-19 will mean that we will continue to look at alternative ways of engaging with colleagues, the public and partners where face to face appointments cannot take place or are not appropriate.

We know that the Wigan Borough has a growing elderly community and that the age of patients accessing hospital services is bias towards the older population, reflecting greater healthcare needs. We know that 21.5% of our local population are living with a disability and that disability is more likely to affect older adults over State Pension age. We know that patients with disabilities often report barriers to using health services and people with learning disabilities have higher levels of unmet need and receive unequal access to treatment.

We recognise that people in our community have different needs and qualities. Understanding the diversity and needs of our local population can help us to plan and deliver services better. To achieve this, we need to engage with our communities to better understand their needs based on their protected characteristics. We need to review our approach to service redesign, ensuring that inclusion and diversity are central to community engagement, consultation and decision making to ensure that the patient voice is heard. Engagement is extremely important to us. We recognise that the key to improving services is by working in partnership with patients and local stakeholders.

Our People

We know that we do not proportionately represent the diversity of our workforce in all areas and at all levels in the Trust. We aim to achieve a more diverse colleague mix at all levels, with an initial focus on leadership positions. We will use our people data to identify areas to target and will trial non-traditional recruitment and selection pathways that are more inclusive to those who we are least representative of in our workforce. We will eliminate all sources of bias in the recruitment and selection processes to enable our people to go as far as their talent takes them.

Eliminate inequality

Our Patients

We are committed to tackling health inequalities and understand that some groups of people, including protected characteristic groups, experience different access, experience, and outcomes when they use NHS services which can lead to inequalities affecting different groups of patients, families, and carers.

Health inequalities remain a key challenge for Wigan Borough. We know that some groups of people within the community experience greater levels of inequality than others, for example due to age, ethnicity, gender, disability, sexual orientation, socio-economic status. Levels of deprivation in Wigan are significantly worse than the England average. People living in deprived areas on average have poorer health and shorter lives. We know that socially excluded groups (homeless people, gypsies and travellers, sex workers and migrant groups) who often need support and help to navigate the health system effectively access healthcare in ways which do not necessarily meet their needs – such as an over-reliance on A&E services.

The COVID-19 pandemic has further exposed and magnified the health and wider inequalities experienced by some in our society. Research shows that COVID-19 has had a disproportionate negative impact upon certain groups, including those living in the most deprived neighbourhoods, people from minority ethnic communities, older people, men, and those who are obese and who have other long-term health conditions. NHS England has set out recommended guidelines and actions to increase the scale of progress of reducing health inequalities. Along with these guidelines and actions, we will continue to work with our partners and local communities to ensure that health inequalities are considered, tackled, and monitored during the COVID-19 recovery phase and beyond.

Our aim is for every patient to receive the same high quality of care, regardless of where they live, what health condition they are experiencing, or any other personal characteristic that may affect their experience of accessing health care services. We want to identify where there are health inequalities in our services and have systems in place to tackle these in an open and transparent way. We want to ensure inequalities are flagged and transformed into improvement measures. To achieve this, we will build on and improve established links with community and third sector services. Through engagement, we will consider the way in which socially excluded groups access and use healthcare. We will promote and raise awareness of access to appropriate health services. We will ensure Equality Impact Assessments are completed for all services and provide evidence that these have informed decision making.

Undertaking Equality Impact Assessments (EIAs) helps us to understand how our policies, procedures and functions may affect different groups of people. We use EIAs to help us identify what we need to do better to meet people's needs. EIAs help us to think about how what we do may impact on all members of the community and provide us with an opportunity to consider how we can further promote inclusion and diversity in everything we do. The culture of EIAs will be pursued to provide assurance that the Trust has carefully considered any potential negative outcomes.

Our People

WWL, as with most employers, has a gender pay gap that it must start to tackle specifically. Recognising that reducing our gender pay gap to zero is something to be worked on in a long-term plan, we still seek to reduce the gap each year. WWL also seeks to reduce our Black, Asian, and Minority Ethnic (BAME) and disability pay gaps. Our first steps will be to identify contributing factors to our pay gaps before putting in place positive action for the affected groups. The positive action will be evidence-based to ensure its effectiveness.

Eliminating inequality can only be achieved if we know about the lived experience of our people. Amplifying the voices of our colleagues using colleague diversity networks will be key to us working on the issues that matter most to our people. Only then will we hear about issues of bullying, harassment, discrimination and/or violence that need to be addressed at our Trust.

WWL provides its employees with many opportunities for personal and professional development. However, we want to be sure that the opportunities are taken up by a diverse range of colleagues. We will improve the attractiveness, relevancy, and accessibility of our wellbeing, learning and development and engagement initiatives to all colleagues.

Improve experience for protected groups

Our Patients

The involvement of patients, their families and others with lived experience in the planning and development of health care services has been shown to improve the health and quality of life of patients. Involving patients with service design has been recognised as an important element in achieving patient centred care. Patient involvement offers the potential to target service redesign to patient needs, thus improving the patient experience and quality of care. We already have strong links with local community groups who help us to shape and improve our services. We will build on these relationships to not only listen but routinely act on their feedback, comments and suggestions.

Developing a culture where patient experience considerations are at the heart of any key service change or development is fundamental. WWL is very keen to embed the philosophy of 'nothing about me, without me'. We will ensure that patients from all protected characteristics have assurance that their voices have been heard and informed the provision and development of health care services through patient informed design. We will continue to improve patient and colleague experience by using methodologies such as Experience Based Design (EBD). The EBD approach is a method of designing better experiences for patients, carers, and colleagues. The approach enables healthcare providers to understand the experience of healthcare from the patients, carers, and colleague's perspective. It is through these stories that we can begin to understand not just the care journey, but the emotional journey people experience when they come into contact with a particular pathway or service. Once we can understand this, we can improve care in ways that matter most to people who use it and the people who deliver it.

We know that the borough has a higher proportion of people from Black and Minority Ethnic groups than the 2001 Census indicates. Although Wigan is the least ethnically diverse borough in the county, migration has significantly changed the wealth of diversity in Wigan. Wigan Borough has received a sizeable number of refugees and migrants over the last decade and it is likely that the population will become more diverse over the coming years.
Dealing with these population changes will pose some significant challenges in terms of delivering responsive and appropriate services across a range of diverse communities and groups of people. The need for good communication between colleagues and service users is essential for the delivery of high-quality care. To achieve this, we will review the effectiveness of our interpretation and translation services to ensure that patients can be communicated with appropriately and effectively as timely as possible. We are committed to ensuring all service users have equal access to services, considering the barriers that may be created due to language or impairment.

Our People

WWL is proud of the diversity of its people. Physical diversity characteristics such as race, age, or sex positively influence performance because team members' contributions are unique based on their lived experiences. Therefore, teams who embrace the diversity within themselves are the happiest, and most effective. Over the recent past, WWL has employed many colleagues from overseas and the cultural integration of these colleagues into our Trust is a priority. But aside from ethnicity, we recognise that *all* our differences are to be celebrated. We want our people to feel like one big work family and this EDI strategy aims for that goal by setting inclusive teamworking as a main lever.

Improving the experience for protected groups will improve the working experience for all our colleagues and will create a more successful, stable workforce that delivers fantastic patient care.

Moving words into action

We aim to become actively inclusive as a Trust. This involves being intentional about our actions for change and continually reviewing our progress. The table below demonstrates how we will achieve the objectives set out in our strategy. Each year, WWL produces an action plan, within which the yearly priorities are identified. Each year will build on the last but will always be aligned to the objectives and be based around the five principles of:

Prioritise:
Our organisation is committed that equality, diversity, and inclusion matter. Our executive leaders will have EDI objectives in their PDPs that they will be proud to talk about, and each of our colleague diversity networks will have an active executive champion. Like all prioritised tasks, EDI will be given the time and resources to become the golden thread that ties all our people and patient services together.
Understand:
WWL will be intentional about understanding the experience of those from protected groups. This involves collecting and analysing data, but also involves listening and learning from lived experience. WWL recognises how important it is to hear from more than one perspective. Therefore, leaders will actively seek to hear from a diverse range of voices and to limit the weathering effect sharing lived experiences can have if the same individuals are always asked to speak. Representatives from each of our colleague diversity networks will have an opportunity to present to the board at least annually, to share their lived experience. As well as hearing the lived experiences of colleagues, we will undertake meaningful patient and public engagement to involve, collaborate and coproduce improvements to quality, ensuring that patients have assurance that their voices have been heard and used to inform the provision and development of healthcare services through patient informed design.
Grow:
Senior leaders will role model inclusion and communicate their desire for diversity at all levels. Our talent pipelines will be unblocked to allow our people to go as far as their talents take them. Middle leaders will have a PDP goal agreed around EDI. Positive action/stretch projects will be available to give people from protected groups the experience and exposure to support with career progression. Senior leaders will work in partnership with our local partners and communities to ensure health inequalities are considered, tackled, and monitored.
Act:
Assurance frameworks will not be used as tick box exercises. Instead, they will be used to prioritise, leverage, and monitor real change. We will also act in partnership with other organisations to enable change to occur at the highest levels. Colleagues will build knowledge and capacity to complete high quality action focused equality impact assessments.
Review:
Leaders at all levels will take a responsibility to understand how their area is performing in relation to key EDI targets and EDI performance will be fed back regularly according to the governing structure outlined in Section 8 of this Strategy document.

Our Patients		
Aims	**Objectives**	**How we will achieve our objectives**
Increase diversity and accessibility	• Understand and improve the experience of patients across all protected characteristics. Ensure our services meet their needs. • Implement an infrastructure for service equality monitoring and roll out accordingly. • Identify variations in access, safety and experience of our services and develop plans to address these. • Meet the information and communication needs of patients, their families and carers with a disability, impairment, or sensory loss by completing the implementation of the Accessible Information Standard	• We will engage with our local community and organisations representing protected groups to understand their experiences of patient services and use this feedback to influence and improve accessibility. • We will work with colleagues, patients, families, and communities to improve the way we collect and use data. • We will ensure all policies, guidelines, business cases, services and tenders will be equality impact assessed across all protected characteristics. • We will embed the Accessible Information Standard (AIS) into all procedures and systems ensuring colleagues understand their roles and responsibilities in delivering the AIS.
Eliminate inequality	• Identify inequalities in our service delivery and develop targeted initiatives to improve them.	• We will build knowledge and capacity to complete high quality action focused equality impact assessments. • We will work in partnership with our local partners and communities to ensure health inequalities are considered, tackled, and monitored during the COVID 19 recovery phase and beyond. • We will further integrate our physical, mental health and learning disability services by working closely with partners to improve experience and outcomes.

Aims	Objectives	How we will achieve our objectives
Improve experience for protected groups	• Develop a culture where patient experience considerations are at the heart of any key service change or development, embedding the philosophy of 'nothing about me, without me'. • Ensure that patients from all protected characteristics have assurance that their voices have been heard and informed the provision and development of health care services through patient informed design.	• We will undertake meaningful patient and public engagement to involve, collaborate and coproduce improvements to quality with our services users, patients, and communities. • We will continuously seek to better patient experience – from our patient experience design projects to our review of FFT scores, complaints, and other patient experience measures. • We will listen to our patients; ensuring we hear from voices representative of our diverse patient populations – including seldom heard groups, using a variety of proactive methods. We will have in place an engagement plan for engaging with diverse patients, their families, and carers. • We will review the effectiveness of our interpretation and translation services to ensure that patients can be communicated with appropriately and effectively as timely as possible.

Our People		
Aims	**Objectives**	**How we will achieve our objectives**
Increase diversity and accessibility	• Pursue inclusive recruitment and selection processes	• We will be data driven to identify inequities in the workforce, such as 'glass ceilings. • We will use data to identify if any stages of our recruitment process produce a set of successful candidates who are not representative of the initial applicants and will address these inequities. • We will use Race Equality Code standards to improve race inequality in the boardroom and senior leadership team. • We will maintain our Disability Confident Employer status. • We will explore less-traditional recruitment practices to enable us to attract and appoint candidates from a diverse range of backgrounds. • We will ensure that secondment opportunities are appointed fairly.

Aims	Objectives	How we will achieve our objectives
Eliminate inequality	• Address our pay gaps	• We will identify contributing factors to our gender, ethnicity and disability pay gaps and provide positive action for groups who are experiencing a pay gap, e.g., coaching, mentoring, role model profiles and talent development programmes.
	• Amplify diverse voices	• We will develop our existing and create new strong colleague networks for diversity groups. Each network will have an executive sponsor and will be made up of members and allies. Networks will have 4 functions: **1.** To exist as a safe space for those who share the protected characteristic to network with each other. **2.** To be consulted via different mechanisms on key decisions in the Trust that affect our people or our service users. **3.** To use their lived experience to improve our inclusive culture. **4.** To work on projects that improve the working culture for those who share the protected characteristic that they represent. • We will investigate whether we are hearing from colleagues from all backgrounds when we go out with surveys and if not, we will explore ways to improve this.
	• Eliminate inequality in employment/HR processes	• We will ensure that flexible/agile working policies are clear and that managers have confidence to use them well for the benefit of their colleagues and their service. We will monitor flexible working requests and the outcomes of these. • We will review our HR policies to ensure they are inclusive. This will be underpinned by quality Equality Impact Assessments that are reviewed by diversity networks. • We will monitor PDR compliance data and ensure compliance is consistent across colleague groups. • We will collect feedback about PDR experience and take associated actions to improve this.
	• Reduce bullying, harassment, discrimination, and violence (BHDV)	• We will work to identify themes and hotspots for colleague-on-colleague and patient-on-colleague BHDV and promote a transparent escalation pathway that our people feel empowered to use if they witness or face BHDV. This will be built on our WWL behaviour framework and underpinned by a robust EDI awareness programme.
	• Widen participation in personal and professional development	• We will improve attraction, accessibility, and experience for all protected groups for learning and development opportunities, engagement events, wellbeing opportunities and our communication methods.

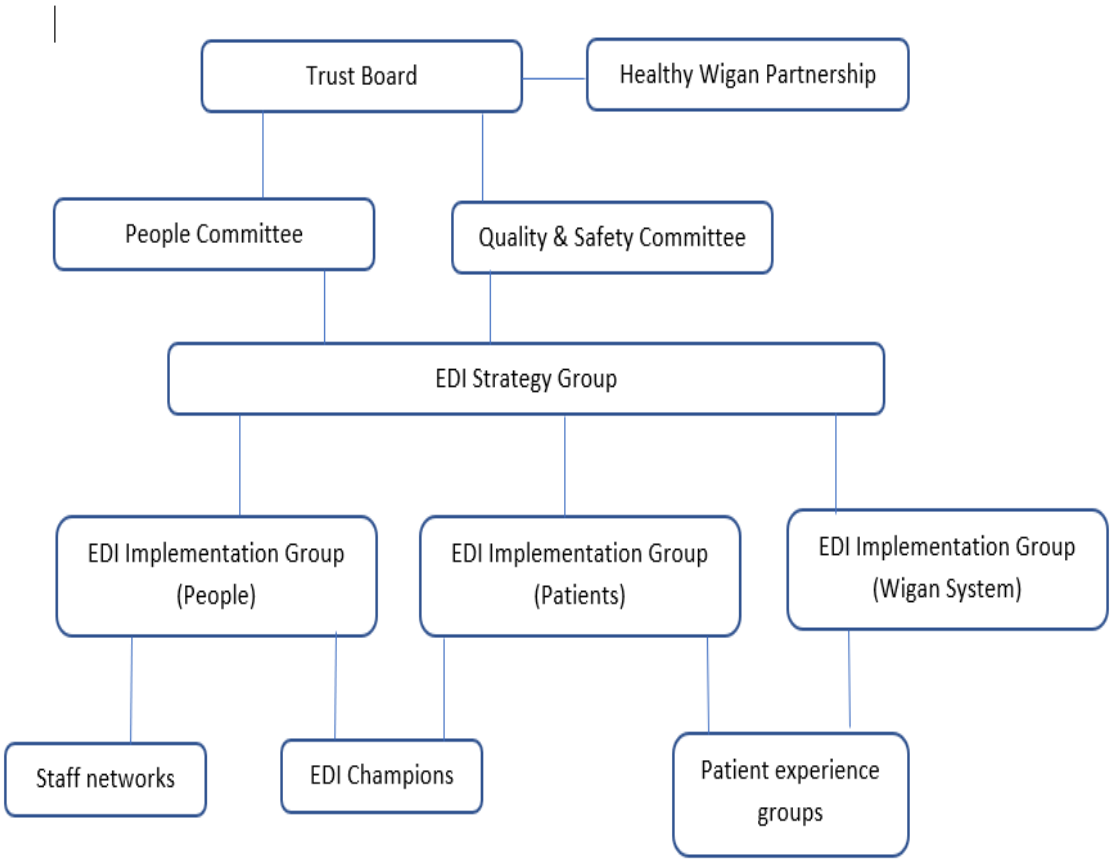
		• We will explore positive action for development such as reciprocal mentoring and redefining our interview panel makeup.

Aims	Objectives	How we will achieve our objectives
Improve experience for protected groups	• Foster inclusive teams	• We will expect and support leaders at all levels to demonstrate their commitment to tackling workplace inequalities. • We will identify and deliver against training needs for our people on health and workplace inequalities that exist for people from protected groups. • We will explore how to foster inclusive teams now that some team members may be working remotely more often. • We will celebrate the diversity of our colleagues who we have employed from overseas and seek opportunities to support them and their teams to achieve cultural integration. • We will use the phase 2 Rainbow Badges awards scheme to assess our LGBTQIA+ inequities and to provide an action plan to tackle these. • We will encourage colleagues at all levels to adopt an actively inclusive approach to EDI: promoting a learning culture where all colleagues are allies to each other. An example of this is anti-racism (it is not enough to be 'not racist', we must all take action to eliminate racism that exists within structures, and the same goes for other protected characteristics).

Governance structure

Historically, EDI has reported through the Trust's People Committee to Trust Board. We will increase the awareness and strategic importance of EDI by reporting assurance of progress against the EDI strategy through both the Quality and Safety Committee and People Committee, with each paying particular attention to the relevant components.

The governance structure is shown below.



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Glossary of key terms

A

Act
A law or piece of legislation passed by both Houses of Parliament and agreed to by the Crown, which then becomes part of statutory law (i.e., is enacted).

Action Plan A practical and realistic plan, with an agreed timetable and targets, showing how an employer is planning to achieve the aims of their Equality Strategy.

Access
Access refers to the mechanisms by which people with a range of needs (such as disabled people, people with children, people whose first language is not English) find out about and use services and information.

Age
This refers to a person belonging to a particular age group, which can mean people of the same age (e.g., 32-year-olds) or range of ages (e.g., 18 - 30-year-olds, or people over 50).

Asexual
A person who does not experience sexual attraction. Some asexual people experience romantic attraction, while others do not. Asexual people who experience romantic attraction might also use terms such as gay, bi, lesbian, straight and queer in conjunction with asexual to describe the direction of their romantic attraction.

B

Bisexual
Bi or bisexual is an umbrella term used to describe a romantic and/or sexual orientation towards more than one gender.

Black and Minority Ethnic (BME) Groups
A national definition used to describe a group of people who differ in race or colour or in national, religious, or cultural origin from the dominant group, often the majority population of the country in which they live.

C

Carers
People who look after a relative or friend who need support because of age, physical or learning disability or illness, including mental illness. There are nearly 5.7 million carers in Great Britain. Carer does not mean care-worker or care staff of any kind, who are paid to provide care as part of a contract of employment. Parent Carer - by parent carer we mean a parent of a disabled child. Parents will often see themselves as parents rather than carers, but their child will have additional care needs and may be entitled to additional services. Young Carers - this means carers who are under the age of 18. The person receiving care is often a parent but can be a brother or sister, grandparent or other relative who needs support. There are estimated to be between 20 and 50,000 plus young carers in the UK.

Care Quality Commission (CQC)
The CQC regulates all health and adult social care services in England, including those provided by the NHS, local authorities, private companies, or voluntary organisations. The CQC makes sure that essential standards of quality and safety are being met where care is provided, from hospitals to private care homes. It has a wide range of enforcement powers to act on behalf of people who use services if services are unacceptably poor.

Consultation

Asking for views on policies or services from staff, colleagues, service-users, or the public. Different circumstances call for different types of consultation. For example, consultation can include public meetings, focus groups, surveys, questionnaires, and meeting with experts.

D

Direct Discrimination
Less favourable treatment of a person compared with another person because of a protected characteristic.

Disability
A person has a disability if he/she has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.

Discrimination
This term is used here in the sense of unfair discrimination i.e., using information, which is unfair, or irrelevant to influence a decision on the way someone is treated.

Diversity
The differences in the values, attitudes, cultural perspective, beliefs, ethnic background, gender identity, sexuality, skills, knowledge, and life experiences of each individual in any group of people. This term refers to differences between people and is used to highlight individual need. It can be used inappropriately as an alternative to equal opportunities. It avoids reference to discrimination and the equality impact that power imbalances have on different communities.

E

EDI
Equality, Diversity, and Inclusion

Ethnicity
An individual's identification with a group sharing any or all of the following: nationality, lifestyles, religion, customs, and language.

Equality Impact Assessments
This mechanism/assessment supports staff to analyse how a policy / service impacts on various groups of people within the community. To ensure there is no discrimination against patients / staff and service users.

Equal Opportunities
The development of practices that promote the possibility of fair and equal chances for all to develop their full potential in all aspects of life and the removal of barriers of discrimination and oppression experienced by certain groups.

Equality Groups (now legally referred to as Protected Characteristics)
These are the 9 commonly used classifications (protected characteristics) for examining equality and diversity issues:
- Age
- Disability
- Gender
- Race
- Religion or belief
- Sexual Orientation
- Marriage & Civil Partnership
- Pregnancy and Maternity
- Gender Reassignment

Equity

This term is defined as the quality of being fair or impartial or something that is fair and just. This may mean not treating everybody in the same way, because their needs may differ.

Experience
The way a person feels about using a service, product, system etc. User experience highlights the experiential, affective, meaningful, and valuable aspects of human interaction and product ownership, but it also includes a person's perceptions of the practical aspects such as utility, ease of use and efficiency of the system. User experience is subjective in nature because it is about an individual's feelings.

G

Gay
Refers to a man who has a romantic and/or sexual orientation towards men. Also, a generic term for lesbian and gay sexuality - some women define themselves as gay rather than lesbian. Some non-binary people may also identify with this term.

Gender
Often expressed in terms of masculinity and femininity, gender is largely culturally determined and is assumed from the sex assigned at birth.

Gender Re-assignment
The process of changing or transitioning from one gender to another.

Glass Ceiling
A term to describe an unseen barrier that prevents a particular demographic from progressing within their careers.

H

Harassment
Unwanted behaviour that has the purpose or effect of violating a person's dignity or creates a degrading, humiliating, hostile, intimidating or offensive environment. Sexual Harassment is any conduct of a sexual nature that is unwanted by the recipient, including verbal, non-verbal and physical behaviours, and which violates the victim's dignity or creates an intimidating, hostile, degrading or offensive environment for them.

Health Inequalities
The differences between people or groups due to social, geographical, biological, or other factors. These differences can have a huge impact, as they can result in people who are worst off experiencing poorer health and shorter lives.

Heterosexual
This term refers to a person who is sexually and/or emotionally attracted to people of the opposite sex.

Homosexual
This might be considered a more medical term used to describe someone who has a romantic and/or sexual orientation towards someone of the same gender. The term 'gay' is now more generally used.

I

Impairment
A functional limitation which may lead to a person being defined as disabled according to the definition under the Act. See disability.

Inclusion
An inclusive environment is one where everyone feels welcome, valued and a sense of belonging.

Inclusive Leadership

As an inclusive leader, a person must adopt - and live - a set of values, which places human relationships centre stage, and which defines the purpose of their enterprise in other than purely financial or commercial terms. Equality Leaders and Champions are supported and developed within the workforce to mainstream equality into every part of the business.

Indirect Discrimination
The use of an apparently neutral practice, provision or criterion which puts people with a particular protected characteristic at a disadvantage compared with others who do not share that characteristic, and applying the practice, provision or criterion cannot be objectively justified.

Inequalities
Lack of equality regarding opportunity, treatment, or status. **See Health Inequalities.**

Intersex
A term used to describe a person who may have the biological attributes of both sexes or whose biological attributes do not fit with societal assumptions about what constitutes male or female. Intersex people may identify as male, female, or non-binary.

L

Legislation
A law or set of laws passed by Parliament.

Lesbian
Refers to a woman who has a romantic and/or sexual orientation towards women. Some non-binary people may also identify with this term.

LGBTQIA+
The acronym stands for Lesbian, Gay, Bisexual, Trans, Queer or Questioning, Intersex, Asexual

M

Marriage and Civil Partnership
The legally or formally recognised union of two people as partners in a personal relationship.

Maternity
See pregnancy and maternity.

Mentoring
Mentoring is a form of human development, where one person invests time, energy, and personal know-how to assist another person to grow and to fulfil their true potential, and to increase their capacity for learning.

Monitoring
A process that involves collecting, storing, analysing, and evaluating information, to measure performance, progress, or change. Monitoring racial equality involves collecting, storing, analysing, and evaluating information about the equality target groups to which people say they belong.

O

Objective
The desired or needed result to be achieved by a specific time. An objective is broader than a goal, and one objective can be broken down into several specific actions.

Outcome
The result of the implementation of a set of goals / plan / actions etc. See Health Outcome.

P

Partnerships
There are many different types of partnerships, and many different reasons that you might want to develop them. Some partners will help you generate ideas or develop content; others will help you to design your engagement activity; some will be able to share their skills and knowledge to ensure your activity is a success and others may be prepared to put resources into the activity.

Policies
Policies are the sets of principles or criteria that define the different ways in which an organisation carries out its role or functions and meets its duties. Policies also include formal and informal decisions made during their implementation. All proposed and current activities which the Authority carries out.

Positive Action
Refers to a range of lawful actions that seek to overcome or minimise disadvantages (e.g., in employment opportunities) that people who share a protected characteristic have experienced, or to meet their different needs.

Pregnancy and Maternity
Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating someone unfavourably because they are breastfeeding/chestfeeding.

Procurement
The contractual or other arrangements that a public authority makes to obtain goods, works or services from an outside organisation.

Protected Characteristics
These are the grounds upon which discrimination is unlawful. The characteristics are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

Public Sector Equality Duty (PSED)
The duty on a public authority when carrying out its functions to have due regard to the need to eliminate unlawful discrimination and harassment, foster good relations and advance equality of opportunity.

Q

Queer
Queer is a term used by those wanting to reject specific labels of romantic orientation, sexual orientation and/or gender identity. It can also be a way of rejecting the perceived norms of the LGBT community (racism, sizeism, ableism etc). Although some LGBT people view the word as a slur, it was reclaimed in the late 80s by the queer community who have embraced it.

Questioning
The process of exploring your own sexual orientation and/or gender identity.

R

Race
Refers to the protected characteristic of race. It refers to a group of people defined by their race, colour, nationality (including citizenship) ethnic or national origins.

Religion or Belief

Religion has the meaning usually given to it, but belief includes religious and philosophical beliefs including lack of belief (e.g., atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

Resources
The term is used here to refer to money, time, people, buildings, and equipment used in the provision of services.

S

Service User
This term is used here to refer to patients, staff, carers, relatives, etc.

Sex
Assigned to a person based on primary sex characteristics (genitalia) and reproductive functions. Sometimes the terms 'sex' and 'gender' are interchanged to mean 'male' or 'female'.

Sexual Orientation
A person's sexual attraction to other people, or lack thereof. Along with romantic orientation, this forms a person's orientation identity.

Stakeholder
A stakeholder is a party that has an interest in an organisation and can either affect or be affected by the organisation.

T

Training
A wide range of career development opportunities, which could include informal in-house training as well as more formal courses.

Translation
The act or process of changing the written word (text) from one language to another, or in other formats, such as audio, large print, and braille. This is distinct from Interpretation, which is defined above.

Trans
Refers to a person who has the protected characteristic of gender reassignment. This may be a woman who has transitioned or is transitioning to be a man, or a man who has transitioned or is transitioning to be a woman. The law does not require a person to undergo a medical procedure to be recognised as a transsexual.

U

Unlawful
Not permitted by law (as distinct from illegal which means 'forbidden by law'). On occasions, unlawful and illegal may be synonymous, but unlawful is more correctly applied in relation to civil (as opposed to criminal) wrongs.

Unconscious Bias
A term that describes the associations a person holds, subconsciously outside of their awareness.

V

Victimisation
Victimisation is defined by the Equality Act as: Treating someone badly because you believe they are making a claim or complaint of discrimination, or they are helping someone else to make a claim or complaint.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	WWL M7 Balanced Scorecard
Presented to:	Board of Directors
On:	24 November 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.

The proposed exception page has been included to show example trends for some of the failing metrics within the Activity and Efficiency quadrant with supporting narrative.

Further feedback is requested prior to the automation of this report being added to the DAA Programme schedule.

Link to strategy
Patient
Partnership

The WWL Way

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, note the content, and confirm automation requirements.

Report: M5 WWL Balanced Scorecard: October 2021

QUALITY & SAFETY

	Month	ON/OFF Track	Why?
Patient Safety (Safe)			
Never Events	M06	Off Track	1 in month, 2 YTD
Number of Serious Incidents	M06	Off Track	3 in month, 46 YTD
Sepsis - Screening and Antibiotic Treatment (Grouped)	M04	Off Track	**Red Flag:** AE Off Track, Ward On Track **Elevated Score:** AE On Track, Ward Off Track
Serious Pressure Ulcers (Lapses in Care)	M06	Off Track	0 Incident in month, 16 YTD (Community & Hospital Acquired)
Serious Falls	M06	Off Track	1 in month, 2 YTD
Infection Prevention and Control (Grouped)	M06	Off Track	4 / 6 in month, 5 / 6 YTD; Metrics Off Track
Clinical Effectiveness (Effective)			
SHMI Rolling 12 months	M02 2021	Off Track	Latest position: 106.81 (June 2020 - May 2021)
National Patient Safety Strategy (Grouped)		*Under Development*	
Patient Experience (Caring)			
Complaints Responses	M06	Off Track	32.6% M04, 32.8% YTD; Target 90%
Improved Discharge (Grouped)		*Under Development*	
Patient Experience		*Under Development*	

ACTIVITY & EFFECTIVENESS

	Month	ON/OFF Track	Why?
A&E Performance (Single)	M07	Off Track	73.05% M06, 81.20% YTD; Target 95%
Cancer Performance (Grouped)	*M06*	*Off Track*	*4 / 7 in month, 2 / 7 YTD; Metrics Off Track*
RTT Performance (18 Weeks)	*M06*	*Off Track*	*61.57% M06, 62.18% YTD; Target 92%*
RTT Performance (52 Weeks)	*M06*	*Off Track*	*2343 patients waiting 52+ weeks (68 Waiting 104+ weeks)*
Diagnostics Patients waiting under 6 weeks	*M06*	*Off Track*	*77.41% M06, 83.78% YTD; Target 99%*
Recovery plan - NHS E/ I	M07	Off Track	2 out of 3 measures achieved
Recovery plan - WWL	M07	On Track	97% of 2019 Activity; Target 90%

PEOPLE

	Month	ON/OFF Track	Why?
Employment Essentials			
Vacancy Rate	M7	Off Track	7.27% M7, 6.06% M6, 5.46% M5, Target 5.0%
Number of active Employee Relations cases (disciplinary, grievance, dignity at work, performance)	M7	On Track	20 M7, 23 M6, 23 M5
Time to Hire- vacancy authorisation granted to start date (average days)	M7	Target not yet agreed	59.8 M7, 70.3 M6, 62.5 M5
Rate Card Adherance- % adhering to rate card	*M6*	Off Track	*49.03% M6 (new indicator - previous data not available) Target 85%*
E-rostering- % rosters approved within 6 weeks	M7	Off Track	57% M7, 42% M6, 37% M5, Target 90%
Trust % Turnover	M7	On Track	9.08% M7, 8.81% M6, 8.3% M5 Target 10%
Your Voice Matters			
Your voice engagement score	Q2	Off Track	3.91 Q2, 3.9 Q1 3.8 Q4, Target 4
Your voice response rate	Q2	Off Track	17.1% Q2, 16% Q1 18.0% Q4, Target 50%
Your voice Wellbeing score	Q2	Off Track	3.22 Q2, Target 4
Learn and Grow			
Mandatory Training over rolling 12 months	M7	Off Track	90.0% M7, 89.7% M6, 91.2% M5, Target 95%
PDR`s over rolling 12 months	M7	Off Track	72.9% M7, 73.0% M6, 72.9% M5, Target 90% NB. Excludes M & D Staff
Steps for Wellness			
Sickness Absence	*M6*	Off Track	*5.82% M6 , 5.71% M5, 5.7% M4 Target 4%*
Special Leave Infection Precaution	*M6*	On Track	*1.41% M6, 1.63% M5, 2.53% M4,*

FINANCE

Financial Position (£000s)

	In Month Actual £000's	In Month Plan £000's	In Month Var £000's	Year to Date Actual £000's	Year to Date Plan £000's	Year to Date Var £000's	H1 Plan £000's	H2 Plan £000's	Full Year Plan £000's
Income	37,481	39,364	(1,883)	268,457	260,415	8,042	221,052	TBC	TBC
Expenditure	(36,280)	(38,173)	1,893	(259,982)	(252,081)	(7,902)	(213,908)	TBC	TBC
Surplus / Deficit	(42)	(12)	(30)	(82)	(82)	0	(70)	TBC	TBC
Cash Balance	49,175	34,221	14,954	49,175	34,221	14,954	34,321	TBC	TBC
Capital Spend	1,379	1,105	(274)	7,725	7,407	(318)	6,302	4,720	11,022

Reported position : M07

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

M5 WWL Balanced Scorecard Commentary: October 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 has reported 2 Never Events during 2021/22. A wrong site surgery incident was reported during August 2021, relating to an anaesthetic block given to the incorrect eye and a retained foreign object relating to a strip found in situ following insertion of a mirena coil post delivery. Further details of this are contained within the Q1/2 StEIS report within the agenda

Within quarter 2 the Trust reported 24 incidents to StEIS. This was a slight increase in Q1 and a decrease in Q2 2020/21. The top 3 types of incidents were Treatment/Procedure not carried out (4), Hospital Acquired Pressure Ulcers (4), Community Acquired Pressure Ulcers (2). Full incident investigations involve all SUI's and learning from these is reported to Executive Scrutiny Group and shared on the weekly Trust Bulletin.

Clinical Effectiveness (Effective)

Whilst SHMI data is currently only nationally available until May, this shows that the Trust is now within expected range and data shows this is continuing to reduce on a monthly basis.

Patient Experience (Caring)

During September 2021, only 14 of the 43 complaints were responded to within the timescales agreed with the complainant at the start of the process which equates to 32.6%. Although this is still low, the position of overdue complaints is reducing.

ACTIVITY & EFFECTIVENESS

COVID:

Although hospital Covid occupancy rates are gradually increasing across Greater Manchester, the proportion of patients hospitalised remains lower than in previous waves. During this fourth wave, the Trust will continue to request mutual support through GM Gold Command for the transfer of Critically Care patients when demand exceeds capacity.

Scheduled Care

Activity levels have seen a steady month on month rise, and we are now currently at 83% of pre-covid levels, with bed occupancy levels rising.

The Trust continues to follow national guidance to facilitate prioritisation of patients based on clinical risk. The Trust has seen the number of 52 week breach patients reduce again this month, there is, however, a larger cohort of patients to manage during October. The amount of Priority 2 patients waiting for treatment is at the highest it has been since December 2020. However the average wait from Decision to Admit to Admission for Priority 2 patients continues to reduce - as a result of the Trust's current elective strategy. As reported previously, within some specialties non-urgent demand continues to grow, further compounded by higher volumes of urgent referrals, staffing constraints and reduced capacity due to infection prevention guidance.

The Trust continues to work closely with Greater Manchester Clinical Reference Groups (CRG) established within those specialties facing the biggest challenge in relation to waiting times.

Unscheduled Care

After very high A&E attendances from the start of 2021/22, August attendances dipped to a daily average of 288, September and October attendances are on the rise again to an average of 302 for October. Average daily attendances have been above the 270 A&E capacity, April to October 2021/22.

Ambulance arrivals went up slightly in October to 2055, which is still 4% below October 2019 numbers. Numbers of self-presenting patients in October (7033) is just 2% below last months 7170, however, this is 16% higher than October 2019 numbers.

There has been a sharp rise in patients waiting over 12 hours from arrival in A&E over the past few months, in October there was 612 patients compared to just 53 in April 21.

We are still seeing a higher than average number of patients under the age of 18 and more specifically aged 5 and under.

The number of patients with a high level of acuity was high at the beginning of 2021/22, these attendances are the most time-critical patients and need to be treated quickly and by the correct service, these numbers had been reducing, however, October has seen a significant increase to 1324 in patients needing this level of care, above the pre-covid average of 1164 .

Although out of area numbers are reducing, there are still more out of area patients presenting at A&E than pre-covid.

We continue to do all we can to support staff in A&E who are working hard to manage unprecedented demand.

PEOPLE

Employment Essentials:

ESR establishment control and vacancy management project key roles appointed to: ESR Project Lead, ESR Manager and 3 x ESR Officers. Considering options for joint analytical and project resource with Empactis roll out.

Patchwork – discussions ongoing with procurement involvement as a result of issues with payroll provision. Fully outsourced payroll model under consideration.

One stop shop recruitment events and social media campaigns underway and planned for ED, ICU and JHRU to support winter resilience plan.

Steps 4 Wellness:

Due to resource pressures, a prioritisation process has commenced to ensure we maximise the available resources. This does mean that not all services will be available to new referrals (subject to triage assessment). This is a result of inability to fill positions on a FTC basis.

Theatres stress management pilot commenced – 80% engagement with diagnostic and good engagement in focus groups. 70% report presenteeism, 77% struggle sleeping and more than half reported well-being impacting on their ability to focus at work and 17% have reported discriminatory behaviour.

Empactis roll out has been delayed due to payroll file run delay. Radiology now confirmed to start week commencing 15/11.

Switch on of Allocate e-roster interface will be available mid-December to enable full roll out.

Learn and Grow

Onboarding compliance significant concern (53%). Deep dive to understand reasons to commence

Leadership development now launching, following ETM approval of the proposal

Kick start – 28 now in post with a further 12 in pre-employment processes. 7 have now secured employment following

27 new apprenticeships commenced (119 now within the Trust)

Your Voice

National staff survey – current response rate 14% (currently lowest response rate for those using QH). National average 26%.

Culture pilots progressing well with second cohort starting in January.

Just culture framework – engagement sessions commenced to develop a WWL version that is aligned to our behaviour framework

FINANCE

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

The Trust is reporting a break-even position in month 7 and year to date. The planning round for the second half of the 2021-22 financial year (H2) has not yet concluded. Therefore, month 7 has been treated as an extension of H1 until the system and provider H2 plan is submitted to NHSE/I. Cash is £49.2m at the end of month 7 which is £15.0m above the plan in the main due to timing of cash inflows / outflows. Capital expenditure is £7.7m year to date which is £0.3m more than planned. For more detail, please see the monthly finance paper.

Please see the monthly finance report for further commentary.

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

Title of report:	Performance Report
Presented to:	Board of Directors
On:	24 November 2021
Presented by:	Deputy Chief Executive
Prepared by:	Deputy Chief Executive
Contact details:	Mary.Fleming@wwl.nhs.uk

Executive summary:

Unscheduled Care

The Trust's Urgent and emergency care services remain very busy. Demand is in part due to seasonal pressures that are expected at this time of year; however, this is compounded by the consistently high levels of demand of people continuing to seek treatment following the pandemic. Higher numbers of people accessing emergency departments are discharged without investigations suggesting they could seek treatment at more appropriate and convenient locations which is why the Trust's investment in expanding Urgent Treatment Centre facilities is key in providing practical alternatives to A&E. High demand also continues to be experienced in mental health services, particularly paediatrics and specifically in the number of people requiring mental health assessments in A&E. A dedicated Wigan 24/7 crisis helpline is in place.

Bed occupancy is high, one of the highest in Greater Manchester. Over the last few months occupancy levels have increased considerably with the acute wards 94% occupied in October. We have also seen a rise in patients who are medically fit and ready for discharge but who's discharge has been delayed, with an average of 51 patients delayed for the first 5 weeks of Quarter 3. The impact is seen in a congested A&E and potential cancellation of clinically urgent and cancer pathway elective patients. Whilst the system works to discharge patients as quickly as is safe to do so, to improve flow additional capacity is required if we are to safely navigate winter pressures, the Winter Plan includes several initiatives to address capacity as follows:

1. commissioning of the Jean Heyes Reablement Unit
2. Support from the Emergency Care Intense Support Team to improve patient flow
3. Reducing the increasing number of patients who have had their discharge delayed
4. Increasing the same day emergency care offer.

Scheduled Care

Greater Manchester was one of the areas hardest hit by Coronavirus in the country and this has impacted the speed of the elective recovery programme. A wide range of transformation programmes are underway, combined with winter planning, to protect elective programme, reduce waiting times and provide support for patients who are waiting for planned appointments. The total amount of elective work that can be delivered is limited by the need to also provide both urgent care and Covid requirements including infection prevention control measures. The Trust continues to prioritise those with the greatest clinical need and will continue to treat as many people as possible within current operational constraints. One of the transformation programmes is virtual consultation, the Trust was very successful during the pandemic at increasing the share of virtual appointments and we are currently above the NHSI/E target of 25% in October at 32.3%. Inpatient activity levels have also increased since April and we are now at 83% of pre-covid levels. Theatre cases as a Trust for October were 75.5% of pre-covid levels, with Wrightington theatre at 86.6%.

Covid

Wigan's covid new case rate at the beginning of November is 329.0 per 100,000 population and is the sixth highest rate in Greater Manchester. Wigan remains Red on the national escalation framework. The total number of confirmed cases is following the same trend as Greater Manchester which is higher than the rate for the Northwest. The Over 60s Weekly Incidence rate for Wigan is the 4th highest in Greater Manchester. Of Wigan's neighbours in Merseyside, Cheshire and Lancashire, Chorley has the highest rate (405 per 100,000), followed by St Helens (404), Warrington (370) and West Lancashire (317).
The number of patients admitted and treated as covid is increasing and critical care mutual aid has been requested during November, however no covid positive beds were available across GM therefore silver command is stood up to prepare escalation plans. The risk is deployment of staff significantly impacts on the elective recovery plan and H2 submission. An operational and escalation framework is being developed at ICS level led by Greater Manchester Chief Operating Officers.

Vaccination programme

As of 11th November, all care home workers and anyone entering a care home to provide a service is required to be fully vaccinated, unless medically exempt. We continue to monitor the impact this, along with outbreaks, is having on delayed discharges given the interdependency on Greater Manchester as a system, in particular admissions arising from batch ambulance diverts to reduce ambulance handover delays in Greater, and the Trust's ability to accept repatriation from tertiary centres such as Hyper Acute Stroke Unit. Wigan Borough local authority continues to work very closely with care homes to monitor uptake of second doses and to put mitigation measures in place for any homes that have larger numbers of staff unvaccinated and are of potential concern.

As of 1st November 94%, of Trust staff have had their first dose vaccination, 92 % have had their second and 41% their booster jab. November also saw the announcement that it will be compulsory for all frontline NHS staff to be fully vaccinated against Covid-19 by the beginning of April 2022. The operational impact of implementation will feature in future briefings.

National roll out of COVID-19 vaccination to all healthy 12–15-year-olds across the borough, within a school setting, has been commenced and will be delivered by the School Age Immunisation Service. A risk assessment is in place to ensure that risks to core delivery are escalated and managed. To date the team have delivered 3,800 vaccines to date over 10 schools and have plans in place to deliver the 18,907 by December.

Link to strategy
Patient
Partnership
Workforce

Risks associated with this report and proposed mitigations

- Occupancy levels rising in critical care and /or General and Acute bed resulting in deployment of staff which will compromise the levels of elective activity maintained on the green sites.
- Independent sector capacity, availability, and utilisation.
- Greater than planned Covid-19 and/or winter pressures compromising delivery of additional activity.
- Ability to recruit to the workforce resources and skills required.
- Staff burnout and fatigue compounded by resource shortages and Winter pressures, and resultant retention implications.
- Ongoing reliance on temporary (bank, locum, and agency) workforce.
- Funding for the Jean Hayes Re-enablement unit.

Mitigation:
Patient Clinical Prioritisation
A&E Safety checklist
Staff health and wellbeing offer
Staff engagement programme
Urgent and Emergency Care Board ownership and delivery of system wide winter plan
Winter planning
Waiting list profiling
Greater Manchester escalation and decision-making framework (due 26th November). No one individual organisation can address these risks alone, they require a system level response and therefore will form part of an overall escalation and decision-making framework being developed by Greater Manchester Chief Operating Officers, the framework is due to be presented to Provider Federation Board on the 26th of November.

Recommendation(s)
The Board is asked to note the current position, the potential risks to urgent care and elective recovery, the WWL approach to mitigate this risk, including the Wigan Borough winter plan and Greater Manchester system wide escalation framework as part of H2 recovery plan.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Month 7 financial position (October 2021)
Presented to:	Board of Directors
On:	24 November 2021
Presented by:	Ian Boyle, Chief Finance Officer
Prepared by:	Senior Finance Team
Contact details:	E: David.A.Hughes@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	37,481	39,364	(1,883)	268,457	260,415	8,042
Expenditure	(36,280)	(38,173)	1,893	(259,982)	(252,081)	(7,902)
Financial Performance	(26)	0	(26)	(26)	0	(26)
Cash Balance	49,175	34,221	14,954	49,175	34,221	14,954
Capital Spend	1,379	1,105	(274)	7,725	7,407	(318)

Key Messages:

- The planning round with NHSE/I and the Greater Manchester system for the second half of the 2021-22 financial year (H2) has not yet concluded. Detailed provider plans are required by the end of November.
- The block contract and system top up funding arrangements have been extended to the end of the financial year, as national tariff remains suspended.
- In month 7 and year to date, the Trust reported a break-even position.

The WWL Way

- Cash is £49.2m at the end of Month 7.
- Capital spend is £1.4m in month and £7.7m year to date.

Title of report:	Emergency Preparedness, Resilience and Response (EPRR) Core Standards Report for 2021
Presented to:	Board of Directors
On:	24 November 2021
Presented by:	Deputy Chief Executive (Accountable Emergency Officer)
Prepared by:	Head of Resilience
Contact details:	T: 07824 599379 E: helen.salvini@wwl.nhs.uk

Executive summary

The Emergency Preparedness, Resilience and Response (EPRR) readiness of NHS organisations is a legal requirement under the Civil Contingencies Act (2004) which identifies acute NHS Providers as type one responders with specific duties and also the NHS Act (2006) as amended by the Health and Social Care Act (2012). NHSI/E fulfil this requirement via an annual self-assessment against the EPRR core standards; this is undertaken by the Head of Resilience on behalf of the Accountable Emergency Officer. In addition to the core standards there is also an annual deep dive into a wider preparedness area which for 2021 is piped oxygen. The assessment for this area was supported by the Chief Pharmacist and the Head of Operational Estates.

Overall the Trust is rated as "substantially compliant" with just 2 out of 46 core standards and 1 out of 7 deep dive competencies being only "partially compliant" and the remainder being "fully compliant". Action plans are in place to resolve 2 of these and the 3rd will remain partially compliant due to one element which would require a regional emergency response, if not national (this is the requirement for a whole site evacuation plan). Greater Manchester providers are consistent in ranking this partially compliant for this reason.

Recommendation(s)

The Board is asked to note the findings of the self-assessment

Report

Introduction

This paper outlines the purpose and outcome of the annual Emergency Preparedness, Resilience and Response (EPRR) core standards self assessment. The assessment was carried out by the Head of Resilience in conjunction with the Chief Pharmacist and the Head of Operational Estates in relation to the Deep Dive section. The overall outcome is "substantial compliance".

Legislative and Statutory Context

The Civil Contingencies Act (2004) specifies that NHS Acute Providers are Category 1 Responders meaning they are at the core of the response to emergencies. Such responders are subject to the full set of civil protection duties as follows

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency plans
- Put in place business continuity arrangements
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance coordination
- Cooperate with other local responders to enhance coordination and efficiency

Similarly the NHS Act places specific duties on the NHS to ensure it is prepared for relevant emergencies which, in relation to providers, are defined as "any emergency which might affect the provider (whether by increasing the need for the services that it may provide or in any other way)".

The underpinning principles of EPRR in the NHS are as follows

- Preparedness and anticipation
- Continuity
- Subsidiarity
- Communication
- Cooperation and integration
- Direction

Background to the Core Standards

NHS England has a statutory duty to seek formal assurance of EPRR readiness through the EPRR annual assurance process. This is a self-assessment which is peer reviewed locally (in Wigan this is done initially by the CCG and then the Greater Manchester Local Resilience Forum).

Due to the demands on the NHS, the 2020 process was much reduced and focused on learning from the first COVID-19 wave and the preparation for future waves and winter. The 2021 EPRR assurance aims to return some of the previous mechanisms to the process, but also acknowledges the previous 18 months and the changing landscape of the NHS.

As a result of Covid-19, the EPPR standards did not receive their tri-annual review and, as a consequence, not all standards reflect current best practice. A small number of standards were removed to accommodate this year's assurance process, until a full review is undertaken.

In addition to the core standards the self-assessment also includes a deep dive each year. As a result of the Covid-19 pandemic the focus for the 2021 return is internal piped oxygen systems.

The full breakdown of the standards and the WWL response is shown at Appendix 1.

Summary of 2021 Results

Core Competencies

For 2021 there are 46 core standards and the Trust is fully compliant with 44 of them. This results in an overall assessment of "substantial compliance" (this does also include the "Deep Dive" standards described in the next section). This is consistent with previous years and is comparable with other Trusts across Greater Manchester.

There are 2 standards against which the assessment is "partially compliant" and these are shown below.

Duty to maintain plans	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.
Business Continuity	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.

In relation to shelter and evacuation this remains assessed at this level due to the lack of a whole site evacuation plan; on-site evacuation policies are in place in the event of a partial evacuation. This has been discussed on a number of occasions with other EPRR leads in Greater Manchester and the combined view is that this would require a North West (and possibly wider) response and would therefore fit within the larger scale major incident plans. All organisations across GM therefore rate this as partially compliant.

The Data Protection and Security Toolkit has a separate action plan to achieve compliance by December 31st 2021 and this will then revert to fully compliant.

Deep Dive

There are 7 deep dive standards relating to piped oxygen. These have been reviewed by Estates and Facilities and by Pharmacy. Based on this the Trust is declaring 6 fully compliant standards and 1 partially compliant standard. Training is provided via a BOC webinar but records are not

maintained because this falls outside of mandatory training. An audit will be undertaken to determine compliance and the EPRR Group will be responsible for reviewing this and agreeing any necessary actions. There is no evidence that the Trust is not compliant but equally the records are not available to determine compliance.

The covid-19 response significantly improved resilience in relation to oxygen without relying on a substantial increase in cylinder use which was the case in many other organisations. This along with the existing infrastructure, policies and procedures ensured a substantial level of compliance and therefore resilience.

Conclusion and Recommendations

The outcome of the self-assessment is "substantial compliance" and in relation to the core standards only two are partially compliant. One of those is consistent with the rest of Greater Manchester and the other will be rectified once the DPST action plan is complete. This assessment should provide significant reassurance in relation to resilience and readiness of the organisation in relation to business continuity and incidents.

In relation to the annual deep dive an audit of training levels will be completed and action plan completed based on the outcomes. However, advice has been provided via the SOP and staff are sign posted to the external BOC training which is considered to be excellent.

Appendix 1 : EPRR Core Standards

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance											
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	Mary Fleming (Deputy Chief Executive) is th	Fully compliant				
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	EPRR Policy TW17-023 - Policy Statement	Fully compliant				
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	Deferred during Covid but annual cycle now	Fully compliant				
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	EPRR Policy TW17-023 - Policy Statement	Fully compliant				
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	EPRR Policy TW17-023 - Policy Statement	Fully compliant				
Domain 2 - Duty to risk assess											
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	The Trust Risk Policy enables reporting of E	Fully compliant				
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	The Trust Risk Policy enables reporting of E	Fully compliant				
Domain 3 - Duty to maintain plans											

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
11	**Duty to maintain plans**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Currently covered in Major Incident Plan. Review of this was suspended during pandemic but revised plan scheduled for sign off by the end of October 2021	Fully compliant				
12	**Duty to maintain plans**	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	See aboove	Fully compliant				
13	**Duty to maintain plans**	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Summer Resilience Heatwave Plan	Fully compliant				
14	**Duty to maintain plans**	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Cold Weather Plan (scheduled to be updated for 2021/22 on publication of the national update on 27th October 2021	Fully compliant				
18	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Major Incident Plan and GM Mass Casualty Framework	Fully compliant				
19	**Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Major Incident Plan	Fully compliant				
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evacution Plans are in place but a whole site evacuation is beyond the scope of WWL planning in isolation and is being considered across GM	Partially compliant	Not applicable (whole site evacuation needs to be considered on a regional or even national basis). Response is consistent with other GM Acute Provider responses	N/A	N/A	N/A
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Lockdown Policy TW15-004	Fully compliant				

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Lockdown Policy TW15-004 and TW16-011 Visits to the Trust by Celebrities and Very Important Persons	Fully compliant				
Domain 4 - Command and control											
24	**Command and control**	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	Major Incident Plan	Fully compliant				
Domain 5 - Training and exercising											
Domain 6 - Response											
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y		Yes - HIS hub Boardroom	Fully compliant				
32	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans	Business Continuity Plans (currently being reviewed) and Incident Plan (currently being reviewed)	Fully compliant				
34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps	On call pack for business continuity incidents and Incident Plan for larger scale incidents	Fully compliant				
35	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	• Guidance is available to appropriate staff either electronically or hard copies	Retained in ED major incident room	Fully compliant				
36	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	• Guidance is available to appropriate staff either electronically or hard copies	Retained in ED major incident room	Fully compliant				
Domain 7 - Warning and informing											
37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Business Continuity Plans (currently being reviewed) and Incident Plan (currently being reviewed). Wigan Borough Comms Group established to ensure joined up rapid comms deployment with support from GM	Fully compliant				
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	Business Continuity Plans (currently being reviewed) and Incident Plan (currently being reviewed). Wigan Borough Comms Group established to ensure joined up rapid comms deployment with support from GM. Evidence of learning in debriefs in incidents	Fully compliant				
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy	Business Continuity Plans (currently being reviewed) and Incident Plan (currently being reviewed). Wigan Borough Comms Group established to ensure joined up rapid comms deployment with support from GM. Evidence of learning in debriefs in	Fully compliant				

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Domain 8 - Cooperation											
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	GM Policies e.g. GM critical care mutual aid process and GM Mass Casualties Plan	Fully Compliant				
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	Business Continuity Plans (currently being reviewed) and Incident Plan (currently being reviewed). Wigan Borough Comms Group established to ensure joined up rapid comms deployment with support from GM. Evidence of learning in debriefs in	Fully Compliant				
Domain 9 - Business Continuity											
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continutiy Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	Business Continiuty Policy (currently being reviewed)	Fully compliant				
48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	Business Continiuty Policy (currently being reviewed)	Fully compliant				
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	Internal action plan in place to deliver compli	Partially compliant	Internal action plan already in place to deliver this	N/A	N/A	N/A
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Business Continuity Plans, On-Call Pack and Incident Plan	Fully compliant				
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	Suspended during covid but currently being re-established as part of revised BCMS. Requirement is specified in current BC Policy	Fully compliant				
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	BC Policy (currently under review)	Fully compliant				
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	EPRR Policy and Procurement process	Fully compliant				
Domain 10: CBRN											
56	**CBRN**	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Available in ED Major Incident Room	Fully compliant				

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
57	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	ED CBRN Incident Policy	Fully compliant			
58	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	ED CBRN Incident Policy	Fully compliant			
59	**CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	• Rotas of appropriately trained staff availability 24 /7	ED staffing pressures currently impacting this but policy is in place to outside of this. Decontamination facilities have been used during the pandemic and therefore wider readiness has been maintained	Fully compliant			
60	**CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material:	Y	• Completed equipment inventories; including completion date	Equipment inventory (e.g. PRPS suits)	Fully compliant			
62	**CBRN**	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	• Record of equipment checks, including date completed and by whom. • Report of any missing equipment	PRPS suit log, decontamination tent service records, Ramgene maintainance records	Fully compliant			
63	**CBRN**	**Equipment Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	• Completed PPM, including date completed, and by whom	PRPS suit log, decontamination tent service records, Ramgene maintainance records	Fully compliant			
64	**CBRN**	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	• Organisational policy	PRPS suit s covered by national scheme	Fully compliant			
65	**CBRN**	**HAZMAT / CBRN training lead**	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	• Maintenance of CPD records	CPD record	Fully compliant			
67	**CBRN**	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	• Maintenance of CPD records	CPD record	Fully compliant			

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
68	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	• Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • A range of staff roles are trained in decontamination technique	Training plan in line with best practice. Training suspended during covid but facilities used several times in response to incidents so readiness has been maintained. Training to be re-established although this is currenly impacted bu ED Staffing issues	Fully compliant				
69	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y		FFP3 training in place, records held locally	Fully compliant				

Appendix 2 : Deep Dive

Ref	Domain	Standard	Detail	Evidence - examples listed below	Acute Providers	Organisational Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Oxygen Supply **Domain: Oxygen Suuply**											
DD1	**Oxygen Supply**	**Medical gasses - governance**	The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B.	•□Committee meets annually as a minimum •□Committee has signed off terms of reference •□Minutes of Committee meetings are maintained •□Actions from the Committee are managed effectively •□Committee reports progress and any issues to the Chief Executive •□Committee develops and maintains organisational policies and procedures •□Committee develops site resilience/contingency plans with related standard operating procedures (SOPs) •□Committee escalates risk onto the organisational risk register and Board Assurance Framework where appropriate •□The Committee receives Authorising Engineer's annual report and prepares an action plan to address issues, there being evidence that this is reported to the organisation's Board	Y	Medical Gas Group meets quarterly and complies fully with requirement	Fully compliant				
DD2	**Oxygen Supply**	**Medical gasses - planning**	The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases	•□The organisation has reviewed and updated the plans and are they available for view •□The organisation has assessed its maximum anticipated flow rate using the national toolkit •□The organisation has documented plans (agreed with suppliers) to achieve rectification of identified shortfalls in infrastructure capacity requirements. •□The organisation has documented a pipework survey that provides assurance of oxygen supply capacity in designated wards across the site •□The organisation has clear plans for where oxygen cylinders are used and this has been discussed and there should be an agreement with the supplier to know the location and distribution so they can advise on storage and risk, on delivery times and numbers of cylinders and any escalation procedure in the event of an emergency (e.g. understand if there is a maximum limit to the number of cylinders the supplier has available) •□Standard Operating Procedures exist and are available for staff regarding the use, storage and operation of cylinders that meet safety and security policies •□The organisation has breaching points available to support access for additional equipment as required •□The organisation has a developed plan for ward level education and training on good housekeeping practices •□The organisation has available a comprehensive needs assessment to identify training and education requirements for safe management of medical gases	Y		Fully compliant				
DD3	**Oxygen Supply**	**Medical gasses - planning**	The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system.	•□The organisation has clear guidance that includes delivery frequency for medical gases that identifies key requirements for safe and secure deliveries •□The organisation has policy to support consistent calculation for medical gas consumption to support supply mechanisms •□The organisation has a policy for the maintenance of pipework and systems that includes regular checking for leaks and having de-icing regimes •□Organisation has utilised the checklist retrospectively as part of an assurance or audit process	Y	All elements in place	Fully compliant				
DD4	**Oxygen Supply**	**Medical gasses -workforce**	The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions.	•□Job descriptions/person specifications are available to cover each identified role •□Rotating of staff to ensure staff leave/ shift patterns are planned around availability of key personnel e.g. ensuring QC (MGPS) availability for commissioning upgrade work. •□Education and training packages are available for all identified roles and attendance is monitored on compliance to training requirements •□Medical gas training forms part of the induction package for all staff.	Y	Compliant with all points except medical gas training being part of induction package for all staff	Partially compliant	Frontline staff are signposted to BOC training but records of this are not routinley maintained. Audit to be undertaken to confirm compliance and if required action plan to be implemented. Action plan to be monitored through the EPRR Group.	Head of Resilience (to ensure action completed and reported to EPRR Group)	31st January 2022	There is no reason to believe the Trust is not compliant but this will provide evidence of training
DD5	**Oxygen Supply**	**Oxygen systems - escalation**	The organisation has a clear escalation plan and processes for management of surge in oxygen demand	•□SOPs exist, and have been reviewed and updated, for 'stand up' of weekly/ daily multi-disciplinary oxygen rounds •□Staff are informed and aware of the requirements for increasing de-icing of vaporisers •□SOPs are available for the 'good housekeeping' practices identified during the pandemic surge and include, for example, Medical Director sign off for the use of HFNO	Y	Compliant with all points	Fully compliant				
DD6	**Oxygen Supply**	**Oxygen systems**	Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU)	•□Reviewed and updated instructions for use (IFU), where required as part of Authorising Engineer's annual verification and report	Y	MGPS Policy and SOPs	Fully compliant				
DD7	**Oxygen Supply**	**Oxygen systems**	The organisation has undertaken as risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6	•□Organisation has a risk assessment as per section 6.6 of the HTM 02-01 •□Organisation has undertaken an annual review of the risk assessment as per section 6.134 of the HTM 02-01 (please indicated in the organisational evidence column the date of your last review)	Y	Compliant with all points	Fully compliant				