Board of Directors - Public Board - Sept 2021

Wed 29 September 2021, 13:00 - 16:00

MS Teams

Agenda

1. Declarations of interest

Information *Robert Armstrong*

2. Minutes of previous meeting

Decision *Robert Armstrong*

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

3. Staff story

Discussion *Alison Balson*

Verbal item

4. Chief Executive's report

Information *Silas Nicholls*

4. CEO report September 2021_APPROVED.pdf (4 pages)

5. Assurance and governance

5.1. Committee chairs' reports

Discussion *Various*

Verbal item

5.2. Board assurance framework

Discussion *Paul Howard*

5.2. BAF - Sep 2021.pdf (32 pages)

6. Patients

6.1. Maternity/Ockenden reports

Discussion *Rabina Tindale*

6.1. Maternity Provider Board Level report Sept 2021 (002).pdf (6 pages)
6.1. August 2021 Provider Board level measures v2.pdf (1 pages)
6.1. Maternity Dashboard Board Report August 2021.pdf (7 pages)

6.1. Data sheet - Maternity Dashboard 2021.pdf (2 pages)
6.1. Dashboard - Maternity Dashboard 2021.pdf (2 pages)
6.1. Regional - Maternity Dashboard 2021.pdf (1 pages)

6.2. IPC board assurance framework

Discussion *Rabina Tindale*

6.2. IPC BAF update for Board 29 Sept 21.pdf (35 pages)

7. People

7.1. Safer staffing report

Discussion *Rabina Tindale*

7.1. Safe Staffing Report for July 2021 v1 FINAL for TB.pdf (22 pages)

8. Performance

8.1. Performance report

Discussion *Mary Fleming*

8.1 M5 Performance Report Sep 21.pdf (20 pages)

8.2. Finance report

Discussion *Ian Boyle*

8.2 Board Report 21-22 August month 5 Public (002).pdf (2 pages)

8.3. Transformation report

Discussion *Richard Mundon*

8.3. Transformation Plan - Trust Board M5 uppdate.pdf (6 pages)

9. Partnerships

9.1. Update on partnership working with GPs

Discussion *Sanjay Arya*

Verbal item

10. Consent agenda

10.1. Updated terms of reference

Decision

10.1 Audit Committee - draft terms of reference.pdf (6 pages)
10.1 Research Committee - ToR 2021.pdf (3 pages)

10.2. Register of CEG referrals

Information

10.2 CEG referrals.pdf (3 pages)

10.3. Risk management strategy

Decision

10.3 Risk management framework.pdf (15 pages)

10.4. GMC revalidation report

Information

10.4 AR Annual Report_22 Sept 2021.pdf (12 pages)

11. Date, time and venue of next meeting

24 November, 12:00-16:00, MS Teams

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

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

HELD ON 28 JULY 2021, 1.15PM

BY VIDEOCONFERENCE

Present:	Mr R Armstrong	Chair (in the Chair)
	Prof S Arya	Medical Director
	Prof C Austin	Non-Executive Director
	Mrs A Balson	Director of Workforce
	Mr I Boyle	Chief Finance Officer
	Lady R Bradley DL	Non-Executive Director
	Dr S Elliot	Non-Executive Director
	Ms M Fleming	Deputy Chief Executive
	Mr M Guymer	Non-Executive Director
	Mr I Haythornthwaite	Non-Executive Director
	Mrs L Lobley	Non-Executive Director
	Ms R Tindale	Chief Nurse
	Mrs F Thorpe	Non-Executive Director
In attendance:	Mr P Howard	Director of Corporate Affairs (minutes)
	Mr A Howard	Public Governor (observer)
	Mrs A-M Miller	Director of Communications
	Mrs J Taylor	Deloitte (observer)
	Ms V Bolton	Patient Advice and Liaison Service (to item 88/21)
	Mrs A-M Rogers	Patient representative (to item 88/21)

The Board reconvened following an adjournment. The Chair opened by thanking Mr Guymer for his work as a Non-Executive Director over the past six years, noting that this would be his last meeting in post as his term of office would be coming to an end on 31 July 2021.

86/21 Declarations of interest

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

87/21 Minutes of the previous meeting

The minutes of the previous meeting held on 26 May 2021 were **APPROVED** as a true and accurate record.

88/21 Patient story

A member of staff, Ann-Marie Rogers, joined the meeting and outlined the experiences of her mother-in-law whilst in the care of the foundation trust with the patient's agreement. She noted the importance of listening to a patient's relatives in order to get a good understanding of a patient's history and to identify changes in their presenting

condition. Particular note was made of how helpful and supportive the Patient Advice and Liaison Service (PALS) had been throughout the whole experience.

The Chair apologised on behalf of the foundation trust for the negative aspects of her mother-in-law's care and the experience of the wider family. The Director of Workforce reminded the Board that visiting restrictions were currently in place as a result of national infection prevention and control guidance and questioned how input from relatives might be better facilitated. In response, the Medical Director acknowledged the challenges and noted that iPads had been provided to clinical areas to facilitate contact with families. Mrs Lobley asked how executive directors will ensure that learning from this case is shared. In response, the Deputy Chief Executive advised that analysis of complaint themes and trends is undertaken and reported through Divisional Assurance Meetings.

The Chief Nurse commented that she had spoken with families around complaints surrounding fundamentals of care, and advised that she intends to chair the Patient Experience Group going forward to ensure a high level of focus is provided. With regard to the specific case under discussion, the Chief Nurse also expressed disappointment at the length of time taken to conclude the complaint, noting that it had first been submitted in September 2019. She advised of the actions that have been taken to address the quality of complaint responses provided, with a particular focus on empathy and compassion. She also noted the need to triangulate complaints with information gathered in other areas, such as through the ward accreditation programme, to ensure effective oversight.

The Chair thanked Ann-Marie for coming to share her family's story with the Board and confirmed that the executive team would be asked to provide an update on how improvements had been implemented to the next meeting of the Quality and Safety Committee.

The Board received and noted the verbal update.

Ms Bolton and Mrs Rogers left the meeting.

89/21 Chief Executive's report

In the absence of the Chief Executive, the Deputy Chief Executive presented his report which had been circulated with the agenda. She also took the opportunity to thank and recognise all staff for their continued work in providing care to the people of Wigan. She confirmed that the COVID-19 surge plan had been activated and that the impact of staff isolating as a result of contact from NHS Test and Trace was being felt.

The Deputy Chief Executive advised that Wigan Borough had reported the highest rate of COVID-19 cases across Greater Manchester and advised that all partner organisations in the borough were continuing to promote the 'hands, face, space' message, as well as continuing with all infection prevention and control arrangements and encouraging uptake of vaccinations. She made reference to the stars that had recently been installed in Believe Square to highlight the work of all teams and also highlighted the focus that had been placed on the 'We Can Talk' campaign as set out in the report.

The Board received the report and noted the content.

90/21 Committee chairs' reports

In the absence of the committee chair, the Chief Nurse provided a verbal summary of the business transacted at the most recent meeting of the Quality and Safety Committee. She noted that work was ongoing to improve the consistency of the divisional reporting arrangements and summarised the various entries on the Board Assurance Framework for those corporate objectives aligned to the patients objective.

Mr Guymer noted that the Finance and Performance Committee had met earlier in the week and expressed real satisfaction with the way in which the suite of reports had been developed and refined. He noted good progress in the development of the Board Assurance Framework and drew attention to activity levels and the level of bank and agency expenditure as of particular focus by the committee. He noted that there was some level of uncertainty on a national scale around financial matters but confirmed that the committee was supportive of the approach adopted by the foundation trust. He noted that a five-year forward approach to capital expenditure had begun to be developed and that it would be important for the Board to review this at an appropriate point in time. Confirmation was provided that the Board Assurance Framework for those corporate objectives aligned to the performance objective had been reviewed.

Mrs Lobley summarised the People Committee meeting in June 2021 and noted that a significant amount of business had been transacted. She drew particular attention to the *Our Family, Our Future, Our Focus* programme which was being developed and noted that an external Freedom to Speak Up service had recently been commissioned which would serve to further improve the independence and transparency of the service. An overview of the Board Assurance Framework for people-related objectives was provided.

Mr Haythornthwaite advised that the most recent Audit Committee meeting had considered year-end matters from FY2020/21 as well as other items such as updates from internal audit and the counter-fraud service. He confirmed that the Board Assurance Framework process had been reviewed, noting that the internal auditors had also expressed support for the new style reporting.

Based on the discussions, the Chair requested that time be scheduled at an appropriate point in time for the Board to focus on the five-year capital programme, on the *Our Family, Our Future, Our Focus* work and the triangulation of items that are considered by committees as part of the wider review of corporate governance that is currently ongoing.

The Board received the verbal updates and noted the content.

91/21 Board assurance framework

In addition to consideration of three Board Assurance Framework dashboards as part of the Committee Chairs' reports, the Board considered those aligned to the partnerships objective.

The Board **APPROVED** the Board Assurance Framework as presented.

92/21 Q4 2020/21 mortality report

The Medical Director presented a report which had been circulated with the agenda to provide the Board with information regarding mortality reviews undertaken during Q4 2020/21.

In response to a question from Mrs Lobley, the Medical Director described the work that is being undertaken to target sepsis and confirmed that this is reported via the Quality and Safety Committee. In response to a question from Dr Elliot, the Medical Director advised that an external report had also been commissioned and any lessons learned would be reported via Quality and Safety Committee. He summarised the process of reviewing deaths and explained the process for determining whether deaths are considered to be preventable or otherwise. In response to a question from Prof Austin, the Medical Director described the process for sharing learning from deaths across the organisation, noting that weekly audit reports are circulated and confirmed the intention to further improve this process by involving junior doctors and nurses in the Trust-wide Executive Scrutiny Group.

Lady Bradley noted the link to COVID-19 in the themes and learning from deaths and noted the challenging nature of addressing some of these issues whilst the global health pandemic continues. She noted the benefits of Non-Executive Directors returning to on-site walkabouts at an appropriate point in time, in order to provide a different perspective and to facilitate further discussion.

The Chair summarised key three themes from the report as being clinical audit oversight within the committee structure; equality of access to clinical services regardless of location, particularly as more regional arrangements are introduced; and the embedding of learning across the organisation.

The Board received the report and noted the content.

93/21 Infection prevention and control board assurance framework

The Chief Nurse presented the Infection Prevention and Control Board Assurance Framework, noting that a new version had recently been introduced by NHS England and Improvement and that any changes had been highlighted in the report for ease of reference. She also noted the staffing challenges within the team but confirmed that recruitment was underway.

In response to a question from Mrs Lobley around the limited provision of side rooms within the foundation trust's estate, the Chief Nurse noted that the refurbishment of the Intensive Care Unit would provide some additional benefits but that this was an issue that needs to be kept under review. The Chief Finance Officer acknowledged the availability of side room pods but noted that these bring additional challenges that need to be taken into account.

Dr Elliot expressed concern that the foundation trust did not currently comply with new national cleaning standards that had recently been published, to which the Chief Nurse explained that mitigations had been put in place and that an associated business case was under development. The Chief Finance Officer confirmed that a gap analysis had been undertaken but noted that no additional funding had accompanied the new standards. He acknowledged the need to take a view on whether investment should be made or whether other approaches could be adopted to mitigate any impact.

Dr Elliot highlighted the number of patients who are not wearing masks as outlined in the report and also the number of staff who have not undergone mask fit testing. He suggested that it would be important to include some context within future versions of the report. The Director of Corporate Affairs highlighted that additional guidance had recently been received from the Department of Health and Social Care which enhanced the requirements around the number and frequency of mask fit tests and confirmed that a scoping exercise had begun to determine what level of additional resource is required to address this.

The Board received the report and noted the content.

94/21 Freedom to Speak Up Guardian's report

The Director of Workforce presented a report which had been circulated with the agenda to provide an update on Freedom to Speak Up arrangements and cases and noted that the new provider would be invited to attend a future board workshop in order to allow for detailed discussion and oversight. Prof Austin also took the opportunity to commend the work undertaken by the Director of Workforce as part of the review of the service and in particular the intention to report Freedom to Speak Up cases via each meeting of the Audit Committee.

The Board received the report and noted the content.

95/21 Safe staffing report

The Chief Nurse presented a report which had been circulated with the agenda to provide the safe staffing report for May 2021. She highlighted a number of areas of concern as outlined in the covering report.

Mr Guymer expressed concern that the overall vacancies across nursing and midwifery could not be provided as the data was not available, to which the Chief Nurse and Director of Workforce described the intention to move away from manual data collection and towards a solution within the electronic staff record. Confirmation was provided that the overarching vacancy position had improved but note was made of the need to streamline processes.

Dr Elliot expressed concern that the maternity unit had been required to close for a short period during the month and queried what happened under such circumstances. In response, the Chief Nurse described the arrangements in place to divert patients to other local units and confirmed that no issues had been encountered.

The Medical Director advised of the intention to further enhance the report towards the end of the calendar year by including medical staffing levels.

The Board received the report and noted the content.

96/21 Performance report

The Deputy Chief Executive noted that Wigan was currently the borough of Greater Manchester with the highest level of COVID-19 cases and confirmed that the COVID escalation plan had been escalated, with segregated pathways remaining in place. She described the mutual aid arrangements in place and noted the increased number of patients requiring CPAP.

With regard to scheduled care, the Deputy Chief Executive confirmed that the foundation trust had achieved its agreed performance as part of the elective recovery plan. Notwithstanding, she noted that the waiting list continued to grow and outlined the work across Greater Manchester to address this. In particular, she noted the ongoing work with Bolton NHS FT and with the private sector, as well as the use of Wrightington Hospital as a green site.

Note was also made of an audit that had recently been completed across Greater Manchester of the reasons why patients are attending the Accident and Emergency Department. She advised that Wigan had been a statistical outlier for the increases experienced, with the department having been designed to accommodate 260 to 270 attendances per day and having had only 21 days in the current financial year where the number of attendances had been lower than 300. She noted that these increased attendances were not translating to increased admissions and that around 40% of patients were being discharged without the need for any investigation. As a result, a summit had been held with local commissioners to seek to address this issue and the Board had recently agreed some additional areas of investment.

In response to a question from Mr Haythornthwaite, the Deputy Chief Executive advised that many patients had felt the need to attend A&E and the need for a system approach to the issue was noted.

The Board received the report and noted the content.

97/21 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 finance report for M3 2021/22 be received and noted.

2. THAT the *Your Voice* survey report be received and noted.

3. THAT the Guardian of Safe Working report be received and noted.

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

5. THAT the terms of reference for the Charitable Trust Committee be **APPROVED** as presented.

6. THAT the table of statutory, mandatory and recommended posts be received and noted.

98/21 Date time and venue of the next meeting

The next meeting of the Board of Directors will be held on 29 September 2021 at 12.00 noon 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:	29th September 2021
Presented by:	Chief Executive
Prepared by:	Director of Communications and Stakeholder Engagement
Contact details:	T: 01942 822170 E: anne-marie.miller@wwl.nhs.uk

Executive summary

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

Link to strategy

The links to overall strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

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

Legal implications

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

People implications

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

Wider implications

There are no wider implications associated with this report.

Recommendation(s)

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

Report

As a Trust, and in line with other Trusts across the NHS, two of our key priorities remain in responding to the COVID-19 pandemic and managing the backlog of elective operations to address waiting lists and waiting times. In that regard, I am delighted to say that WWL has been chosen as the Greater Manchester elective care hub for orthopaedic surgery which means we are able to treat patients from across Greater Manchester who have been waiting longer due to the pandemic. We are currently in the middle of an initiative to recruit to several clinical roles, adding further expertise and resources to our teams, further enabling us to tackle surgery backlogs. At the Wrightington Hospital site, we also received confirmation that the hospital has been identified as a Major Revision Centre for knee surgery as part of the Revision Knee Network, an NHS England and Improvement project designed to pioneer a new way of funding complex care.

As always, our response to infection rates of COVID-19 continues and we are currently in the process of restarting our COVID-19 vaccination programme to offer booster doses, in line with national guidance, to further protect our staff and patients from infection. Our first and second dose programme has been a huge success with 95% of our staff receiving the vaccine, and we aim to make the booster dose programme just as successful. This is being carried out in conjunction with the yearly flu vaccination programme, as we prepare our workforce for the anticipated winter pressures.

As well as our focus on COVID-19, and the associated recovery from the pandemic, we are proactively working to address the increased pressures on our Emergency Care Department as discussed at previous Board meetings. Work has already started on the expansion of the Urgent Treatment Centre at Christopher Home on the Royal Albert Edward Infirmary site, allowing for increased capacity and extended opening hours to mirror the Emergency Care Department. This work is to ensure our patients are treated and seen to in the right place, at the right time by the right team. In addition to this we continue to work with our Borough Partner organisations to raise awareness of all the alternative services to Accident and Emergency that are available to the community such as Pharmacy, GP and NHS 111.

Over the past two months, our internal communications and staff engagement work has continued to pick up pace. The Executive Team and leaders across the Trust have shown increasing commitment towards this, particularly with the launch of our new staff engagement programme – Our Family, Our Future, Our Focus. This was formally introduced to our staff at the first 'All Staff Team Brief', two virtual events, open to all staff, at which we presented details of how we are making improvements to our communications and engagement. We shared the latest information on what we are doing as a Trust, our plans for the future; and how we will continue to support staff, as well as giving everyone the opportunity to ask questions. It was great to see interaction and debate at the two sessions with many meaningful questions and answers, particularly around our community services, and I was really pleased to see staff from all specialties and sites in attendance. Our board commitment to communications was recently recognised at the NHS Communicate Awards that took place earlier this month.

Our monthly Leaders' Forum virtual events continued, with this month's session focused on Divisional Plans, with representatives from Surgery, Community, Specialist Services and Medicine detailing how we have clear and collectively owned visions for each of our Divisions and their priorities and plans for the next three years. It's never been more important for us to have robust, clear plans in place amidst the pressure and challenges we face.

Another of our key internal programmes is our new Freedom to Speak Up function which will be provided by an external company, the Guardian Service, who will provide a designated Guardian based across our sites. The service will support the psychological safety of our people and will ensure staff feel they can raise any concerns; they are listened to, and appropriate action is taken to address their concerns. A lot of work is taking place behind the scenes to communicate this with our teams ahead of the service launching, next week on 1st October.

I recently had the pleasure of spending some valuable time with our Clinical Outreach Team earlier this month. They are doing some amazing work with asylum seekers and other hard to reach groups of people in the community. This work is going to be more and more critical for the population of the Wigan Borough and our community services and forms an integral part of our Strategy 2030.

And finally, I have several teams and individuals to offer recognition to. As you may have seen in the local news, we said our congratulations and goodbyes to Dr Nayyar Naqvi, who retired from his long-standing position as a Consultant Cardiologist at the Trust, whilst at the same time, congratulations went out to Dr Ashish Dhawan for his election to the position of Chairman of the British International Doctors Association and to Dr Abdul Ashish on receiving an award from the National Institute for Health Research Clinical Research Network (NIHR CRN) and Royal College of Physicians. It's in that same breath that I offer my congratulations to a number of teams who have been named as finalists across a range of award ceremonies, including Community React, Steps 4 Wellness, Data Analytics and Assurance and our Communications Team. Work around submitting the Trust, teams and individuals for further awards is ongoing, including a number of nominations set to be submitted from our Research teams for the upcoming NIHR CRN Greater Manchester's Evening of Excellence.

AGENDA ITEM: 5.2

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Board assurance framework

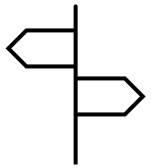
September 2021

The content of this report was last reviewed as follows:

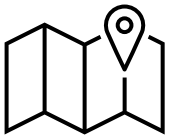
Quality and Safety Committee:	8 Sep 2021
Finance and Performance Committee:	27 Sep 2021
People Committee:	22 Sep 2021
Audit Committee:	7 Jun 2021
Executive Team:	21 Sep 2021

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

How the Board Assurance Framework fits in

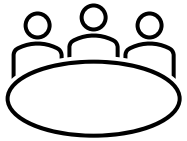


Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how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



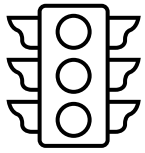
Corporate objectives: Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives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

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



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

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



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

Understanding the Board Assurance Framework

RISK RATING MATRIX (CONSEQUENCE x LIKELIHOOD)

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

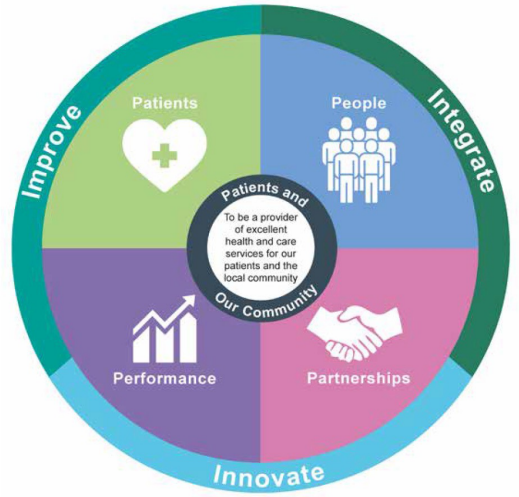
DIRECTOR LEADS

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

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

Our approach at a glance

Our Strategy 2030



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

FY2021/22: A year of balance

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

Recovering from the impact of COVID-19

- Supporting our workforce
- Recovering the elective care programme

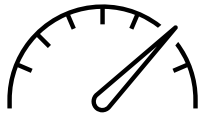
Progressing key elements of the strategy that make us unique

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

Ensuring we have a robust foundation to build on

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

Risk management

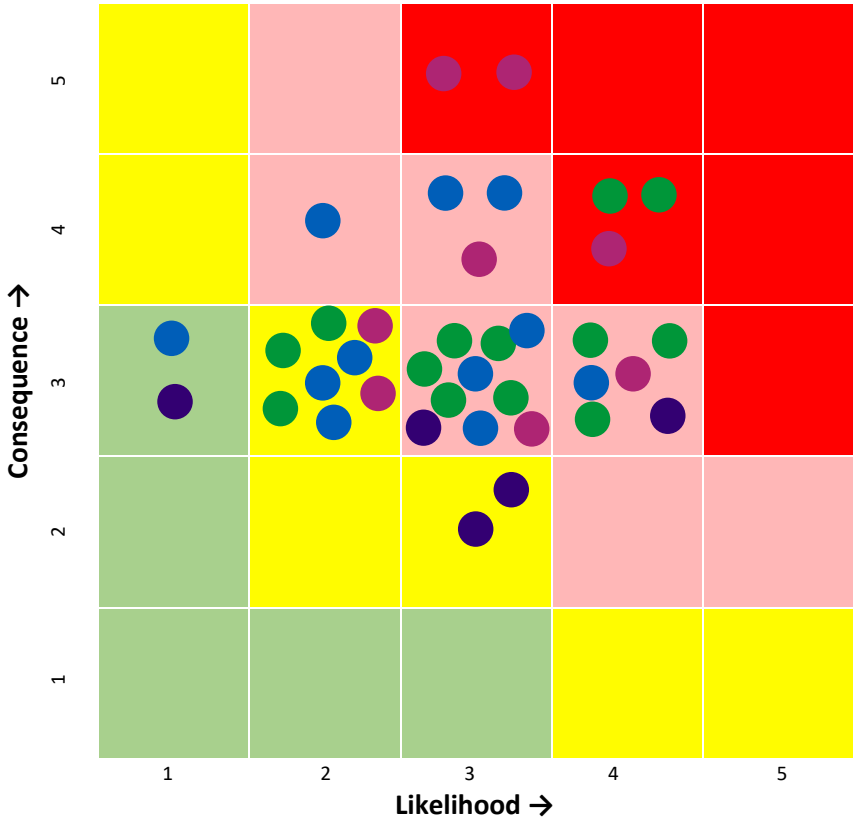


We recognise that it is best practice for organisations to have in place an agreed risk appetite statement to direct and govern decision-making at both Board and operational level. An agreed risk appetite sets the framework for decision-making across the organisation to ensure consistency of decisions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

Our risk appetite statement is as follows:

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

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



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

Patients

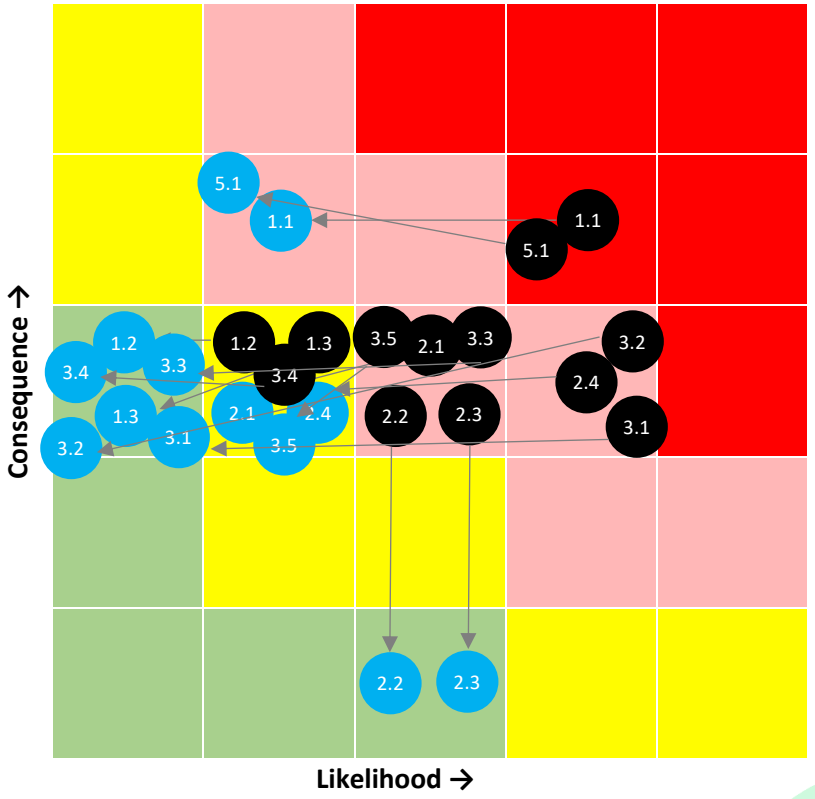
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

Monitoring: Quality and Safety Committee

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

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

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



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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
1.1 Our bed base is the second lowest in GM and lower than the average general and acute beds per 100,000 population. As SHMI calculations are based on percentages derived from bed figures, there is a risk that this artificially inflates our SHMI.	L4 x C4 16 Significant	L4 x C4 16 Significant	L2 x C4 8 High	Additional beds are available on Bryn Ward (51 beds) and Jean Heyes Reablement Unit (20 beds). Community Assessment Unit now open which will increase bed capacity (21 beds) for medically optimised patients.	Jun 2021 Jun 2021	Staffing model for permanent beds on Bryn Ward not funded, therefore the beds cannot be included in our bed base. Retrospective planning permission for Bryn Ward not yet obtained.	A business case to permanently fund the medical and nursing staffing model to be developed and presented to the Business Case Oversight Group.
1.2 There is a risk that patients will present late or be readmitted following discharge due to the lack of a joined-up pathway between primary and secondary care.	L2 x C3 6 Moderate	L2 x C3 6 Moderate	L1 x C3 3 Low	Dedicated resource now in post to provide a link between primary and secondary care and working on a joint Mortality Improvement Plan. Monthly meetings with BI/Dr Foster in place to review data Mortality Board in place Mortality mandatory agenda item at Divisional Clinical Cabinet	Jun 2021 Jun 2021 Jun 2021 Jun 2021	A pathway for common conditions with high mortality needs to be developed and monitored through the Mortality Board	Community AKI pathway devised; further training requirement identified for community staff before launch. 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 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. Further audit planned for September to explore link between length of stay and sepsis

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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
2.1 There is a lack of recognition, screening and treatment of the deteriorating patient across the foundation trust	L3 x C3 9 High	L3 x C3 9 High	L2 x C3 6 Moderate	This is a dedicated corporate objective for FY2021/22 Rapid Improvement Group Sepsis QI group Sepsis Improvement Plan Visibility of AKI and Sepsis Nurse in clinical areas AKI and sepsis audits undertaken	Jun 2021 Jun 2021 Jun 2021 Jun 2021 Jun 2021 Jun 2021	Workload demands for AKI and Sepsis nurses AKI Improvement Plan needs to be developed	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 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 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 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:	The board has recently received a detailed report on pressure ulcers which sets out a number of workstreams. The BAF entries below will therefore be amended to align with those workstreams and presented to the next meeting of the Quality and Safety Committee for review.		

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

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 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 There is a risk that poor staff retention will result in loss of skills and higher vacancy levels, meaning that staff cannot be released to undertake the training.	L3 x C3 9 High	L3 x C3 9 High	L2 x C3 6 Moderate	A diagnostic is in the process of being undertaken and will be concluded by the end of Q1 2021/22.	N/A	To be determined once the diagnostic is complete.	To be determined once the diagnostic is complete.

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

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

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

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

People

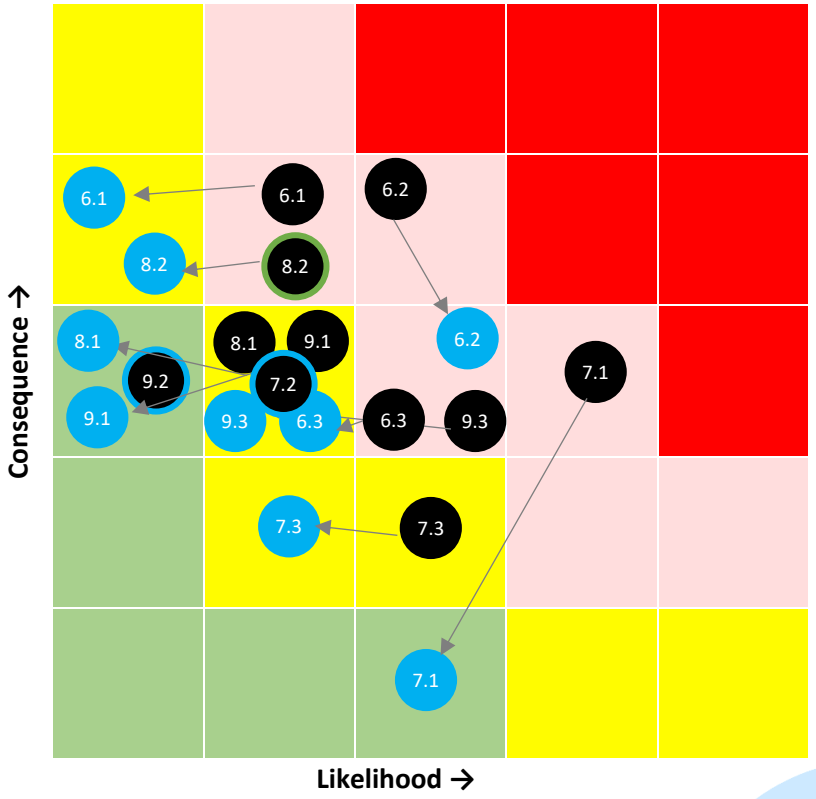
To create an inclusive and people-centred experience at work that enables our WWL family to flourish

Monitoring: People Committee

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

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

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



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

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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
6.2 There is a risk that, because of workload pressures, sufficient time is not available for staff to participate in preventative and restorative wellbeing activities within working hours, meaning that engagement levels will be lower and evidence suggests this will reduce the success of the programme.	L3 x C4 12 High	L3 x C4 12 High	L3 x C3 9 High	Targeted in-reach activities in high-risk areas. Current focus on returning redeployees and critical care. Feedback from wellbeing walkabouts 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
6.3 There is a risk that organisational commitment to wellbeing reduces as operational pressures and expectations increase.	L3 x C3 9 High	L3 x C3 9 High	L2 x C3 6 Moderate	Executive team focused on this issue at the moment 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)

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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
7.1 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 *(new risk added in Sep 2021)*	L4 x C3 12 High *(new risk added in Sep 2021)*	L1 x C3 3 Low *(new risk added in Sep 2021)*	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 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 *(new risk added in Sep 2021)*	L2 x C3 6 Moderate *(new risk added in Sep 2021)*	L2 x C3 6 Moderate *(new risk added in Sep 2021)*	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 LNA requirements may not meet the funding criteria set by HEE resulting in gap in funding	L3 x C2 6 Moderate *(new risk added in Sep 2021)*	L3 x C2 6 Moderate *(new risk added in Sep 2021)*	L2 x C2 4 Moderate *(new risk added in Sep 2021)*	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.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
8.1 There is a risk that participation in the programmes will not be prioritised as a result of other service pressures.	L2 x C3 6 Moderate	L2 x C3 6 Moderate	L1 x C3 3 Low	"Our family – Our future – Our focus" engagement reset programme under DCE leadership Board visibility of programme Launch events for Our FFF and associated programmes of work	Jul 2021 September 2021	Metrics to be reported via Board	Workforce team
8.2 There is a risk that the funding for the leadership development programmes and behaviour based 360 feedback will not be prioritised.	L3 x C4 12 High	L3 x C4 8 High *(reduced from L3 x C4=12 in Sep 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

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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
9.1 There is a risk that the organisation will not commit to person-centred employment policies which take a different approach from a more robust escalation and trigger framework	L2 x C3 6 Moderate	L2 x C3 6 Moderate	L1 x C3 3 Low	New disciplinary policy approved without amendments. Work ongoing around grievance and dignity at work policies. Coordinated move across the North West regarding attendance management / well-being policy.	Mar 2021	Focused communications around changes, particularly in relation to capability and attendance management policies linked to culture work programme	Communications Team

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 There is a risk that the organisation does not have workforce EDI expertise nor any supporting infrastructure	L3 x C3 9 High	L1 x C3 3 Low *(reduced from L3 x C3=9 in Sep 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	Director of Workforce
9.3 There is a risk that we will not get buy-in or funding for a locality-wide workforce EDI strategy	L3 x C3 9 High	L3 x C3 9 High	L2 x C3 6 Moderate	Nil 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)

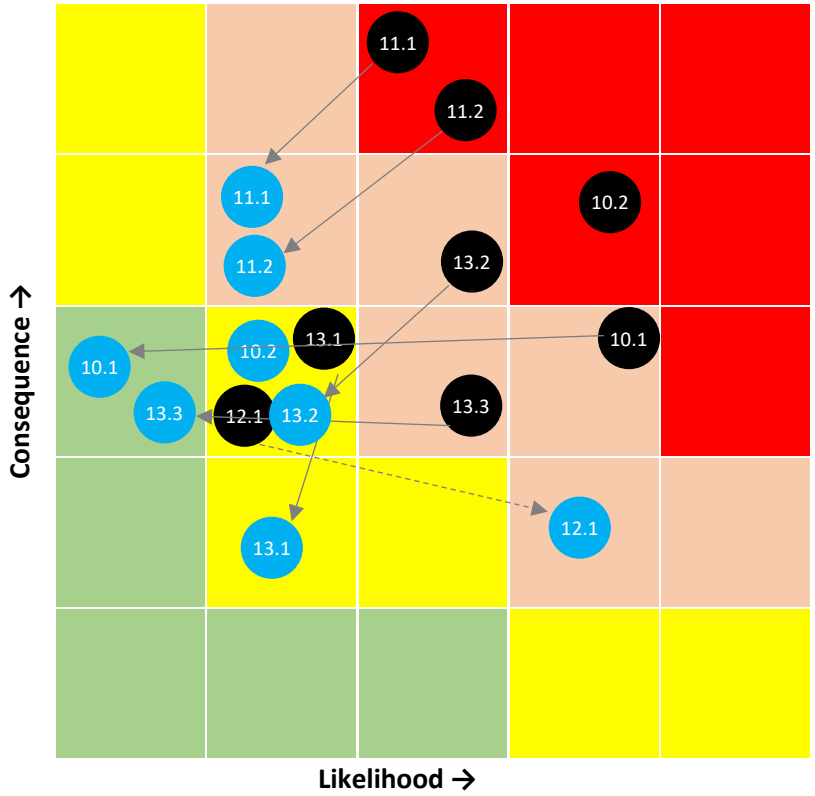
Performance Our ambition is to consistently deliver efficient, effective and equitable patient care

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:	Despite the overall 18-week waiting list continuing to grow, the number of patients waiting over 52 weeks for treatment has dropped for the fourth consecutive month, a 24% reduction against the peak in March 2021. This, combined with a 7% year-to-date reduction in the number of priority 2 urgent and cancer patients waiting for treatment, indicates that the elective strategy continues to deliver. During August, WWL had the highest activity levels in England for follow-up patients, second-highest for day case recovery and the fourth-highest for elective and first outpatients. Not all theatre capacity has been opened.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
10.1 There is a risk that because the overall waiting list is growing due to increased numbers of referrals, the waiting list is growing more quickly than we are able to address the backlog which would lead to us not being able to reduce the backlog in a timely way across all three indicators	L5 x C3 15 Significant	L4 x C3 12 Significant	L1 x C3 3 Low	Regular reviews of risk stratification are undertaken according to clinical priority in accordance with Royal College recommendations. Additional clinical check has been introduced in Div. of Surgery where largest volume of long waits are. Patient lists managed by risk stratification National communications being issued around how patients will be contacted for review (Ext)	Aug 2021 Aug 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. Harm reviews undertaken for patients waiting 104 weeks on elective pathways and 104 days on cancer pathways. Joint correspondence from WWL and CCG being sent to every patient to update them and provide contact information.

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

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

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

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 (where applicable) 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. A revised target date to create and communicate the Digital Strategy is proposed as 30 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?)
12.1 No funding is available to deliver the bullets above as the capital application was rejected on the basis of CDEL being allocated to business critical or existing commitments.	L4 x C3 12 High	L2 x C3 6 Moderate	L4 x C2 8 High	Digital strategy stakeholder engagement sessions are underway. Further sessions are due to take place in coming weeks. Lobbying via GM (Ext) 6,000 MS Office deployments completed, expected to be completed by end of October 2021. Telephone business case approved and pre-contract activity commenced. Storage cases also approved. Sepsis pathway now live.	Jul 2021 Jul 2021 Jul 2021 Jul 2021 Jul 2021	Alternative funding for digital developments to be explored sought.	Chief Information Officer to monitor availability

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

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

Partnerships

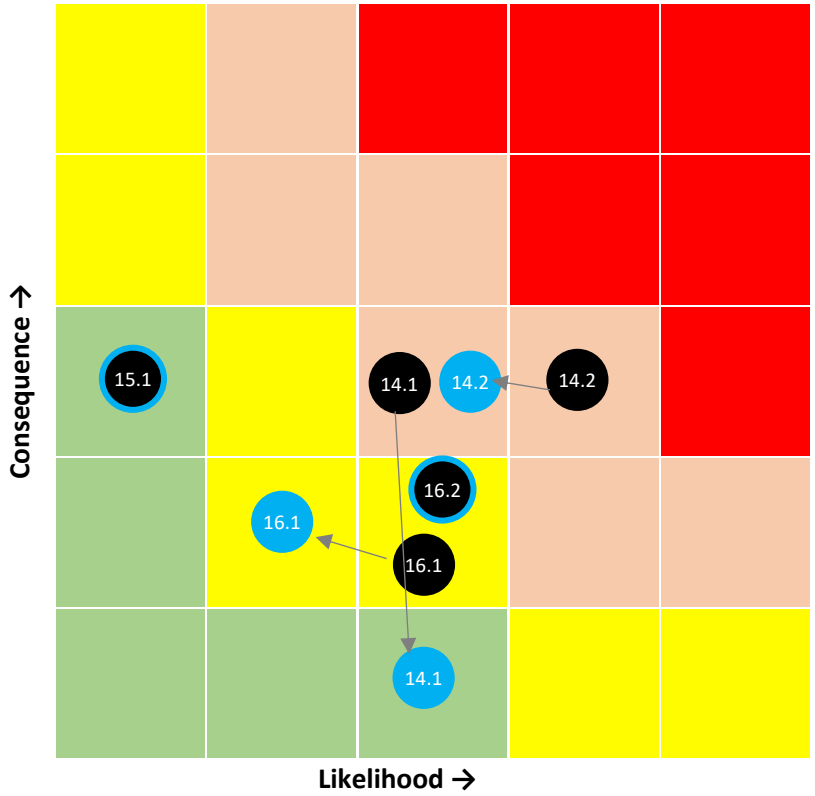
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

Monitoring: Board of Directors

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

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

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



CO14: Elective hub			
Lead Director: DSP	**Risk appetite:** Moderate (Financial and VFM)	**Assurance level:**	
Detailed objective:	We will become an elective recovery hub at Wrightington to contribute to reducing inequality of access across Greater Manchester and beyond for patients waiting for elective orthopaedic procedures. By the end of March 2022 we will have: • seen an increase in our out-of-area referrals to 10,000; and • restored and recovered to pre-COVID capacity of 20 orthopaedic sessions per working day		
Rationale for assurance level:	Wrightington has been confirmed as one of Greater Manchester's elective hubs for orthopaedics and has been awarded £800k of ERF money to support this development. Cumulative out of area referrals are on track against plan as at month 5 and advanced stages of discussion continue with Lancashire and South Cumbria ICS and also Jersey and Guernsey.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
14.1 There is a risk that there will be insufficient staff available to undertake the levels of additional activity	L4 x C4 16 Significant	L3 x C3 9 High	L3 x C1 3 Low	Additional funding secured to recruit additional staff and proactive recruitment campaign underway.	Sep 2021	National workforce constraints impacting on ability to increase establishment in key clinical posts. Ability to protect elective capacity during future surges of COVID.	Proactive approach to recruitment campaign being taken SRO member of the orthopaedic CRG and influencing the system principles around elective hubs
14.2 There is a risk that WWL will be both restricted in the amount of capital it is able to spend and capital availability.	L4 x C3 12 High	L4 x C3 12 High	L3 x C3 9 High	Submission made to Greater Manchester	Aug 2021	---	Reviewing ability to deliver within capital slippage one element of the CM capital submission.

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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
15.1 There is a risk that the organisation will not generate sufficient RCF in 2021/22 to qualify for University Hospital Association membership due to a change in criteria	L2 x C3 6 Moderate	L1 x C3 3 Low *(reduced from L2 x C3=6 in Sep 2021)*	L1 x C3 3 Low	Monitoring of NIHR grant research funding	Aug 2021	-	University Hospital Programme Board being established, which will report into the newly established Research Committee

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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
16.1 There is a risk that staff with local knowledge and understanding may be lost given the changes anticipated with CCGs	L3 x C2 6 Moderate	L3 x C2 6 Moderate	L2 x C2 4 Moderate	Locality meeting structures in place to support lasting corporate knowledge	May 2021	---	---
16.2 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 *(new risk added in Sep 2021)*	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:	Trust Board
On:	29.09.2021
Presented by:	Rabina Tindale
Prepared by:	Cathy Stanford Acting Divisional Director of Midwifery and Neonates
Contact details:	Cathy.stanford@wwl.nhs.uk 01942 773107

Executive summary

Safety Action 1 of the Ockenden Immediate and Essential actions stipulate that Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks.

All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight, and transparency. This must be done at least every 3 months.

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.

In addition to Board oversight the LMS has a responsibility from Safety Action 1 to receive all maternity Serious Incident (SI) reports for scrutiny oversight and transparency from maternity providers with onward reporting if concerns are seen. Themes or trends will be highlighted to ensure learning can be shared and quality of care is improved across GMEC.

The Maternity Safety Improvement Group (SIG) will monitor safety and outcomes in maternity services drawing on data from:

i. MBRRACE UK reports
ii. GMEC Maternity Dashboard
iii. National Maternity reviews

to fulfil the recommendations of the Royal College of Obstetrics and Gynaecology (RCOG), MBRRACE-UK and the Secretary of State's 2015 ambition for safer maternity care, the aims of the Maternity Transformation Project and Better Births.

Recommendation(s)

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

Incident exception reporting.

There are no concerning metrics to report in August however some as detailed below require the board to be provided with assurance that these are being appropriately managed and reviewed.

There have been no cases reported to the Healthcare Safety Investigation Branch (HSIB) or babies diagnosed with HIE 2 or 3, and no other Steis reportable incidents have occurred.

There was 1 Stillbirth in August at 24 weeks gestation which has undergone the recommended Perinatal Mortality Review Tool (PMRT) multi-disciplinary review. No immediate cause has been identified however additional investigations are still awaited and mother was Covid + in the weeks prior to delivery.

Ockenden Exception Report to Board

Maternity services have submitted their evidence to the Ockenden Portal for review by the regional and National teams. Feedback has been delayed and is now expected in late October. The Ockenden Task and Finish group led by the Medical Director and Chief Nurse remains ongoing and meets monthly at present to review the ongoing action plan for the 7 Immediate and essential actions (IEA'S).

Twice daily Consultant ward rounds was an outstanding action, and these are now in place 7 days per week since July 31, 2021.

Audits to demonstrate compliance with the recommendations within the 7 IEA's are due to be repeated to ensure that actions are embedded into normal practice.

There is one amber action remaining for **IEA7: Informed Consent :** All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery. Work is ongoing and progressing well with this. There has been a full website re-design to meet the Ockenden recommendations with information streamlined and easier to access. Links to approved sites with additional signposting to further information is available. The web pages are currently undergoing testing and just awaiting some further topics to be finalised.

CNST

Compliance was declared in July with all 10 Year 3 CNST Safety Actions, with 2 actions requiring an action plan which have also be submitted to NHSR and feedback is still awaited.

The 2 actions plans are being progressed and a business case has been developed to support the recruitment of 2 Advanced Neonatal Nurse Practitioners to support the Tier 1 Junior Doctors rota and provide senior expertise within the neonatal unit.

The second is in respect to CO monitoring for women at 36 weeks gestation, this was halted during the peaks of Covid and gradually reintroduced back into practice earlier this year, full compliance is expected to be achieved and ongoing audits are in place each month to monitor compliance.

The Maternity Incentive Scheme Year 4 was published on the 9 August 2021 and requires completion and submission by June 30, 2022. The 10 safety actions remain the same but with some additional requirements. These are currently being analysed by the leads for each safety standard.

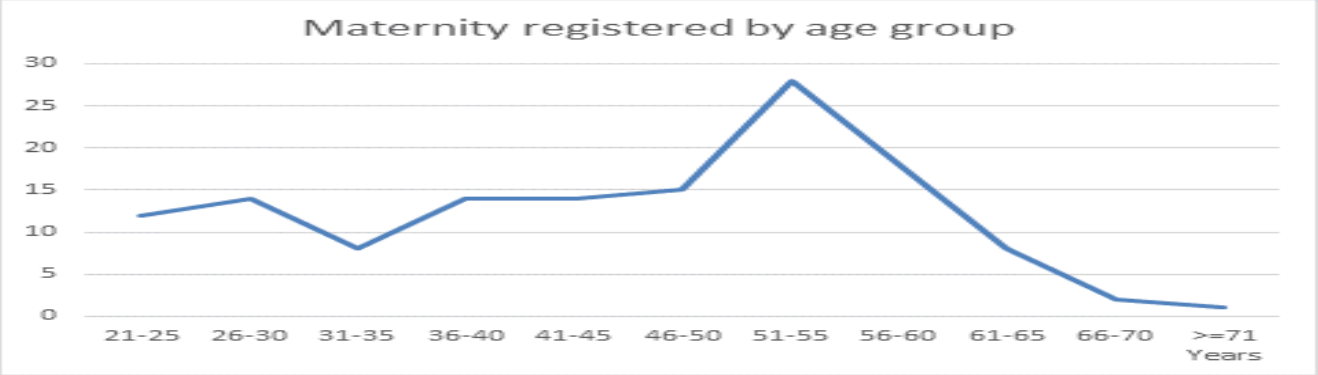
An evidence template has been supplied this year which will be useful to provide the Board with ongoing assurance that all actions are being advanced.

The timeframe for completion is reduced this year as only 10 months has been given to demonstrate compliance therefore it is intended that quarterly updates will be provided to the Board with the first to be in November 2021.

Staffing

Maternity services have been allocated funding for staffing and training purposes to improve safety and quality of care, from the Ockenden funding bid that was submitted based on Birthrate+, Midwifery staffing reports, and training requirements. The funding has enabled recruitment to the current vacancies based on 2400 births per year.

A full staffing report is due to be presented in October 2021 to The Board, and to project the numbers of Midwives required going forward we have looked at the age profile of the current headcount of qualified Midwives and 43% are aged over 50, which may result in increased retirements over the next 5 years onwards.



Midwifery Turnover		
	19/20	20/21
Annual Turnover	13	21
Annual % Turnover	9.69%	15.07%
Average Maternity Leaves Per Month	3	3

It is known Nationally that there is an aging workforce in Nursing and Midwifery, therefore the HIE's have been working with Trust's to increase the number of student Midwives that we train for the next 5 years with the end column below indicating approximately how many may qualify each year. Not all of these students will go on to qualify or stay at WWL after completion of their course, but this gives an indication of projected numbers coming through training to offset the number of staff retiring and leaving the service.

Year	Number Short Course, Post RN (18months)	Number Long course(3 years)	Total
2022	10	1	11
2023	16-19 (3 on mat leave)	0	16-19
2024	18-24 (depending on numbers from Salford)	0	18-24
2025	18-24(depending on numbers from Salford)	0	18-24
2026	18-24(depending on numbers from Salford)	0	18-24

At the start of the recruitment process there were 13.58 WTE Registered midwife vacancies across the Maternity service, 9.44 WTE will be in post in September/ October 2021, as they are all newly qualified and awaiting PIN numbers .(6 are WWL trained Midwives and 4 from other organisations)

Due to ongoing attrition with staff leaving and staff reducing hours for flexible retirements we currently still have 5 WTE posts to recruit to and we have also been successful in securing an additional International Midwife through the LMS/ GTEC allocation process and it is hoped that we will be able to secure further recruits going forward. Due to the lower numbers of student midwives qualifying in 2022 there is a high likelihood that we will have a shortfall if attrition follows the same upward trajectory.

In addition to the vacancies for midwives the service continues to have significant challenges with absences due to Covid, some are LTS but predominately these have been for self-isolation due to family members however in recent weeks there have been increasing numbers of staff testing Positive.

The short and long-term sickness in addition to the on-going vacancies is adversely affecting staffing levels across the service and many shifts are not staffed to the appropriate ratios, however it is hoped that we will have an improved position by the end of October / early November when the majority of the new staff in post will have completed their supernumerary period.
There have been no Maternity Diverts in August as staff have been re-deployed wherever possible and NHSP has been utilised to cover, however this is being managed daily to ensure safe staffing numbers are in place wherever possible.

Maternity Risks

There are no maternity risks scoring 15 or above. All risks have recently been reviewed and updated. Old risks that are no longer appropriate have been archived. 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) recommends that the time midwives spend co-ordinating a service, for example labour ward, should not be included in calculating staffing requirements. Anytime dedicated to these duties should be supernumerary.

All mitigations are in place. Staffing levels were increased to ensure adequate staffing establishment to allow coordinators to remain supernumerary. In times when this has not been possible it is reported as a Maternity Red Flag incident and is also captured monthly on the maternity dashboard. Average compliance is usually above 99%, however this has been reduced slightly for periods in the last 2-3 months due to the ongoing staffing issues due to the vacancies and increased sickness. No harm events have been identified during any period where the coordinator was not able to remain supernumerary.

Conclusion

Overall a positive month with no serious incidents to report despite high rates of activity and acuity and shortfalls in staffing.

All incidents continue to be reviewed and escalated appropriating through ESG, with additional local and regional oversight of all moderate and above incidents.

Training compliance remains on track with a robust training programme in place to meet the requirements of CNST and Saving Babies Lives recommendations.

It is hoped that staffing will stabilise in the coming weeks with the new starters and that sickness levels may recover to pre covid levels. Regular review of staffing is undertaken and escalated through the maternity management team. There is a comprehensive escalation policy in place which follows the regional recommendations for divert and closure of the unit.

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	Sep	Oct	Nov	Dec
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		Q2 Report to be presented at October meeting			
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				
The number of incidents logged graded as moderate or above	7	6	5	6	6	7	9	2				
Training compliance for all staff groups in maternity as per CNST requirments (need 90% compliance rate for all staff groups by July 2021)												
Cardiotocograph (CTG) training and competency assessment	Midwives 82% Consultant 72% Registrars 75%		Midwives 92.8% Consultant 100% Registrars 90.4%	Midwives 98% Consultant 100% Registrars 90.4%	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	Midwives % Consultant % Registrars %	Midwives % Consultant % Registrars %		
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 HCA's Consultant Registrars Anaesthetists	Midwives HCA's Consultant Registrars Anaesthetists		
Rolling Percentage												
Prospective Consultant Delivery Suite Cover (60 as standard for WWL)	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%				
Supernumeray Shift Co-ordinator	100%	100%	100%	100%	95.20%	100%	98.50%	95.20%				
Number of Datix submitted when shift co-ordinator not supernumerary	0	0	0	0	3	0	4	5				
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.				
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.				
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				
Coroner Reg 28 made directly to Trust	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.				
Number of StEIS Reportable Incidents/HSIB case	1	0	1	0	0	0	0	0				
Number of Stillbirths	1	1	0	0	0	0	0	1				
Number of Neonatal Deaths	0	1	0	0	0	0	0	0				
Number of Maternal Deaths	0	0	0	0	0	0	0	0				

Title of report:	Maternity Dashboard
Presented to:	Trust Board
On:	29.09.2021
Presented by:	Rabina Tindale
Prepared by:	Cathy Stanford Acting Divisional Director of Midwifery and Neonates
Contact details:	Cathy.stanford@wwl.nhs.uk 01942 773107

Executive summary

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

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

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

• Green – Performance within an expected range.

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

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

Recommendation(s)

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

Maternity Dashboard August 2021

Introduction
The Better Births report (2016) recommended that multi-professional teams and their organisations must be able to regularly compare their own outcomes over time and with their peers, to track, benchmark and improve the quality of maternity services. This should be facilitated by a nationally agreed set of indicators.

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.

August 2021 Exception report

Summary.
Predominantly the dashboard is green or amber for August. There has been a sustained increase in activity and births throughout the last 3 months.
There have been no cases reported to the Healthcare Safety Investigation Branch (HSIB) or babies diagnosed with HIE 2 or 3, and no other Steis reportable incidents have occurred. There have been no letters of claim received.
Once again, we have received no formal maternity complaints in August and the service continues to receive positive feedback letters and messages from women regarding the excellent care they have received.
There was one Stillbirth in August at 24 weeks gestation however the overall stillbirth rate remains very low to date and is currently the lowest in GM. All stillbirths are subject to a multi-disciplinary review utilising the Perinatal Mortality Review Tool (PMRT) in line with National recommendations.
There were no Neonatal Deaths.
Whilst it is not a RAG rated metric the number of major obstetric haemorrhages has been at 0.5% or less for the whole of the year which is significantly assuring

It is noted from the July minutes that the Board wished to seek assurance regarding:

- **Maternal re-admissions within 30 days of delivery.** As advised by the coding team currently the process for patients attending the assessments areas and SDEC is for them to be recorded as admissions and the length of stay is not considered. BI have been asked if a separate report can be created for Maternity patients for attendance over 4 hours which may give a clearer reflection of those who were admitted to an in-patient area for a period. However, all cases are reviewed to identify any themes and trends.
- **Robson Group Criteria** , this will be incorporated into the Maternity information system Euroking but requires the system providers to update our current version which is scheduled within the coming months. Upon completion reports can be generated against each Robson Group identifying the type of delivery as certain groups will have a higher risk of a Caesarean Delivery.
- **Triangulation of community data with in-hospital data.** Predominantly the maternity dashboard looks at birth outcomes from a regionally agreed set of indicators.
  These indicators aim to provide a holistic picture of the performance of maternity services and cover mortality and morbidity, choice and continuity of carer, clinical care and health promotion, and user experience. Providing WWL include the minimum data set to be included within the

regional dashboard we are free to add any additional metrics as we see fit. Whilst there are some community indictors and outcome measure it is agreed that it is very heavily in-patient focused and the service will look to develop relevant indicators that can be extracted from the Maternity system, such as compliance with CO monitoring at 36 weeks and completion of individualised care plans.

- **Review of green indicators.** The majority of the data for the dashboard is extracted from the Maternity information system and as such is verified, any data entered which would be outside of the expected ranges have inbuilt warning flags, to check data inputted is correct. Monthly Quality and validation reports are generated as extracts are uploaded to NHSX for the Maternity System Data Set (MSDS) by BI.
  These data uploads form part of the CNST Safety Action 2 to assess completeness and quality of data. Other data that is taken from internal data bases and systems such as BI Apps and Datix etc will have their own verification and data quality checks. Internal training logs and data bases record the attendance at mandatory training and skills drills sessions and can be verified against the E Roster system. The maternity service has recently recruited a Digital Midwife who will have the responsibility for ensuring data quality checks are in place and that data extracted and submitted is validated to support the successful completion of safety Action 2 and to ensure staff are trained and understand the importance of ensuring data is captured correctly and accurately. The Digital Midwife will also help to drive the Maternity Digital agenda forward within the Trust with the support of IM&T team.

Green
The Midwife to Birth ratio is currently at 1:28. However this does not factor in the acuity of women.

- Due to the recommended interventions to reduce the prevalence of stillbirths, perinatal deaths and the number of term babies admitted to neonatal units, the consequence of these appropriate interventions is an increase in the number of inductions and more women reporting concerns about fetal movements.
- Women with greater health needs, high rates of smoking prevalence and higher BMI scores increase still further the demands placed on maternity services.
- More recently Maternity has seen an increase in women who are Covid Positive with a small percentage of these being very unwell and requiring higher level care and intervention.

However, despite the increase in activity and acuity across the service 1-2-1 care in labour has been maintained at 100%.

Amber
The overall Caesarean section rate has remained around the national average; this rate will continue to fluctuate month on month. Work will be commenced to introduce the Robson method which classifies all deliveries into one of ten groups based on five parameters: obstetric history, onset of labour, fetal lie, number of neonates, and gestational age and gives a more accurate analysis and comparison of caesarean section rates.

Induction of Labour (IOL) has remained consistently high, these are reviewed and are appropriate to clinical conditions and within National recommendations. Induction of Labour should not be considered in isolation and should always viewed in conjunction with outcomes such as Stillbirth and HIE rates.

Red
Supernumerary Shift coordinator compliance has been reduced in August due to staffing shortages and increased activity and acuity.

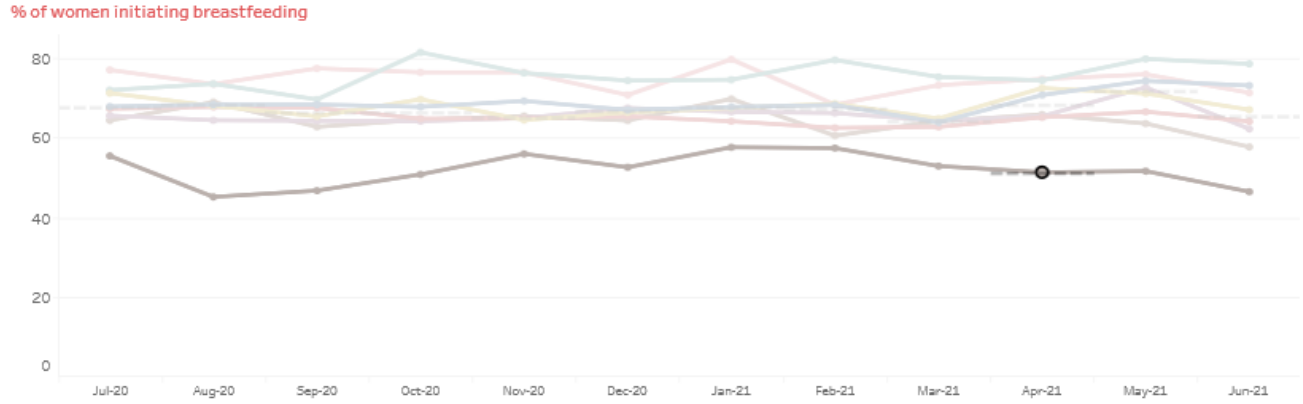
- To maintain 1-2-1 care in labour there have been several occasions where the shift co-ordinator has been unable to remain in a supernumerary capacity, this is reported via Datix,

and no avoidable harm events have been linked with these periods. However there has been an increase in the number of Red Flag incidents reported.

The service strives to maintain safe staffing levels, and any shortfalls are covered by NHSP whenever possible however this is becoming increasingly more challenging and short-term sickness due to Covid isolations is impacting on staffing levels. Recruitment to vacancies remains ongoing and 6 newly qualified Midwives are due to commence in September.

The number of mothers who have opted to breastfeed has remained below target for some time and is significantly reduced in August. The midwifery team in conjunction with the infant feeding team continue to actively promote the benefits of breastfeeding to all mothers and families.

The benefits of initiating breastfeeding are widely understood however there remains a cultural element within the borough that keeps the rates low. It is known that women from lower socio-economic backgrounds and those not exposed to this within the family dynamic will be less likely to choose to breastfeed. However, there is a requirement that this is addressed more widely within the system as a whole and this will be discussed with our partners in the CCG and council as to how we can collectively address the barriers to initiating breastfeeding and supporting parents to make this choice.



Hospital Name	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Bolton	67.92	68.40	68.41	67.84	69.32	67.07	67.80	68.29	63.93	70.81	74.37	73.20
East Cheshire												
MFT - North Manchester	71.29	68.08	65.45	69.74	64.53	66.43	67.57	68.64	64.89	72.56	71.19	67.12
MFT - Oxford Road	67.38	67.83	67.59	64.85	64.90	65.44	64.21	62.54	62.80	65.20	66.62	64.19
MFT - Wythenshawe	72.05	73.63	69.70	81.54	76.34	74.44	74.66	79.63	75.36	74.50	79.89	78.65
Pennine O	65.63	64.47	64.34	64.22	65.02	67.54	66.58	66.28	64.35	65.45	72.73	62.30
Stockport	77.12	73.56	77.51	76.53	76.51	70.82	79.78	68.40	73.29	74.81	76.01	71.38
Tameside	64.43	69.02	62.81	64.58	65.54	64.41	69.83	60.59	64.20	65.92	63.64	57.75
WWL	55.50	45.18	46.76	50.84	56.00	52.63	57.67	57.46	52.94	51.38	51.67	46.49
MEDIAN	67.65	68.24	66.52	66.34	65.28	66.75	67.69	67.29	64.28	68.36	71.96	65.65

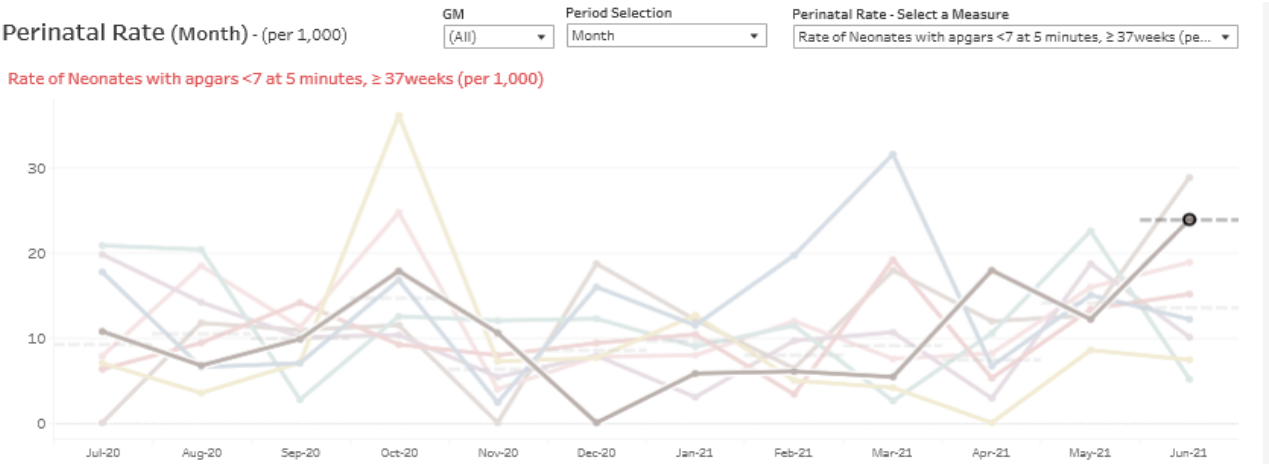
Re-admissions of babies within 30 days of Birth has seen a significant increase in August further analysis of these admissions will need to be undertaken to determine if this is due to the expected increase in respiratory conditions in babies and children or just a spike in normal admission spells, however higher admission numbers usually coincide with seasonal illness.

All infants with Apgar's less than 7 at 5 minutes will have an IPIR completed to review the care and management and to ensure that correct procedures were followed.

The National average for Apgars less than 7 at 5mins is currently 1.2%. WWL has an annual rate of 1.02% which is below the National average however we will continue to monitor this and review all cases Apgar's less than 7 at 5 minutes are an important indicator of the baby's well-being at birth.

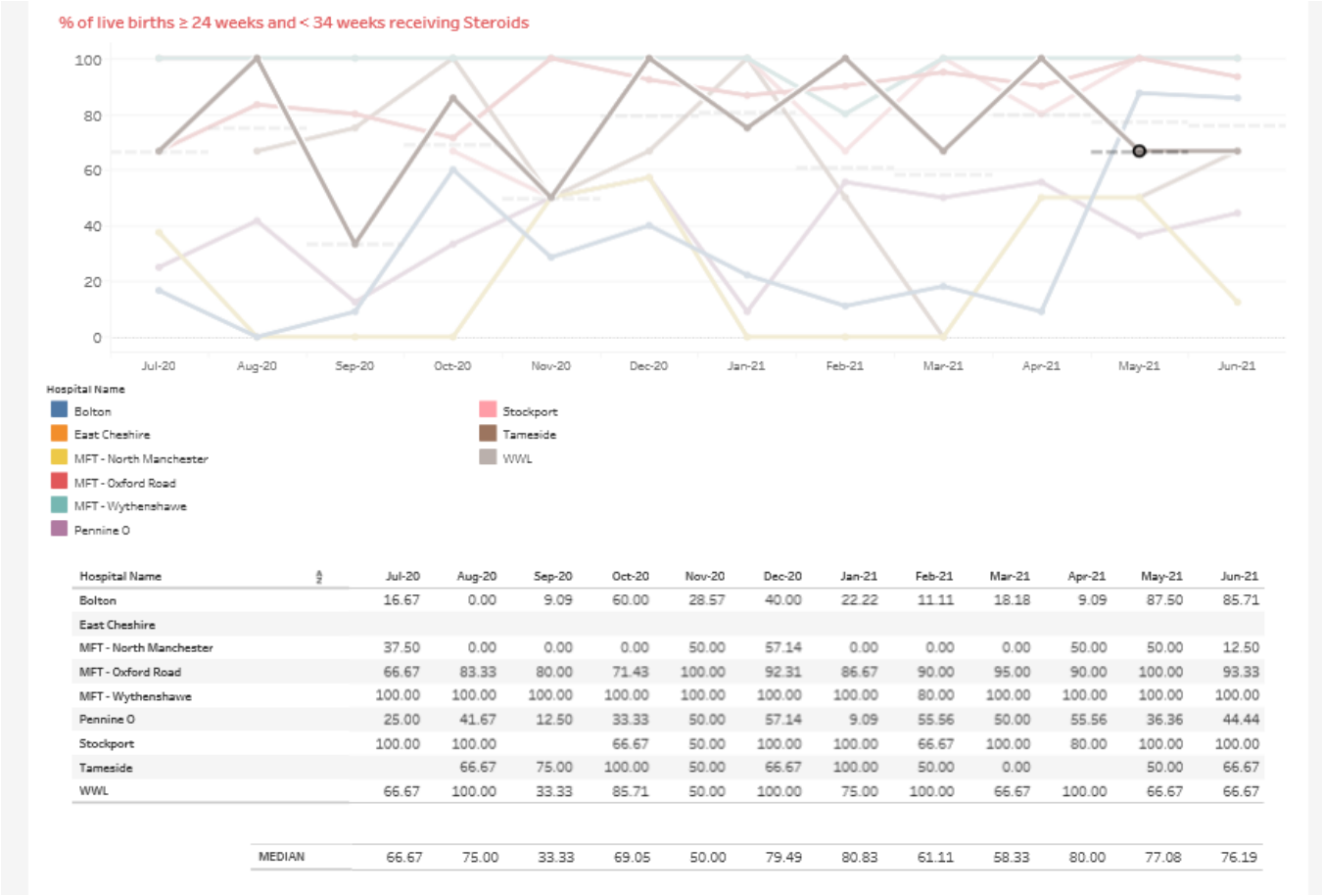
Whilst WWL numbers are not significantly raised, they are showing a steady increase when mapped within the regional dashboard as demonstrated below. A look back of all the cases since March when the upward trend started will be completed and the findings relayed to the Board.

The Apgar score alone should not be considered as evidence of asphyxia or evidence of an intrapartum hypoxic event, however low Apgar scores at 5 minutes can correlate with increased morbidity and indicate that increased surveillance and monitoring is required. It should be noted that most infants with low Apgar scores do not go on to develop any Neurological deficit.



Hospital Name	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Bolton	17.66	6.52	6.99	16.74	2.37	15.92	11.42	19.61	31.46	6.64	14.96	12.14
East Cheshire												
MFT - North Manchester	6.99	3.50	7.04	36.00	7.19	7.60	12.61	4.95	4.12	0.00	8.51	7.38
MFT - Oxford Road	6.27	9.36	14.08	9.17	7.91	9.35	10.36	3.34	19.11	5.22	13.31	15.08
MFT - Wythenshawe	20.76	20.29	2.70	12.47	11.98	12.20	8.93	11.40	2.56	10.50	22.47	5.12
Pennine O	19.72	14.12	10.05	10.28	5.38	7.87	3.00	9.62	10.61	2.87	18.62	10.03
Stockport	7.81	18.38	11.19	24.65	3.94	7.75	7.91	11.90	7.49	8.13	15.87	18.80
Tameside	0.00	11.70	10.87	11.43	0.00	18.63	12.05	6.37	17.86	11.90	12.58	28.74
WWL	10.70	6.71	9.80	17.78	10.53	0.00	5.78	6.02	5.38	17.86	12.12	23.81
MEDIAN	9.25	10.53	9.93	14.60	6.29	8.61	9.65	7.99	9.05	7.38	14.14	13.61

Maternal steroids are given to mature the fetal lungs when premature labour is suspected, or early delivery is required.
It is recommended that the mothers of all babies born less than 34 weeks gestation are offered 2 single doses of intramuscular steroids(at least 12 hours apart) to aid fetal lung maturity. The national compliance is expected to be 85%. There were 5 eligible singleton births in April and 60% compliance was achieved. However, all babies had at least one dose prior to delivery, and all have been reviewed and identified that here was no opportunity to administer the second dose before delivery.



Hospital Name	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Bolton	16.67	0.00	9.09	60.00	28.57	40.00	22.22	11.11	18.18	9.09	87.50	85.71
East Cheshire												
MFT - North Manchester	37.50	0.00	0.00	0.00	50.00	57.14	0.00	0.00	0.00	50.00	50.00	12.50
MFT - Oxford Road	66.67	83.33	80.00	71.43	100.00	92.31	86.67	90.00	95.00	90.00	100.00	93.33
MFT - Wythenshawe	100.00	100.00	100.00	100.00	100.00	100.00	100.00	80.00	100.00	100.00	100.00	100.00
Pennine O	25.00	41.67	12.50	33.33	50.00	57.14	9.09	55.56	50.00	55.56	36.36	44.44
Stockport	100.00	100.00		66.67	50.00	100.00	100.00	66.67	100.00	80.00	100.00	100.00
Tameside		66.67	75.00	100.00	50.00	66.67	100.00	50.00	0.00		50.00	66.67
WWL	66.67	100.00	33.33	85.71	50.00	100.00	75.00	100.00	66.67	100.00	66.67	66.67
MEDIAN	66.67	75.00	33.33	69.05	50.00	79.49	80.83	61.11	58.33	80.00	77.08	76.19

Conclusion

Overall a very positive dashboard highlighting many areas of good practice during a period of high acuity and activity. Further review of the red metrics against regional rates has demonstrated that WWL is not an outlier within all these areas, but there are some that require further monitoring and review to demonstrate improvements going forward.

A further review of breastfeeding support within the borough is to be explored with the aim to increase the initiation rates and improve the health and outcomes for mothers and babies within the Wigan and Leigh areas. The number of infants re-admitted within 30 days of birth will be carefully monitored to see if there is a trend emerging with respiratory conditions as the service prepares for the expected surge in this in the coming months.

	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of Women Delivered	166	216	238	200	190	189	181	204	181	180	228	229	241				
Number of Registerable Births	167	220	241	202	193	192	182	208	181	182	232	229	241				
Number of Bookings(retrospective 1 month)	216	247	233	226	246	238	252	285	231	214	222	205	222				
Normal Births as % of births	104	120	130	135	120	101	105	125	106	112	132	131	137				
% of Successful Planned Home Births	2	2	2	4	4	5	7	4	4	5	0	4	2				
Instrumental Deliveries as % of births	16	22	43	20	15	30	23	22	27	16	32	30	29				
Total Caesarean Sections as % of births	46	78	68	65	58	61	54	61	48	54	68	68	75				
% Emergency Caesaean Sections	29	51	35	37	34	40	34	37	26	28	44	32	36				
% Elective Caesarean Sections	18	27	33	28	24	21	20	24	22	26	24	36	39				
Number of successful VBAC deliveries	2	3	2	7	3	8	6	3	5	8	9	7	6				
%of Caesarean Sections at Full Dilatation	7	7	1	5	6	6	4	1	4	4	5	1	2				
Induction of Labour as % of women delivered	74	77	92	80	79	82	75	94	69	72	97	80	100				
% of women induced when RFM is the only indication <39 weeks	2	3	2	4	0	2	3	3	2	2	1	1	4				
% of women induced for Suspected SGA	13	15	15	13	14	13	22	25	14	20	14	26	16				
Average Postnatal Length of Stay	1.6	1.5	1.7	1.6	1.5	1.4	1.6	1.6	1.5	1.6	1.3	1.5	1.4				
Number of In-utero transfers in from other units	2	1	0	1	1	1	0	0	0	0	0	3	1				
Number of In-utero transfers out to other units	1	1	6	0	0	0	4	1	0	5	0	0	0				
%of Women Smoking at Booking	14%	16%	18%	15%	10%	15%	10.71%	8.42%	11.69%	7.94%	13.51%	13.10%	11.20%				
% of Women Smoking at Delivery	16%	19%	15%	15%	12%	15%	16.57%	10.10%	15.10%	10%	11.84%	14.85%	8.6%				
Babies in Skin-to-Skin within 1 hour of birth	144	176	195	169	160	156	146	171	146	145	174	184	192				
Percentage of Women Initiating Breastfeeding	85	101	121	112	100	109	104	108	93	93	125	117	114				
Percentage of Women booked by 12+6 weeks	190	218	212	210	232	219	223	263	210	193	202	200	198				
Prospective Consultant hours on Delivery Suite	60	60	60	60	60	60	60	60	60	60	60	60	60				
Midwife: Birth Ratio	23	22	23	25	25	25	24	25	24	25	25	26	28				
1:1 Care in Labour	139	172	196	167	156	156	153	172	151	145	192	200	200				
Percentage of shifts where shift Co-ordinator able to remain supernumerary	100%	100%	100%	100%	100%	100%	100%	100%	100%	95.20%	100%	98.45%	95.16%				
Diverts: Number of occasions unit unable to accept admissions	0	0	0	0	0	0	0	0	0	0	0	1	0				
Diverts: Number of women during period affected by unit closure	0	0	0	0	0	0	0	0	0	0	0	0	0				
Number of Midwives in Post	138	140	140	133	134	134	134	137	137	137	144	144	144				
Attendance at Skills Drills/Mandatory Training	16	14	13	14	16	18	14	23	16	10	9	9	12				
3rd/4th Degree Tear as % of births	2	3	8	6	3	6	6	6	7	5	8	9	3				
with unassisted births (normal)	2	1	4	4	3	5	3	3	2	4	5	3	2				
with assisted births (Instrumental)	0	2	4	2	0	1	3	3	5	1	3	6	1				
Episiotomies in Normal Birth	11	12	11	6	9	8	5	11	8	9	9	4	10				
PPH >2.5L as % of births	1	0	3	1	2	1	0	1	0	1	0	0	0				
Number of Blood Transfusions > 4 Units	1	0	1	1	1	1	0	1	0	4	0	0	0				
Number of Women Requiring Level 2 Critical Care	4	4	0	2	2	2	3	1	1	0	1	1					
Number of Women Requiring Level 3 Critical Care	1	0	0	0	0	0	0	1	0	0	1	0					
Maternal Deaths	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	2	0	1	2	2	1	1	3	5	1					
Stillbirths **	1	1	0	1	0	1	1	0	0	0	1	0	1				
Early Neonatal Deaths (before 7 days)	0	0	0	0	1	0	1	0	0	0	0	0	0				
Number of Neonates with Apgars <7 at 5 minutes (>37 weeks gestation)	1	2	4	2	0	1	1	1	3	2	5	1	3				
HIE 2 &3 > 37 weeks (reported retrospectively)	0	0	0	0	0	1	0	0	0	0	0	0	0				
Shoulder Dystocia	2	6	2	1	0	0	4	2	4	3	4	2	1				
Singleton Babies born <30 weeks gestation	3	1	0	1	1	0	2	1	0	0	1	2	1				
% whose mother received magnesium sulphate	3	1	0	1	1	0	2	1	0	0	1	2	1				
Singleton Babies born <34 weeks gestation	8	3	7	2	2	4	4	3	3	4	4	5	5				
% whose mother received full course steriods (1 week prior to delivery)	6	1	5	0	1	3	3	1	3	2	4	3	3				
Births >37 weeks gestation	149	204	225	190	171	173	166	186	168	165	210	211	223				
Unexpected Term Admissions to NNU as % of births > 37 weeks gestation.	5	5	4	5	5	8	2	8	8	3	9	5	10				
Number of babies re-admitted with 28 days of birth	12	15	18	14	12	21	9	14	17	14	18	15	28				
Number of indicents reported	53	57	91	42	53	67	58	51	61	70	86	60	65				
Number of Concise Investigations	0	0	0	0	0	0	1	2	0	0	0	0	0				
Number of StEIS Reported Incidents	0	0	0	0	0	1	0	1	0	0	0	0	0				
Number of Midwifery Red Flags Reported	0	0	0	0	0	0	0	0	0	4	0	2	3				
Number of Complaints	0	0	0	1	0	0	1	0	0	0	0	0					
Number of Letters of Claim Received	0	0	0	0	0	0	0	0	0	0	0	0					

REGIONAL METRICS

Number of Live Births born ≥16 weeks to <24 weeks	0	0	0	0	0	0	1	0	0	0	0	0	0				
Number of Live Births born ≥24 weeks to <37 weeks	17	15	16	11	22	18	14	23	13	17	21	17	16				
Number of Live Births born ≥24 weeks to <34 weeks	9	3	7	4	4	6	6	3	3	6	6	5	5				
Number of Live Births ≥38 weeks	132	175	198	177	149	159	149	167	152	147	182	191	203				
Number of Live Births ≥39 weeks	115	146	170	144	112	134	129	133	120	113	130	150	163				
Number of Episiotomies performed	27	26	47	21	21	36	25	27	29	25	34	27	37				
Number of babies born <3rd centile	.	.	.	.	.	.	.	.	9	9	14	9	9				
Number of Major Haemorrhages ≥ 2500mls	1	0	3	1	2	1	0	1	0	1	0	0	0				
Intrapartum Stillbirths	0	0	0	0	0	0	0	0	0	0	0	0	0				
Number of Early Neonatal Deaths 20+0 to 23+6 weeks	0	0	0	0	0	0	1	0	0	0	0	0	0				
Number of Early Neonatal Deaths > 24 weeks	0	0	0	0	1	0	0	0	0	0	0	0	0				
Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received magnesium sulphate	5	1	2	4	2	6	6	2	2	3	4	4	4				
Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received steroids	6	1	3	4	3	5	6	2	3	4	4	5	5				
Number of babies less than 3rd centile delivered >38 weeks	2	9	4	3	7	0	4	5	3	4	8	4	5				
Number of women smoking at the time of booking	30	40	43	33	25	36	28	24	27	17	30	30	27				
Number of women smoking at delivery	26	41	37	30	24	31	30	23	20	18	27	34	21				
Friends & Family Test:Q2 Birth:Percentage returned complete	.	.	.	.	.	.	.	.	.	.	.	.	.				
Friends & Family Test:Q2 Birth:Percentage of completed surveys returned as recommended	.	.	.	.	.	.	.	.	.	.	.	.	.				
Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were symptomatic	.	0	1	3	0	2	0	0	0	0	2	4	2				
Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were asymptomatic	.	1	12	4	4	1	3	3	1	1	0	3	5				
Number of babies born at Home Midwife NOT present	.	2	1	1	1	2	1	0	4	0	1	1	1				
Number of babies born in Other location Midwife NOT present	.	1	0	0	0	1	0	0	0	1	1	1	1				

NHS
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					582	595	470		1647	
	Number of Bookings(retrospective 1 month)	≥240	≤200	2020 Bookings	216	247	233	226	246	238	252	285	231	214	222	205	222					775	667	427		1869	
	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%					56.9%	58.8%	57.0%		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%					2.7%	1.5%	1.3%		1.9%	
	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%					12.9%	12.6%	12.6%		12.7%	
	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%					30.2%	28.6%	30.4%		29.7%	
	% 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%					19.1%	16.5%	14.5%		16.8%	
	% 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%					11.2%	12.1%	16.0%		12.9%	
	Number of successful VBAC deliveries			Births/month	2	3	2	7	3	8	6	3	5	8	9	7	6					17	22	13		52	
	%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%					6.3%	7.6%	2.1%		5.5%	
	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%					43.1%	40.0%	38.3%		40.6%	
	% 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%					1.4%	0.8%	1.1%		1.1%	
	% 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%					10.3%	8.1%	8.9%		9.1%	
	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	1.4					1.5	1.5	1.0		1.0	
	Number of In-utero transfers in from other units				2	1	0	1	1	1	0	0	0	0	0	3	1					1	0	4		5	
	Number of In-utero transfers out to other units				1	1	6	0	0	0	4	1	0	5	0	0	0					5	5			10	
	%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%					11.4%	11.0%	8.1%		7.6%	
	% 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%					14.0%	12.3%	7.8%		8.5%	
	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%					81.6%	78.3%				
	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%					55.3%	52.4%				
	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%					91.0%	90.7%	93.2%		91.4%	
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					180	180	120		480	
	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					1.74	1.74	1.54		3.02	
	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					99.6%	99.4%	5049.7%		1337.1%	
	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%					100.0%	98.4%	96.8%		98.6%	
	Diverts: Number of occasions unit unable to accept admissions				0	0	0	0	0	0	0	0	0	0	0	1	0					0	0	1	0	1	
	Diverts: Number of women during period affected by unit closure				0	0	0	0	0	0	0	0	0	0	0	0	0					0	0	0	0	0	
	Attendance at Skills Drills/Mandatory Training	≥8%	<8%	Training Database	11.6%	10.0%	9.3%	10.5%	11.9%	13.4%	10.4%	16.8%	11.7%	7.3%	6.3%	6.3%	8.3%					13.6%	8.4%	7.3%		10.0%	
aternal 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%					3.1%	3.4%	2.6%		3.1%	
	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%					1.9%	1.9%	1.1%		1.7%	
	with assisted births (Instrumental)			2020 Births	0.0%	0.9%	1.7%	1.0%	0.0%	0.5%	1.7%	1.5%	2.8%	0.6%	1.3%	2.6%	0.4%					1.2%	1.5%	1.5%		1.4%	
	% 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%					7.3%	7.4%	5.2%		6.7%	
	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%					0.3%	0.2%			9.7%	
	Number of Blood Transfusions ≥ 4 Units			Births/month	1	0	1	1	1	1	0	1	0	4	0	0	0					2	4			6	
	Number of Women Requiring Level 2 Critical Care			Births/month	4	4	0	2	2	2	3	1	1	0	1	1	4					6	2	1		9	

Mi	Number of Women Requiring Level 3 Critical Care			Births/month	1	0	0	0	0	0	0	1	0	0	1	0	1					1	1			2	
	Maternal Deaths			Nat rate per 1000	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					5	9	1		15	
Neonatal Morbidity & Mortality	Stillbirths **			Nat rate 3.5 per 1000 births	1	1	0	1	0	1	1	0	0	0	1	0	1					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					1	0			1	
	Number of Neonates with Apgars <7 at 5 minutes (≥37 weeks gestation)	≤1	≥3	GM av 10 per 1000	1	2	4	2	0	1	1	1	3	2	5	1	3					3	10	4		17	
	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					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%					1.0%	1.8%	0.6%		1.2%	
	Singleton Babies born <30 weeks gestation			Births/month	3	1	0	1	1	0	2	1	0	0	1	2	1					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%					66.7%	33.3%				
	Singleton Babies born <34 weeks gestation			Births/month	8	3	7	2	2	4	4	3	3	4	1	2	5					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%					63.6%	81.8%	60.0%		68.8%	
	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%					3.4%	3.7%	3.5%		3.5%	
	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					44	49	43		136	
Risk Management	Number of indicents reported				53	57	91	42	53	67	58	51	61	70	86	60	65					176	217	125		518	
	Number of Concise Investigations				0	0	0	0	0	0	1	2	0	0	0	0	0					3	0	0	0	3	
	Number of StEIS Reported Incidents				0	0	0	0	0	1	0	1	0	0	0	0	0					2	0	0	0	2	
	Number of Midwifery Red Flags Reported				0	0	0	0	0	0	0	0	0	4	0	2	3					0	4	5	0	9	
	Number of Complaints				0	0	0	1	0	0	1	0	0	0	0	0	0					1	0	0	0	1	
	Number of Letters of Claim Received				0	0	0	0	0	0	0	0	0	0	0	0	0					0	0	0	0	0	

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

			2020 Data					2021 Data												
	Indicator		Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
DENOMINATOR Metrics	1	Number of Bookers	216	247	233	226	246	238	252	285	231	214	222	205	222					1869
	2	Number of Registrable Births	167	220	241	202	193	192	182	208	181	182	232	229	241					1647
	3	Number of Women Delivered	166	216	238	200	190	189	181	204	181	180	228	229	241					1633
	4	Number of Successful Planned Home Births	2	2	2	4	4	5	7	4	4	5	0	4	2					31
	5	Number of Midwifery Led Unit births	166	216	238	200	190	189	181	204	181	180	228	229	241					1633
	6	Number of Live Births at any gestation	167	220	241	202	193	192	182	208	181	182	232	229	241					1647
	7	Number of Live Births born ≥16 weeks to <24 weeks	0	0	0	0	0	0	1	0	0	0	0	0	0					1
	8	Number of Live Births born ≥24 weeks to <37 weeks	17	15	16	11	22	18	14	23	13	17	21	17	16					139
	9	Number of Live Births born ≥24 weeks to <34 weeks	9	3	7	4	4	6	6	3	3	6	6	5	5					40
	10	Number of Live Births ≥37 weeks	149	204	225	190	171	173	166	186	168	165	210	211	223					1502
	11	Number of Live Births ≥38 weeks	132	175	198	177	149	159	149	167	152	147	182	191	203					1350
	12	Number of Live Births ≥39 weeks	115	146	170	144	112	134	129	133	120	113	130	150	163					1072
	13	Number of Episiotomies performed	27	26	47	21	21	36	25	27	29	25	34	27	37					240
	14	Number of babies born <3rd centile									9	9	14	9	9					50
MATERNAL Morbidity and Mortality Metrics	15	Number of Maternal Deaths	0	0	0	0	0	0	0	0	0	0	0	0	0					0
	16	Number of Blood Transfusions ≥ 4 Units	1	0	1	1	1	1	0	1	0	4	0	0	0					6
	17	Number of Women Requiring Level 2 Critical Care	4	4	0	2	2	2	3	1	1	0	1	1						9
	18	Number of Women Requiring Level 3 Critical Care	1	0	0	0	0	0	0	1	0	0	1	0						2
	19	Number of Major Haemorrhages ≥ 2500mls	1	0	3	1	2	1	0	1	0	1	0	0	0					3
	20	Number of Women readmitted to same Obstetric unit within 30 days of delivery	1	2	2	0	1	2	2	1	1	3	5	1						15
	21	Number of 3rd and 4th degree tears	2	3	8	6	3	6	6	6	7	5	8	9	3					50
	22	Number of Episiotomy performed using Episcissors Instrument	11	12	11	6	9	8	5	11	8	9	9	4	10					64
	23	Number of Emergency LSCS	29	51	35	37	34	40	34	37	26	28	44	32	36					277
	24	Number of Elective LSCS	18	27	33	28	24	21	20	24	22	26	24	36	39					212
	25	Number of LSCS at Full Dilatation	7	7	1	5	6	6	4	1	4	4	5	1	2					27
	26	Number of Operative Vaginal Deliveries	16	22	43	20	15	30	23	22	27	16	32	30	29					209
	27	Number of Normal Vaginal Deliveries	104	120	130	135	120	101	105	125	106	112	132	131	137					949
	28	Number of Inductions (excluding augmentations)	74	77	92	80	79	82	75	94	69	72	97	80	100					669
	29	Number of women induced only when RFM is the only indication < 39 weeks	2	3	2	4	0	2	3	3	2	2	1	1	4					18
PERINATAL Morbidity and Mortality Metrics	30	Number of Stillbirths	1	1	0	1	0	1	1	0	0	0	1	0	1					4
	31	Number of Intrapartum Stillbirths	0	0	0	0	0	0	0	0	0	0	0	0	0					0
	32	Number of Early Neonatal Deaths 20+0 to 23+6 weeks	0	0	0	0	0	0	1	0	0	0	0	0	0					1
	33	Number of Early Neonatal Deaths > 24 weeks	0	0	0	0	1	0	0	0	0	0	0	0	0					0
	34	Number of Neonates with suspected HIE Grade 2 and 3, ≥ 37 Weeks	0	0	0	0	0	1	0	0	0	0	0	0	0					1
	35	Number of Neonates with Apgars <7 at 5 Minutes, ≥ 37 Weeks	1	2	4	2	0	1	1	1	3	2	5	1	3					17
	36	Number of admissions to Neonatal Unit ≥ 37 Weeks	5	5	4	5	5	8	2	8	8	3	9	5	10					53
	37	Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received magnesium sulphate	5	1	2	4	2	6	6	2	2	3	4	4	4					31
	38	Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received steroids	6	1	3	4	3	5	6	2	3	4	4	5	5					34
	39	Number of babies less than 3rd centile delivered >38 weeks	2	9	4	3	7	0	4	5	3	4	8	4	5					33
PROCESS	40	Average Postnatal Length of Stay for Women	1.6	1.5	1.7	1.6	1.5	1.4	1.6	1.6	1.5	1.6	1.3	1.5	1.4					11.9
	41	Number of In-utero Transfers In	2	1	0	1	1	1	0	0	0	0	0	3	1					5
	42	Number of In-utero Transfers Out	1	1	6	0	0	0	4	1	0	5	0	0	0					10
	43	Diverts: Number of occasions the unit has been unable to accept admissions	0	0	0	0	0	0	0	0	0	0	0	1	0					1
	44	Diverts: Number of women during the period affected by the units closures	0	0	0	0	0	0	0	0	0	0	0	0	0					0
	45	Number of women booked by 12 + 6 weeks	190	218	212	210	232	219	223	263	210	193	202	200	198					1708
	46	Number of women smoking at the time of booking	30	40	43	33	25	36	28	24	27	17	30	30	27					219
	47	Number of women smoking at delivery	26	41	37	30	24	31	30	23	20	18	27	34	21					204
	48	Number of women initiating breast feeding including attempted and expressed	85	101	121	112	100	109	104	108	93	93	125	117	114					863
	49	Number of babies that received Skin to Skin contact within 1 hour of birth	144	176	195	169	160	156	146	171	146	145	174	184	192					1314
	50	Number of successful VBAC deliveries	2	3	2	7	3	8	6	3	5	8	9	7	6					52
Patient Experience	51	Friends & Family Test:Q2 Birth:Percentage returned complete																		0
	52	Friends & Family Test:Q2 Birth:Percentage of completed surveys returned as recommended																		0
Workforce	53	Number of women receiving 1:1 midwifery in labour	139	172	196	167	156	156	153	172	151	145	192	200	200					1369
	54	Midwife to Birth Ratio	23	22	23	25	25	25	24	25	24	25	25	26	28					202
COVID -19	55	Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were symptomatic		0	1	3	0	2	0	0	0	0	2	4	2					10
	56	Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were asymptomatic		1	12	4	4	1	3	3	1	1	0	3	5					17
Safety	57	Number of babies born at Home Midwife NOT present		2	1	1	1	2	1	0	4	0	1	1	1					10
	58	Number of babies born in Other location Midwife NOT present		1	0	0	0	1	0	0	0	1	1	1	1					5

Title of report:	IPC Board Assurance Framework update
Presented to:	WWL Board
On:	29 September 2021
Presented by:	[Rabina Tindale, Chief Nurse, Director IPC]
Prepared by:	[Rebecca Gerrard, Deputy Director IPC]
Contact details:	T: [07798741695] E: [3115]

Executive summary

Summary

A new version of the IPC Board Assurance Framework was released by NHE England/Improvement on 30th June 2021 to support implementation and delivery against the 'COVID-19: Guidance for maintaining services within health and care settings Infection prevention and control recommendations Version 1.2' published June 2021. This report provides an update on progress with the IPC BAF. Ongoing gaps in assurance are also listed below before the main table.

Gaps in Assurance and Mitigating Actions – these are listed below with more detail in the table in the report.

- There is no current risk assessment that extends the use of RPE. IPC and H&S are reviewing the use of FFP3 masks for high risk areas - a new risk assessment has been drafted.
- The use of FRSMs in non-clinical areas is not currently audited. The need to wear FRSMs in non-clinical areas is being reviewed.

- There is no data available on how many staff are actually still carrying out twice weekly lateral flow tests. The Trust plan to simplify the reporting process to encourage staff participation.
- WWL are not meeting the new National Cleaning Standards. New risk assessment drafted on cleaning scored 12 approved at IPC Committee. The business case is being finalised.
- There is no separate Decontamination group now. Decontamination is covered at the IPC Committee.
- Compliance of inpatients wearing masks has improved but remains low. An action plan is in place.
- Due to constrictions on the Estate and the number of patients with COVID 19, WWL are not able to separate pathways at all times in all places. Environmental risk assessments have been completed at ward and department level.
- Due to the number of patients with COVID 19, we are not always able to separate pathways. Tracking patients through the Bed management team, the number of transfers and outbreak occurrences to minimise risk. This is monitored and supported by IPC.
- There is a lack of siderooms to isolate every patient who should be. There is a risk assessment on lack of siderooms. IPC attend bed meetings and support bed managers with decision making and are available 24/7 if required. A Datix is completed if unable to isolate a patient who should be – this includes those who have infections, those suspected to have an infection and CEV patients.
- Fit testing training records are not fully complete for staff who wear air purifying respirators (PAPR) (mechanical respirators with hood). Health and Safety are working with Divisions to identify staff who rely on or choose to wear PAPR to ensure they have all been fully trained.
- There is a temporary solution for mask fit testing in place. The JD for the substantive post is being banded and is to be recruited to.
- Face fit testing continues but the Central Register of staff tested indicates that not all staff are tested to a model that is currently in stock. Fit test sessions continue to be advertised. Divisions have been provided with a list of compliant staff to review.
- Fit testing results are not reviewed regularly by the Board. A member of the Board had weekly oversight of a summary of the register during the first wave.
- Head of E&F has reviewed non-clinical staff allocation but it was not possible to achieve everywhere. Some staff do have to move between different areas on a daily basis. This includes circulating staff such as porters and phlebotomists.
- Workforce data flows and the lack of accurate real time workforce data is on the corporate risk register. Project underway to roll out Trust wide.
- The Empactis absence management systems was launched in Specialist Services in Sept 21. It will be rolled out service by service across the Trust. All departments are expected to be supported by Empactis by April 2022. Sept 21: ESR project commenced to centralise establishment control and vacancy management and improve the availability of accurate, real time workforce data.

Link to strategy

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

Risks associated with this report and proposed mitigations

IPC risks are managed via the IPC Committee and the new Corporate Risk Meeting.
Some IPC actions required may have adverse reactions in other areas of patient care e.g. not continually moving patient cohorts may lead to an increased number of closed beds.

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

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

People implications
Additional resource will be required in some areas e.g. cleaning to fully comply with national guidance.
The current challenges associated with COVID-19 on top of the standard IPC workload continues to create additional ongoing pressure on the IPC team and increased again in August.

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

Recommendation(s)
Please acknowledge the key points in this paper and continue to support the implementation of actions required to enable compliance with national guidance and reduce hospital onset COVID infection.
IPC BAF Framework (last updated 13 Sept 21):

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff;	• A new COVID risk assessment has been drafted using this process titled 'There is a risk that non-compliance with best practice guidance associated with sessional use of protective gowns by staff on	None	NA

	Winstanley ward for the care of CPAP, BiPAP, NIV patients, could lead to lack of patient confidence and increased risk of infection' to go to IPCC meeting in July. • A new COVID risk assessment has been drafted using this process 'There is a risk that if appropriate measures are not adhered to regarding front-line staff who have been a contact of a confirmed COVID-19 positive individual, there is a risk of nosocomial infections to patients and of transmission of infection to staff and visitors' • August 21: the new risk manager has reviewed and advised on all IPC risks.		
• the documented risk assessment includes: ○ a review of the effectiveness of the ventilation in the area; ○ operational capacity; ○ prevalence of infection/variants of concern in the local area.	See above	See above	See above
• triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways;	• All patients attending AED are screened for COVID on registration with a risk assessment completed. Symptomatic and asymptomatic patients are segregated at this point. • All patients requiring admission undergo a LAMP test as well as PCR. • Flow chart is in place for ward allocation of symptomatic, asymptomatic, positive and negative patients.	None	NA

	• All patients within the community are contacted to ensure a face to face visit is clinically required ensuring that staff do not mix visits for both symptomatic and asymptomatic patients. • Telephone advice lines are in place where visits are not required. • Patients who are admitted straight to wards e.g. ASU are tested on admission.		
• when an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be given;	• Wording from the latest national guidance has been added to the SOP. Introduction of this would be in collaboration with the IPC Team. • Staff are currently able to wear FFP3 masks through choice if preferred. • 20/8/21: Staff on the outbreak ward were asked to wear FFP3 masks.	There is no current risk assessment that extends the use of RPE	Sept 21: IPC and H&S are reviewing the use of FFP3 masks for high risk areas - a new risk assessment has been drafted.
• there are pathways in place which support minimal or avoid patient bed/ward transfers for the duration of admission unless clinically imperative;	• Microbiology results are obtained and documented in HIS before patients are moved to designated COVID negative or positive wards. • If symptomatic but negative, patients are reassessed by medics. If COVID still suspected, patients stay on the ward and are retested which is all documented on HIS. • There is a Flowchart on Screening of admissions for COVID-19 infection' and in the SOP. • There is an agreed process flow chart to limit the number of times patients who have been a contact of a positive case can be moved and re-	None	NA

	cohorted. • IPC attend bed meetings each morning to support appropriate patient placement.		
• that on occasions when it is necessary to cohort COVID-19 or non-COVID-19 patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per national guidance;	• Part of the COVID SOP. • Assurance obtained via regular audits including cleaning, hand hygiene and PPE in clinical areas.	None	NA
• resources are in place to enable compliance and monitoring of IPC practice including: o staff adherence to hand hygiene; o patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE; o staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: ▪ a) clinical; ▪ b) non-clinical setting; o monitoring of staff compliance with wearing appropriate PPE, within the clinical setting	• Monitoring of IPC practices against key policies (including COVID-19) is included within IPC audit programme and includes environmental checklists, hand hygiene (monthly) and PPE (RAEI wards audited at least every other month). • Monitoring of IPC practice is also included within matron's mini audits. • Beds/trolleys are at least 2m apart. • Configuration 'bed/chair/locker' is used on ward when patients sit out. • COVID safety Champions audit non-clinical settings. • Vacant posts in the IPC nursing team are being actively recruited to.	The use of FRSMs in non-clinical areas is not currently audited.	The need to wear FRSMs in non-clinical areas is being reviewed – Rebecca Gerrard
• that the role of PPE guardians/safety champions to embed and encourage best practice has been considered;	• COVID Safety Champions in place; complete audits of own areas. Results collated by IPC and reported via IPCC.	None	NA
• that twice weekly lateral flow antigen testing for NHS patient facing staff has been implemented and that organisational systems	• Implemented as requested in 2020 but compliance has reduced since then.	There is no data available on how many staff are actually still carrying out	20/8/21: The Trust plan to simplify the reporting process to

are in place to monitor results and staff test and trace	• Staff are encouraged to complete tests twice weekly and report all results on line – regular items/reminders in newsletter. • COVID positive staff are followed up by dedicated team and risk assessments completed and shared with IPC. • 20/8/21: LFT reporting data now available and was 6% for w/c 2/8/21. • 20/8/21: Staff in the outbreak ward have been asked to carry out daily lateral flow testing. • Sept 21: staff have been informed of the move to national ordering of LF kits.	twice weekly lateral flow tests.	encourage staff participation.
• additional targeted testing of all NHS staff, if your location/site has a high nosocomial rate, as recommended by your local and regional Infection Prevention and Control/Public Health team;	• Part of the outbreak SOP. • Introduction of this would be in collaboration with the IPC Team.	None	NA
• training in IPC standard infection control and transmission-based precautions is provided to all staff;	• Mandatory training via e-learning is provided for all staff and levels monitored and reported to the IPCC.	None	NA
• IPC measures in relation to COVID-19 are included in all staff Induction and mandatory training;	• IPC measures in relation to COVID-19 form part of the above • COVID-19 module launched Dec 20 and is mandatory for all staff. • Jan 21: IPC level 1 and 2 and COVID-19 module reviewed and updated.	None	NA
• all staff (clinical and non-clinical) are trained in: ○ putting on and removing PPE;	• A PowerPoint Presentation on PPE (along with a quiz to test learning) is on e-learning for all staff and is	None	NA

○ what PPE they should wear for each setting and context;	mandatory. • PPE modules reviewed and updated in Feb 21. • Monthly PPE audits in clinical areas.		
• all staff (clinical and non-clinical) have access to the PPE that protects them for the appropriate setting and context as per national guidance;	• PHE national guidance is in place across the Trust • There is a PPE Store at each main site: PPE is delivered daily to wards and additional stock is available 24/7 if required. • July 21: Agreed that the PPE store is to remain for the remainder of this financial year and to extend the temporary contracts of staff accordingly.	None	NA
• there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace;	• Multi-modal communications strategy in place which includes posters, roller banners and newsletter campaign and regular reminders. • IPC COVID SOP. • Items from National PHE Toolkit being used in newsletters, websites and social media.	None	NA
• IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way;	• DDIPC is on circulation list for updates from PHE and attends GM and NW IPC meetings and relevant webinars. • All new guidance is acted upon in a timely manner. Where necessary SOP's are updated. • Changes are communicated through the IPC team, newsletters and Divisional leads and meetings.	None	NA

• changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted;	• DIPC presents to the Board through the performance report or specific agenda items. • IPC Committee and Quality and Safety committee review quarterly IPC reports.	None	NA
• risks are reflected in risk registers and the board assurance framework where appropriate;	• Trust Risk register. • IPC BAF reviews by IPCC, Exec and Board. • August 21: the new risk manager has reviewed all IPC risks.	None	NA
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens;	• Q&S sign off for IPC audit programme annually. • IPC Committee monitors progress and establishes mitigating actions to be taken. • RCAs/PIRs carried out on CDT cases and MRSA, MSSA and gram negative bacteraemias post 48 hour admission.	None	NA
• the Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep	• IPC check and validate data on HOCI that is downloaded from HIS before submission. CEO and DIPC are copied in so can check data.	None	NA
• the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board;	• New IPC BAF last presented to the Exec on 5/8/21. • IPC BAF document presented to the Board July 21 and Sept 21.	None	NA
• the Trust Board has oversight of ongoing outbreaks and action plans;	• Outbreaks that meet StEIS criteria are reported through Safety Committee. • IPC report through IPC Committee up to Q&S and monthly Performance report to Board.	None	NA

• there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas.	• Senior Leadership Walkabouts take place each month. • Senior Nurses are establishing a rota and proforma for visiting all areas.	None	NA
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • designated nursing/medical teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• All redeployed staff undertake additional training to meet their needs. • PPE training is mandatory.	None	NA
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas;	• Domestic Response team and designated Domestics in place. • All Domestics are trained in the correct use of PPE and have been mask fit tested.	None	NA
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	• Domestic provision for the cleaning of isolation rooms and cohort areas follow PHE and National Guidance. • SOP in place agreed in conjunction with IPC. • Rapid Response Domestic team cover terminal cleans and work out of hours.	None	NA
• assurance processes are in place for the monitoring and sign off following terminal cleans as part of outbreak management and actions are in place to mitigate any identified risk;	• Document in supervisors office to show what terminal cleans have been undertaken. • New sign off form for ward manager to complete introduced in July 21.	None	NA
• cleaning and decontamination is carried out with neutral detergent followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an	• SoChlor is used for the routine cleaning of the environment across all risk pathways and will continue. • SoChlor used at 1,000ppm is used for cleaning in all clinical areas.	None	NA

alternative disinfectant is used, the local IPCT should be consulted on this to ensure that this is effective against enveloped viruses;	• Green disinfectant wipes are available in non-clinical areas. • IPC sign off any new business cases.		
• manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products as per national guidance;	• Manufacturers guidance followed and available on the intranet and included in decontamination SOPs.	None	NA
• a minimum of twice daily cleaning of: ○ areas that have higher environmental contamination rates as set out in the PHE and other national guidance; ○ 'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails; ○ electronic equipment e.g. mobile phones, desk phones, tablets, desktops and keyboards; ○ rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff;	• All clinical areas undergo decontamination of the environment at least twice daily. • IPC liaise with Facilities to highlight and agree high risk areas. • The wards have Housekeeping schedules outlining frequency of cleaning. • Compliance is audited via Matron and IPC Spot audits and reported to the IPC Committee. • Disinfectant wipes are used in non-clinical area PCs and phones. • SOP's in place for all Facilities staff. • There are limited designated PPE doffing areas.	Not meeting new National Cleaning Standards	New risk assessment drafted on cleaning scored 12 approved at IPCC. David Evans is finalising the business case
• reusable non-invasive care equipment is decontaminated: ○ between each use ○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol • before inspection, servicing or repair equipment	• Decontamination SOP in place. • SOP on Medical Equipment Management Procedure for Decontamination Cleaning of Devices – reminder sent out in June 21 newsletter. • Departmental and divisional SOPs for more specialised equipment e.g. ultrasound probes.	None	NA
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other	• Linen system managed in line with National guidance. • SOP available on the Intranet.	None	NA

national guidance and the appropriate precautions are taken;	• External contractor performance is monitored against the contractual requirements.		
• single use items are used where possible and according to single use policy;	• Single Use SOP in place. • Single Use is included in mandatory level 2 IPC training. • Patient Safety Alerts communicated through internal Newsletters, Governance Team and changes to individual policies.	None	NA
• reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance and that actions in place to mitigate any identified risk;	• There is a Decontamination Lead at Executive level. • Decontamination is covered at the IPCC. • Decontamination SOP both WWL wide and at department levels in place. • All reusable equipment is decontaminated in line with national guidance. • Audit programme in place. • Risk assessment process in place to minimise risk. • Deputy DIPC has to sign off new business cases.	There is no separate Decontamination group now.	Decontamination is covered at the IPC Committee.
• cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment;	• Kitchens and toilets are cleaned in non-clinical areas. • With current resources the focus remains on clinical areas. • Monitoring only occurs annually in non-clinical areas.	Additional resource is required to meet new cleaning standards	New risk assessment drafted on cleaning – Nick Bastow. David Evans is finalising the business case
• where possible ventilation is maximised by opening windows where possible to assist the dilution of air.	• Mechanical ventilation available in some admission and waiting areas. • Where mechanical ventilation is not	None	NA

	available, managers have been advised to encourage the dilution of air by opening windows. • Window restrictors are in place for all windows. • Estates are completing a review of ventilation on all sites – to be discussed at the IPC Committees.		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements for antimicrobial stewardship are maintained	• Regular remote antimicrobial ward rounds are performed by the Consultant Microbiologist. • Daily Antimicrobial ward rounds undertaken within Critical Care by Consultant Microbiologist • Data collected on each intervention and feedback given. • Antimicrobial Pharmacist continues to review prescribing and new guidance as appropriate. • Antimicrobial audit programme. • Antibiotic audits done on wards following each new CDT case in line with Saving lives guidance and repeated if <95% scored.	None	N/A
• mandatory reporting requirements is adhered to and boards continue to maintain oversight	• Mandatory reporting through the Board performance report. • Mandatory reporting through the quarterly IPC paper to Quality and Safety Committee. • Monthly reporting through Divisional Quality Assurance Groups.	None	N/A

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
• **Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • national guidance on visiting patients in a care setting is implemented	• National guidance in place - policy and SOP. • Changes communicated through Divisional Teams and via COVID Newsletter. • Visitor disclaimer in use. • Visiting is still subject to restrictions but Exec have agreed visitors can attend in exceptional circumstances. Decision tree drawn up and agreed by Exec for special circumstances which includes IPC requirements. • July 21: New guidance drawn up for a pilot scheme for when visiting can be re-introduced.	None	NA
• areas where suspected or confirmed COVID-19 patients are being treated have appropriate signage and have restricted access;	• Blue, yellow, green and cohort bay system in place with supporting SOP. • Entry to wards is via swipe which restricts unauthorised access. • Colour coded signs for all wards in place. • Signs include key instructions e.g. PPE required • Clear signage in AED indicating symptomatic and asymptomatic patient areas.	None	NA
• information and guidance on COVID-19 is available on all trust websites with easy read versions;	• Dedicated COVID tab on landing page of Trust Intranet with divided sections including PPE and IPC. • External website has clear information and advice.	None	NA

• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved;	• Infection status is communicated verbally before the patient is transferred and then in writing via a transfer form when the patient is moved. • Discharge to assess process works to rapidly discharge patients to the most appropriate setting with a philosophy of home wherever possible reducing contact with others. • Patients swabbed 48 hours before discharge to nursing or care home.	None	NA
• there is clearly displayed, written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	• Roller banners are displayed at each entrance to prompt patients, visitors and staff to comply with hands, face, space. • Alcohol hand gel mask stations are available at entrances. • Patient leaflets includes information on masks, hand hygiene and social distancing.	None	NA
• Implementation of the Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been considered C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	• Review of all resources by IPC and Comms. • Several items have been used in internal and external comms. • Toolkit also shared with HR staff.	None	NA
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • screening and triaging of all patients as per IPC and NICE guidance within all health and other	• Patients are assessed on admission and admitted to the most appropriate area. • All patients attending A/E are	None	NA

care facilities is undertaken to enable early recognition of COVID-19 cases;	screened for COVID-19 symptoms on registration. • Patients are swabbed on day of admission (day 1; PCR and LAMP tests), day 4, day 6 and then weekly thereafter. • Reminders on HIS tracking board to alert staff when swabs are due. • Telephone screening is in place for all elective patients; they are swabbed 3 days prior to admission and asked to self-isolate prior to coming in. • SOPs are in place to support guidance. • App in place to show compliance with swabbing. • Sept 21: Audit shows compliance with inpatient swabbing was 89% overall.		
• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from non Covid-19 cases to minimise the risk of cross-infection as per national guidance;	• Patients are further assessed at triage and segregated appropriately to different areas/wards.	None	NA
• staff are aware of agreed template for triage questions to ask;	• COVID-19 risk assessment questions included within COVID SOP. • HIS core assessment questions are included in the COVID-19 checklist.	None	NA
• triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible;	• Staff within AED have received specific training in relation to COVID-19 clinical case definition. • Pathways of care are defined within	None	NA

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

• patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.	• Seating rearranged or areas blocked off to ensure segregation. • Floor markings where required. • Hot clinic areas in the community have reduced and have clear signage. • Staff are not utilising patient entrances in order to reduce footfall. • Perspex screens in place at receptions.	None	NA
• isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, until proven negative;	• COVID SOP in place. • Symptomatic patients moved to symptomatic ward while awaiting swab result and then moved to either negative or positive wards depending on results (and a medical review if still positive). • Patient incident forms completed for all HOCI >8days that includes test and trace requirements. • IPC carry out daily tracking to monitor patient moves. • IPC attend bed manager meetings each day. • Bay closure spreadsheet maintained by IPC.	None	NA
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly;	• See above	None	NA
• there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document;	• App available to report on compliance with swabbing and data reported to IPCC and in quarterly IPC report.	None	NA

• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	• In line with departmental SOPs, should patients attend who are symptomatic a risk assessment is undertaken. • All COVID departmental SOPs are signed off by IPC.	None	NA
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • patient pathways and staff flow are separated to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage and restricted access to communal areas;	• Patient pathways have been risk-stratification and included within the Trust COVID-19 SOP. • Display posters and updates on the Trust intranet also available. • One way system in place in Leigh hospital.	Due to constrictions on the Estate and the number of patients with COVID 19, currently we are not able to separate pathways at all times in all places.	Environmental risk assessments have been completed at ward and department level.
• all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other national guidance to ensure their personal safety and working environment is safe;	• Mandatory e-learning for all staff. • Environmental risk assessments have been completed at ward and department level. • Where concerns are raised additional bespoke training is undertaken by the relevant individual to ensure staff comply. • A detailed IPC Checklist was used to assess areas for the safe return of CEV staff.	None	N/A
• all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;	• Don and doff posters are displayed in all wards and departments. • IPC check posters are present on ward visits. • IPC advice is available 24/7. • The Professional Practice Team	None	N/A

	support IPC to carry out classroom training on donning & doffing. • Don and doff guidance is included in the PPE e-learning module.		
• a record of staff training is maintained;	• All mandatory training is recorded through personal passports and electronically through the Trust mandatory training system. • FFP3 mask fit training is organised by H&S and records held centrally and shared with divisions.	None	NA
• adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk;	• IPC visit wards regularly. • All key wards PPE compliance is audited at least every 2 months. Results fed back to clinicians, reported to IPCC and to Q&S via the quarterly report.	None	NA
• hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: ○ hand hygiene facilities including instructional posters; ○ good respiratory hygiene measures; ○ staff maintaining physical and social distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care; ○ staff are maintaining physical and social distancing of 2 metres when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace;	• Instructional posters available at all sinks. • Instructional posters at hand gel stations throughout the hospital and ward/ department entrances. • Guidance is given to all elective patients within the patient information booklet. • Patient information leaflet has information on hands, face and space. • Facemasks are available at all hospital and ward/ department entrances. • Roller banners and posters are used to promote mask use, good respiratory hygiene and social distancing.	None	NA

○ frequent decontamination of equipment and environment in both clinical and non-clinical areas; ○ clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas.	• Trust SOPs clearly define the need to maintain 2 metres distance unless wearing PPE as part of patient care. • There are signs on doors to indicate the maximum number of people who should be in the room at any one point. • Floor markings are present in many outpatient areas and 'keep left' signs in corridors. • Staff asked to avoid car sharing via SOP, newsletters etc. • Comms highlight key messages internally and externally through variety of medias.		
• staff regularly undertake hand hygiene and observe standard infection control precautions;	• Hand hygiene training is mandatory. • Hand hygiene audits take place monthly in all clinical areas and the results are monitored by IPCC. • There is an annual programme of CQC Spot audits for clinical areas monitoring the environment and practice.	None	NA
• the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance;	• There are no hand dryers in any clinical areas at WWL. Where hand dryers were available for the public these have been deactivated and replaced with paper towels.	None	NA
• guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas;	• Hand hygiene posters are available from IPC and on the intranet. • Laminated posters are displayed in all areas – checked by COVID Safety Champions.	None	NA

• staff understand the requirements for uniform laundering where this is not provided for onsite;	• National guidance has been followed with information for staff on laundering their uniforms. • Staff have been updated through the COVID Newsletters.	None	NA
• all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms;	• National guidance is being followed and available on the intranet. • Updates are included in the COVID Newsletters. • There is a drive through facility for staff testing at Leigh and Wrightington. • IPC liaise closely with H&S and Occupational Health as required. • Staff now have lateral flow kits for twice weekly testing. • Advice is available 24/7.	None	NA
• a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals);	• An electronic laboratory reporting process (Queue) provides the IPCT with timely COVID results. • Positive results from elsewhere come via PHE emails to the IPC inbox and are acted upon. • An in-house COVID-19 App has been developed that supports the collation, evaluation and summary of COVID cases. • HOCI are reported via the daily nosocomial sitrep. • Local PHE information on population transmission is circulated to IPC.	None	NA
• positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases	• Patient investigation templates are completed for patients who test positive for COVID 8 or more days	None	NA

linked in time and place trigger an outbreak investigation and are reported;	after admission. • If the criteria for outbreak is met this is declared and acted upon and reported to DIPC and NHSE/I. • SOP in place that is updated and monitored through IPCC.		
• robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings.	• SOP for the identification and management of COVID-19 outbreaks that incorporates national guidance. This has been approved by the IPCC. • Daily outbreak meetings are held when necessary and minutes recorded. • Outbreaks reported to StEIS where relevant.	None	NA
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff;	• Patient pathways according to risk stratification have been defined and included within the Trust COVID-19 SOP which has been disseminated to all clinical teams. • Environmental risk assessments have been completed by wards and departments to establish safe flow of patients and staff. • Visiting policy and SOP based on national guidance.	Due to the number of patients with COVID 19, currently we are not always able to separate pathways.	Tracking patients through the Bed management team, the number of transfers and outbreak occurrences to minimise risk. This is monitored and supported by IPC
• areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas;	• 'Zone' display posters developed and updates on the Trust intranet provided. • Entry to wards is via swipe which restricts unauthorised access.	None	NA

• patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate;	• Patients are currently cohorted on admission into symptomatic or non-symptomatic areas then wards. • Where a designated side room is available this would be used. • Once the COVID result is known they are moved to either positive or negative wards. • There is an Operational flowchart and COVID SOP.	There is a lack of siderooms to isolate every patient who should be.	There is a risk assessment on lack of siderooms. IPC attend bed meetings and support bed managers with decision making and are available 24/7 if required. A Datix is completed if unable to isolate a patient who should be – this includes those who have infections, those suspected to have an infection and CEV patients.
• areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance;	• All bed spaces have been reviewed • Ward staff are requested to use privacy curtains between beds to minimise close contact where safe to do so; reminder in Newsletters and in COVID SOP. • IPC guidance on blue, green and yellow wards has been implemented and circulated to all wards; reinforced through Newsletter and meetings. • SOP covering all actions required. • IPC environmental checklists are reviewed every time an outbreak is declared.	None	N/A
• patients with resistant/alert organisms are managed according to local IPC guidance,	• All previous IPC policies, SOPs and patient information leaflets are in place and up to date to identify and	None	NA

including ensuring appropriate patient placement.	appropriately place patients. • Side rooms on non-COVID wards are used for patients requiring isolation for other reasons e.g. MRSA. • C.diff patients are managed on Pemberton ward if possible. • COVID positive CPAP ward has a separate SOP. • Mandatory surveillance data is reported to IPCC and Trust Board.		
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals;	• The Laboratories used are UKAS accredited.	None	N/A
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance;	• Testing is performed in line with national guidance. It is provided by Northern Care Alliance, monitoring of compliance is through contractual discussions. • Trust guidance is in line with national guidance on testing for suspected COVID cases and for other infections. • The HIS tracking board highlights when patients need re-swabbing. • System established for antibody testing. • March 21: System established for carrying out additional testing on vaccinated patients and for identifying patients who may have new variants.	None	N/A

• regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available;	• App shows turnaround times. • HIS alert if takes longer than 24 hours.	None	N/A
• regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data);	• National policy is followed. • Patient incident reviews are carried out on all probable and definite hospital onset COVID patients.	None	N/A
• screening for other potential infections takes place;	• National policy is followed. • Alert organisms are reported as required on national database and at IPCC and investigated according to national guidance.	None	N/A
• that all emergency patients are tested for COVID-19 on admission;	• All patients tested on admission via LAMP and PCR.	None	NA
• that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise;	• COVID SOP. • Patients reswabbed if symptoms occur in line with national guidance and moved to a symptomatic ward.	None	NA
• that emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission;	• National policy is followed. • An App is in place to monitor compliance. • There are electronic reminders on the HIS tracking board to highlight when swabs are due. • Sept 21: Audit shows compliance with inpatient swabbing was 89% overall.	None	NA
• that sites with high nosocomial rates should consider testing COVID negative patients daily;	• In COVID SOP for IPC to consider if nosocomial rates high. Usually swab all patients 3 times per week in any outbreak.	None	NA
• that those being discharged to a care home are tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the	• National policy followed. • In COVID SOP.	None	NA

previous 90 days) and result is communicated to receiving organisation prior to discharge;			
• that patients being discharged to a care facility within their 14 day isolation period are discharged to a designated care setting, where they should complete their remaining isolation;	• National policy followed. • In COVID SOP.	None	NA
• that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.	• National policy followed. • In COVID SOP.	None	NA
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • staff are supported in adhering to all IPC policies, including those for other alert organisms;	• IPC Policies and SOPs are approved at IPCC and are on the Intranet and kept up to date. • IPC and microbiology advice is available 24/7. • IPC level 1 and 2 e-learning is mandatory in line with national guidance.	None	N/A
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff;	• All new guidance is acted upon in a timely manner. • Where necessary SOP's are updated. • Changes are communicated through the IPC team, newsletters and Divisional leads.	None	N/A
• all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance;	• Trust adheres to national guidance and Waste Legislation. This is evidenced within the Trust's Waste Management Policy and Procedures under Category waste. Community staff also follow the Trust's Policies including the national guidance regarding the disposal of COVID-19 PPE within a patient's home	None	N/A

	environment. • The Clinical Waste Management Module is mandatory for all staff.		
• PPE stock is appropriately stored and accessible to staff who require it.	• PPE is distributed to the wards on a daily basis. The main PPE store is on the RAEI site and is accessible 24/7. Opening times are highlighted in COVID Newsletters. • PPE stores also at Leigh and Wrightington. • In Community, PPE store is well stocked and accessible to all teams.		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported;	• All staff requested to complete a self-declaration form confirming if they fall within the extremely vulnerable or high risk categories as defined by PHE. Where staff have been determined to fall within these groups, personal risk assessments have been completed by line managers with the support of Occupational Health. Records of the outcomes from the self-declarations forms logged and maintained within HR. • A comprehensive programme of support has been developed for all staff, including: Access to rest spaces with trained volunteers to provide a listening ear; in-reach support for teams when requested (e.g. at times of higher stress), training for	None	N/A

	managers in supporting staff; a 24/7 telephone helpline; staff counselling (including remotely); development of roles as clinical wellbeing leads and wellbeing champions; communications and information about self-care and sources of support. This is accessible by all staff, including those who are at-risk. Regarding those staff that are shielding, developing tailored support in addition to the above, in terms of accessing support remotely, and having access to information about supporting positive mental health when shielding. • Regular communications have been sent via senior managers; the HR team continue to be proactive and engaged with managers and individuals to obtain this information. • Home working supported for all staff where possible. • Staff vaccination programme began 23/12/20. • March 21: Working areas for vaccinated high risk staff has been extended. • April 21: CEV staff returned to work in lower risk areas.		
• that risk assessments are undertaken and documented for any staff members in an at risk	• Personal risk assessments have been completed by line managers with	None	NA

or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff;	the support of Occupational Health. • Records of the outcomes from the self-declarations forms logged and maintained within HR.		
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally;	• Face fit testing is available across all acute sites and at one location in the community on rotation every 2-3 weeks and is run by the H&S team. • All mask fit testers have been trained in line with national legislation. • A SOP has been developed and shared with all Testers. • Some staff cannot wear a close fitting FFP3 mask e.g. due to facial hair. Air powered hoods are available if required and issued to Wards and Departments with instructions for use. • Reusable FFP3 half masks have been withdrawn from use.	Fit testing training records are not fully complete for staff who wear air purifying respirators (PAPR) (mechanical respirators with hood).	Health and Safety are working with Divisions to identify staff who rely on or choose to wear PAPR to ensure they have all been fully trained.
• staff who carry out fit test training are trained and competent to do so;	• Fit test training is overseen by the Trust H&S team and conducted by staff who have been trained in line with national legislation and competent to do so. • 20/8/21: The business case for sourcing a permanent face fit testing service has been approved.	There is a temporary solution for mask fit testing in place	The JD for the substantive post is being banded.
• all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used;	• Face fit testing sessions are continuing on a regular basis to ensure staff can receive fit test training in the FFP3 masks currently available	Face fit testing continues but the Central Register of staff tested indicates that not all staff are	Fit test sessions continue to be advertised. Divisions have been provided with a list of

	• Data to end of August: 1262 staff fit tested to a current model. Pass rate from 01/07/2021-31/08/2021 is 89%.	tested to a model that is currently in stock.	compliant staff to review – Lynne Bushell.
• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation;	• Record of the fit test and result is given to the staff member and mask fit training records are held centrally by the H&S team. • The Health and Safety Team are working with Payroll to ensure results can be uploaded onto ESR. All results should eventually be available on ESR.	None	NA
• those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods;	• Individuals that fail a fit test are tested on an alternative model until options are exhausted. If a secure fit cannot be achieved staff are advised to use a mechanical respirator and hood. Records are kept by the individual and held centrally by the H&S team	None	NA
• members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm;	• Included within the Respiratory Protective Equipment- Training Guidance SOP • Individuals that continue to fail fit tests and are unable to be provided with alternative respirators and hoods are provided with the opportunity for redeployment in line with Occupational Health and HR policies. • The Trust has a designated Redeployment team who oversee staff skill mix, knowledge and	None	NA

	experience.		
• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health;	• Documented records of staff redeployment are kept in line with Occupational Health and HR policies.	None	NA
• following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record;	• Documented records of staff redeployment are kept in line with Occupational Health and HR policies.	None	NA
• boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board;	• A centrally held mask fit register is maintained and is available.	Fit testing results are not reviewed regularly by the Board	A member of the Board had weekly oversight of a summary of the register during the first wave.
• consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance;	• Healthroster system used for nurses which includes Staff risk status. • Medical rotas for medical staff. • Where safe and practicable staff are only moved between similar colour coded areas in response to acuity and dependency of patients. There has also been a reduction in the volume of temporary staff working across the Trust.	Head of E&F has reviewed non-clinical staff allocation but it was not possible to achieve everywhere.	Some staff do have to move between different areas on a daily basis. This includes circulating staff such as porters and phlebotomists.
• all staff to adhere to national guidance and are able to maintain 2 metre social & physical distancing in all patient care areas if not wearing a facemask and in non-clinical areas;	• National guidance has been adopted and promoted. Staff reminded regularly via Newsletters and Posters. Also in COVID SOP. • Office space has been redesigned to	None	NA

	ensure social distancing. • All community premises have been reviewed for social distancing and a number of work areas have been designated as no longer in use. • Wards asked to include minimum numbers at staff handovers.		
• health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone;	• Space planning exercise undertaken at the start of the pandemic. • Maximum staff allowance per room assessments completed and supportive guidance provided to Departmental managers. • Environmental risk assessments completed. • COVID Safety Champions promote and support compliance in own areas – supported by IPC.	None	NA
• staff are aware of the need to wear facemask when moving through COVID-19 secure areas;	• Trust SOP for Masks in place and circulated to all departments. Regular reminders given at senior nursing and medical meetings for cascade, provided within Trust Newsletters and by the use of posters and roller banners. • July 21: As guidance changed externally, staff were reminded of the IPC measures required in healthcare via a global email and at Silver command and at divisional meetings.	None	NA
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing;	• Staff absence is recorded for payroll purposes through e-roster and through e-SVLs. This means that	Workforce data flows and the lack of accurate real time workforce data is on	Project underway to roll out Trust wide.

	data taken from ESR can be 4/6 weeks in arrears. In order to comply with the daily SITREP requirements, absence data is recorded either in spreadsheets submitted by Divisional representatives or from the e-roster. • E-roster is currently rolled out to the majority of nurses and some AHPs. • Well-being offers are widely available to staff members, with pro-active holistic well-being provision through our Steps 4 Wellness and occupational health services. Psychological support programmes are in place including access to well-being apps, EAP, SOS rooms with trained facilitators, critical incident debriefing and departmental support programmes. There are nursing, AHP and medical well-being leads identified along with over 70 well-being champions within wards and departments. • The Trust continues to actively manage and support staff through attendance management procedures. The Strategic HR lead completes a monthly review of all long-term sickness absence cases with HR Business Partners. • Staff have access to COVID swab tests via a Trust drive through facility and home testing.	the corporate risk register.	The Empactis absence management systems was launched in Specialist Services in Sept 21. It will be rolled out service by service across the Trust. All departments are expected to be supported by Empactis by April 2022. Sept 21: ESR project commenced to centralise establishment control and vacancy management and improve the availability of accurate, real time workforce data.

	• Sept 21: All staff continue to be able to access lateral flow testing and are asked to complete tests twice per week. Results are reported through a local WWL system which is in the process of being simplified to make recording easier and quicker. • Sept 21: The Central Unplanned Absence Team continues to contact staff on first day of absence and support managers through the attendance management process. This has been rolled out to add staff groups on e-roster.		
• staff who test positive have adequate information and support to aid their recovery and return to work.	• Flow charts based on national guidance outline the processes and time periods to follow and are on intranet. Staff are supported via managers during absence in accordance with all sickness absence. • HR advisors are available to staff and managers to seek advice and support where any individuals are concerned or have questions around returning to work or being absent due to COVID.	None	NA

Title of report:	Safe Staffing Report
Presented to:	Trust Board
On:	29 September 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. The Trust also remains an outlier for the uplift of nursing and midwifery establishment levels. The Trust agreed uplift is 20% against an advised 23.3%. Recommendations to uplift these levels will be made in the Bi-annual staffing review due to Trust Board in November 2021.

- 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%. A business case has been developed to support the remainder of the staff clinical time. this is regarded as a significant enabler in improving quality and safety across all inpatient areas, and in the ability for the Trust to obtain an Outstanding CQC rating with the demonstration of how lessons learnt from incident/complaints/feedback are driving improvements. Ward Leaders are currently

unable to achieve this protected time, which is impacting negatively on the areas previously articulated.

- There remains a risk associated with the increased caseload within District Nursing Services with the skill mix and vacancies within certain teams creating additional pressures for existing staff. An enhanced hourly rate of pay has been agreed by the Executive Team which has had a positive impact on both reduction of caseload, and the morale of the staff within the service. The division are actively working with GTEC to improve the profile of Community Services with IN as the service delivery model and career pathways vary significantly across countries. In addition, year 2 International Nurses (Ins) who are interested in the learning opportunities available with the Community are being approached to transfer into the service.

- There is a risk associated with the number of registered staff vacancies across theatres within the Trust and targeted recruitment is being undertaken to mitigate any risk to the delivery of care and to mitigate the risk of patient cancellations. Consideration of targeting ODP's with the skills/knowledge to work across all areas of the theatre complex is essential and exploration of direct international recruitment of experienced ODP's. Recruitment utilising sound bites from existing staff is having a significant impact on recruitment on the Wrightington site. In addition, year 2 IN's who are interested in the learning opportunities available with the Community are being approached to transfer into the service.

- There is a risk associated with the safe staffing of the Emergency Department (ED) aligned to increased attendances and the additional ED areas associated with promoting safe patient flow through the COVID-19 pandemic. Winter monies have been provided to support fixed term recruitment of staff to assist in the mitigation of this risk. In addition, staff within this critical area are receiving an enhanced rate of pay via NHSP which has improved fill rates and which have impacted positively on improvement in morale.

- Discussions with regards to the immunisation and vaccination of 12-15 year olds remain ongoing, however it should be noted that delivery of this service by the School Nursing (SN) team will significantly impact on the ability to deliver other core service requirements, and there is the potential for other epidemics which will impact on inpatient services as a consequence of a reduction in the delivery of the programme. The model of service delivery is currently under review.

- A review of the establishment on Winstanley is currently underway to support the area transitioning into an Enhanced Respiratory Unit in line with Royal College of Physicians Guidance. This will require additional investment in the service but will provide resilience in respiratory support for patients that do not meet the criteria for admission to Critical Care.

- The Community Division continue to provide a Monitoring at Home Service which is staffed via temporary staffing as there is no agreed funding for the service. The service is an essential component in admission avoidance and the initial service was recognised as excellent practice. Discussions remain ongoing to fully commission and fund the service to enable substantive recruitment.

- Recruitment remains ongoing within Critical Care because of the investment in the supervisory shift leader role required in the National Critical Care Specifications. It should be noted that support to enhance the overall workforce to support the provision of 11 Level 3 beds was not supported.

- There has been an increase in the reporting of red flags within nursing aligned with the proactive use of SafeCare to monitor patient acuity. This is aligned to the ongoing scrutiny within the

divisions to improve compliance with safe care and to reprioritise the use of the SafeCare module.

- NHSP Booking reasons have been reduced within month to improve the accuracy of the information collected

- Collaborative work with the E-Roster Team and NHSP is assisting in improvements in the lead in time for roster completion. A metric for improving this has been added to the Workforce Efficiencies programme board objectives. Wards/Departments now receive a prospective roster report from the E-Roster Team which informs Divisional leaders of the % of unfilled shifts that have been sent through to NHSP prior to the roster that is being worked. The prospective report will also add additional rigor to check and challenge meetings being undertaken by the Division Teams and provide greater assurance around planned roster safety and effectiveness.

- There has been 1 CDT where lapses in care were identified on Astley Ward. An improvement plan has been developed. This plan will be monitored and overseen by the Infection Prevention and Control Committee.

- 0 Falls with harm have been reported, this is a consequence of improved compliance with the Enhanced Observation Policy and SOP.

- 0 medication incidents with harm have been reported in month.

- A collaborative piece of work is currently being planned to map the 2nd and 3rd years of the recruitment programme aligned to the Earn, Learn and Return philosophy. Consideration of not disadvantaging internal newly qualified registrants by having a two-tier training/support scheme is being factored into the programme alongside the potential impact on clinical time associated with the uplift in funded establishment provided for training.

- A business case proposing focussed recruitment of IN's in hard to recruit to areas is to be submitted. It is acknowledged that further revision of the business case will be required once a scoping exercise has been undertaken on speciality turnover and the age profile of service workforce. This will be completed by September 2021.

- There has been an overall increase in demand for bank and agency staff of 1.9%. £290,911 of temporary spend is unavoidable as this is required to maintain IPCC patient flows and the provision of safe patient care. Bank fill rate increased to 94.2% whilst agency staffing accounted for only 3% of temporary staffing requests which is a positive change. Funding has been identified to support more permanent staffing within ED and is also being explored for the unfunded ward within the Trust. It is recognised that this will increase the number of vacancies within the Trust once the gap has been identified, which, in turn, will increase the number of IN's required within the business case.

Link to strategy

Delivery of safe care

Risks associated with this report and proposed mitigations

- Registered and unregistered nurse recruitment is being proactively managed. Further work is required to understand turnover by grade of staff and to evaluate the Trust offer to improve retention.
- Registered staff vacancies within theatres present 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.

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

Legal implications

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

People implications

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

Wider implications

- Increased scrutiny from Commissioners and Regulators

Recommendation(s)

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

Safe Staffing Report – July 2021.

1.0 INTRODUCTION

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

2.0 SAFER STAFFING EXCEPTION REPORT

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

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

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

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

3.0 CURRENT POSITION – July 2021

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

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

The 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.

The Trust also remains an outlier for the uplift of nursing and midwifery establishment levels. The Trust agreed uplift is 20% against an advised 23.3%.

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, patient safety and experience, and quality improvement. The Trust position regarding this metric remains 50%. Due to staffing gaps the ward leaders are rarely able to achieve this time allocation.

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

Community Division

There are currently 70.18 wte vacancies across Community Division. Across Community Services there is currently no over recruitment and all vacancies have been actioned as per recruitment process. Overall Divisional sickness is under 5%.

Adult Services

District Nursing Services (DNS)

Wigan District Nursing has been benchmarked in month compared to national figures. Face to face contacts per 100,000 population nationally are recorded as 55,962 whereas in Wigan this figure is recorded as 99,256. This translates to WWL completing 43,294 more contacts per year than the national average. Therefore, face to face contacts per WTE nationally are 1,656 compared to WWL which is 2,287. This translates to each WTE staff member completing 631 more face to face contacts than the national average

A review of establishments is being undertaken to ascertain if these are fit for purpose. Initial results indicate that there is a shortfall of over 12 wte within the service to allow the average number of visits to be at the ideal level of 12 per day.

Caseloads per staff member have been between 17 and 20. There have been no patient harms reported in month because of the caseload numbers but the effect of the workload on staff is significant and is reflected in sickness and staff turnover. There has been high utilisation of NHSP in month resulting from vacancies in the service and other leave to mitigate the risk in addition to staff working additional hours.

NHSP enhanced rates will be introduced for district nursing from 16/8/21 – 31/10/21 to provide incentives for staff to work additional hours, and block booking via agency have also been instigated.

Better at Home

There are currently 7.2 WTE vacancies within the service which represents 37% of the workforce. All vacancies are currently out to recruitment. There have been no reported incidents because of the staff shortfall, however the staff working within the service have reported a negative impact on their well-being as a consequence.

CAU

There are 2 WTE vacancies within the service which represents 7.62% of the establishment for the area. Temporary staff have been utilised to mitigate staffing risks. There have been no reported harms within the service. Staffing establishments will be reviewed alongside the acuity and dependency of the patients and patient flow to determine whether further enhancements are required to support the needs of those accessing the service.

Monitoring at Home

This service was initiated to support the monitoring of patients with COVID 19 who did not require hospital admission but required ongoing observation and review. The service is being continued however there is currently no allocated funding stream for the service resulting in the use of NHSP.

Children's Services

Health Visiting (HV)

In July the HV service had vacancy arising from retirement (both flexible and absolute) for Health Visitors at 4wte, these posts were advertised and recruited staff are currently in the recruitment checks stage of process with start dates in August and September. In addition, there is significant long-term sickness within the service and support has been offered in accordance with HR policy. Team Leaders are supporting utilising Occupational Health referral, phased return support and considering all options regarding flexible working.

HV service is utilising NHSP according to need of service where available, however due to the specialist qualification required for these roles this can be a challenge. It should be noted that a significant proportion of the workload of HV's is safeguarding. Service managers are assessing need and operationalising the use of staff appropriately. The service is currently exploring the IN workforce to develop into the specialist service.

School Nursing (SN)

In July the vacancy of 0.86 wte B5 was recruited to and continues to progress through recruitment checks. 0.8 wte Nurse Associate position is currently in a stage of review of the job description in collaboration with HR and Professional Practice Team.

Long term sickness levels within the SN service are not work related and these staff have now returned to work with support e.g., phased return, OH review and operationalisation of workload demand across Borough to ensure safe allocation of cases to support patient care.

Discussions with regards to the immunisation and vaccination of 12–15-year-olds remain ongoing, however it should be noted that delivery of this service by the SN team will significantly impact on the ability to deliver other core service requirements, and there is the potential for other epidemics which will impact on inpatient services as a consequence of a reduction in the delivery of the programme.

Children's Specialist Services (Complex Children Nursing Team (CCNT), Audiology & Newborn Hearing Screening, Speech and Language, Physiotherapy and Occupational Therapy)

In July CCNT had a vacancy of 0.53 across Band 3&4 due to staff members taking a temporary reduction in contracted hours; this will be reviewed in August. There has been long term sickness within the service, however these staff are planned to return to work with appropriate supportive measures by 9 August.

Physiotherapy had 1.8wte vacancies all of which are in the recruitment process with 0.8 B5 start date 11 October. Interviews for the B7 1.0wte interviews are scheduled for W/C 23 August.

The Occupational Health service has 1.8 WTE vacancies out to advert with interviews scheduled in September.

Summary and Next Steps

There are pressures in maintaining safe caseloads of patients within DN Services. Active recruitment to vacancies is ongoing. In addition, the Division is exploring the utilisation of IN's in year 2 of their Earn, Learn, Return programme who wish to transfer into the service. In addition, GTEC are exploring direct recruitment to the service supported by advancement onto the Specialist Qualification (SPQ) once core competencies have been achieved. The division are proactively block

booking bank and agency staff to augment the service and to mitigate the impact on quality and outcome.

There are risks associated with vacancies within the HV team which are being proactively managed. Maintenance of services is challenging because of the lack of availability of HV via temporary staffing roots. Further exploration of IN's into the service is being explored.

A model for the delivery of COVID-19 vaccinations of 12-15 year olds by SN's is currently being developed.

Proactive temporary staff recruitment is to be undertaken by NHSP to support additional resilience within these services.

The division are actively working with GTEC to improve the profile of Community Services with IN as the service delivery model and career pathways vary significantly across countries.

The Division continue to provide a Monitoring at Home Service which is staffed via temporary staffing as there is no agreed funding for the service. The service is an essential component in admission avoidance and the initial service was recognised as excellent practice. Discussions remain ongoing to fully commission and fund the service to enable substantive recruitment.

Specialist Services

Wards A and B

Fill rates continue to be exceeded on the say shifts due to the need for continued support to overseas nurses to gain competencies whilst they are supernumerary. This will continue to decrease as skills and competencies are achieved. Additional support is being provided by GTEC.

4 red flags were raised across these areas in month, 1 due to shortfall in RN (A Ward), 2 intentional rounding/lack of DOLS supervision, 1 due to delay in pain relief due. This latter incident occurred because of their being only 1 RN on duty who could undertake IV drug administration and is linked to the deficit in skills previously mentioned.

1 fall occurred on A Ward at the time a shortfall in RN was raised as a red flag. No harm to the patient occurred.

1 CDT was reported on B Ward which occurred in a surgical patient at WTN. The patient was discharged home. Initial review identified no lapses in care; executive review of the case is scheduled for September.

Aspull

Fill rates for Unqualified Staff remain higher than planned across the 24-hour continuum.
This is predominately driven by the requirements for 1:1 supervision of patients as part of enhanced care needs.

There are currently 1.8 wte vacancies which are being advertised, the remaining vacancies have been recruited to and start dates have yet to be arranged. Sickness remains consistent and continues to be managed in accordance with Trust policies.

9 red flags were raised in month, 4 for delays in medications, and 5 for a shortfall in RN time.

1 Medicine administration incident was reported resulting in no harm to the patient.

1 CDT was attributed to the ward in month. This was a medical patient who had been readmitted to hospital but had had a previous inpatient stay on Aspull ward. Initial review identified no lapses in care; executive review of the case is scheduled in September.

3 falls with no harm were reported in month.

John Charnley Wing (JCW)

1 red flag was raised in month due to a delay in the administration of pain relief medication. This was not linked planned staffing levels but was indicative of workload pressures at the time.

Hand hygiene remains a concern within the division. Discussion and training are ongoing for auditors in areas. Missed opportunities occurred in month when audits were not completed fully. Non-Submission is being addressed through ward/team leader focus.

Theatres

Theatre recruitment remains challenging, with few applications being received, and skill mix remains a concern particularly for staff with anaesthetic and recovery skills. The impact of COVID has resulted in delays in staff enrolling on required courses. Education plans now in place to support this longer term.

The theatres vacancy position is B5 x 3 wte Anaesthetic and Recovery, and B5 5.28 wte Scrub

Monthly HR/absence meetings are being held with the HR business partner, HON and Matron. Matrons review all absences and escalate as required throughout month. Some areas carrying higher sickness percentage rates coincide with the impact of Track &Trace and isolation requirements, many are household contacts. The impact in smaller teams, eg Patient flow. has been significant. Sickness remains static and above KPI. All are being managed in line with HR processes and staff support measures implemented. Some returns for LTS which should positively impact in month 6.

E roster real time input is being scrutinised with ward managers to understand and change behaviours where needed. The division is also working with NHSP to understand some of the concerns the ward managers are highlighting to achieve improved KPIs.

Summary and next steps

There has been an increase in falls reported within the inpatient areas. Although these are no harm falls, the Board should note the psychological impact a fall can have on an elderly patient and the associated increase in length of stay.

Vacancies within theatres remain a significant pressure for the division and have the potential to impact negatively on the elective recovery programme. An enhanced rate of pay has been agreed via NHSP to assist in the filling of staffing gaps and reduce the impact on patients through cancellations. The Division has an ongoing recruitment campaign utilising the videos of staff promoting the speciality as an excellent area to work.

IN recruitment of experienced ODP's is reaching maturity. It has been identified that there is a skills gap and insufficient training placements domestically, despite an uplift being agreed with HEI's, to meet future work.

The division recognises the impact of increase workload and staffing shortfalls on staff morale and have proactively engaged the Staff Well-Being Team to assist with improving staff well-being.

Division of Medicine

Division Medicine Emergency Village

The Emergency Village has an overfill currently in both Registered and Unregistered staff due to the escalated areas for Symptomatic/Asymptomatic patients requiring additional staffing via NHSP/Agency. Unregistered overfill is particularly higher as these shifts will also be enhanced at short notice where there has been no Registered Nurse pick up. CDW is currently under the function of the Emergency village.

There was a critical internal incident declared within this month, during the night there were extreme pressures. Patients remained in ambulances with a paramedic during this period and there were no patient harms reported although there were severe delays in care. Rounding of patients and the Emergency Department Checklist was completed during these periods to support the delivery of safe care to patients. During the day there was a Trust wide response and appropriate staffing was redeployed to care for patients with increased length of stay within the department.

There have also been 2 occasions where 2 young patients with mental health needs have remained in the Emergency Department for (ED) in excess of 24 hours whilst an appropriate placement has been sought. This impacted on one occasion on the delivery of care within the department, due to the challenges in meeting the patients' needs, and resulted in the patient being cared for in the relative's room with additional support from external staff. The lack of inpatient bed facilities nationally continues to impact negatively on patient's time in the department and the overall experience for the patient and their families/carers due as a consequence of the lack of ability to access appropriate care.

There are currently 2.36 WTE established vacancies within ED and 3.0 WTE vacancies of Emergency Care Practitioners in the Walk-In Centre/Urgent Treatment Centre.

An enhanced NHSP rate of pay is currently in place to assist in the mitigation of risks associated with escalated areas.

Medical Wards

The medical wards have overfilled due to a combination of over-establishment and additional NHSP staff utilised to support the supernumerary status of INs rates for Registered and Unregistered staff across ASU, Astley, Ince and Pemberton. The overfill for unregistered staff is predominantly associated with an increase in the acuity of patients admitted to these areas, and increased adherence to the enhanced observation policy where patients are at risk of harms from falls. The Board should note that the increased fill rate with Astley Ward is associated with the number of patients being cared for with a DoL's in place; this has averaged 19 patients/day throughout the month.

Winstanley ward overfill rate is associated with the increased care requirements of patients on CPAP. The funded establishment of the ward is insufficient for the increased dependency of the patients. The division is currently undertaking an establishment review to address this moving forward, and to ensure that there is a sustainable staffing model to future proof the service.

25 red flags were raised in month which have all been reviewed and actioned. The Head of Nursing undertakes a review of red flags alongside patient safety incidents raised on Datix; no patient harms have been identified during this time

2 CDTs were attributed to Astley Ward during the reporting period where lapses in care were identified. The lapses relate to

- Inappropriate use of antibiotics
- Inappropriate prescribing of PPI

- Stool sample was unlabelled and there was a delay in it getting it to the lab which led to a delay in treatment. The second sample was not taken until 3 days later.
- Late to isolate the patient – they were only isolated after the CDT result was received.

An improvement plan has been developed and is being monitored by the division.

1 CDT was attributed to Shevington ward where no lapses in care or learning points were identified.

1 further CDT was reported on Standish ward which identified the requirement to record a patients stool type and frequency of bowel movement on admission as a learning

No falls with harm were noted in month.

2 Category 1/2 pressure ulcers were reported on Standish and Winstanley Wards which are subject to review via agreed governance channels. The division continues to progress its pressure ulcer reduction programme.

2 drug administration errors were also reported in month with no associated patient harm.

The Division continues to work with the e roster team to review all rosters within the division and support the input of flexible working patterns. The matron team within the division are working with the ward managers to ensure rosters are compliant with the lead in time for roster approval and NHSP lead time to ensure timely planning of safe staffing levels.

Hot spots of concern are currently MAU and Lowton with junior skill mix, and ward leader and matron posts currently out to recruitment.

Summary and next steps

There remains over-recruitment in some inpatient areas against budgeted establishment as a consequence of the allocation of IN's to these areas. A solution to funding the escalated ward is being explored by finance and this will allow the deployment of staff to other areas to support their career development or to support enhancing skills and knowledge.

Winter Monies have been agreed to support the increased staffing requirements for ED. The Division is proactively recruiting to these vacancies but is also exploring options to redeploy staff onto the department to offset the over-establishment previously mentioned as well as providing opportunities for staff growth and development.

An enhanced rate of pay remains in place within ED to support staffing levels.

A review of the establishment on Winstanley is currently in progress to support the area transitioning into an Enhanced Respiratory Unit in line with Royal College of Physicians Guidance. This will require additional investment in the service but will provide resilience in respiratory support for those patients that do not meet the criteria for admission to Critical Care.

Division Of Surgery

ICU/HDU

Fill rates for registered staff have been met for this month, however there is an expectation that rates would be higher to cover the supernumerary shift leader requirement which is yet to be fully recruited to. Within the non-registered staff establishment, there has been deficits due to long term sickness affecting the fill rate for days.

There have been no red flags documented.

There has been 1 category 3/4 PU detected but following panel review, no lapses in care were identified.

There are currently 3.6 wte B6 vacancies to support backfill of supernumerary shift leader.

All absences are being appropriately managed utilising the support of HR as per the Trust Attendance Management policy.

LANGTREE WARD

This month's fill rates for registered day staff remain low. Current vacancies have been back filled by the IN workforce who are in their induction period and remain supernumerary. Daily Surgical Matron staffing reviews of skill mix within all the ward areas has provided oversight and release of staff where able to lend further support. Focused work with NHSP has commenced to educate and allow for investigation into booking behaviours, demand, fill and utilisation.

There have been 29 red flags documented this month, a vast improvement from previous months in response to the awareness drive that has been undertaken within the Division. There was no association with the red flags raised and harms reported in month.

There have been 2 episodes of CDT in the reporting period. Hand hygiene audits remain an issue this month with audit results reduced further to 55%. The audits identified missed opportunities from various disciplines.

1 MRSA Bacteraemia was also reported. Missed opportunities were identified and an action plan is in progress to address the missed opportunities identified. Focused work is being undertaken with the IPCC team including ANTT training.

There have been 5 falls and 1 drug admin error this month, with no harms identified.

There are 6 vacancies within the area which have been backfilled by our IN workforce. The B7 ward leader position is in the recruitment process. The ward leader for Swinley ward is to be released and will remain supernumerary to provide leadership oversight to both areas as an interim measure. An initial service review is indicating that an additional uplift in staffing is required of 3 staff members on all shifts.

ORRELL WARD

Fill rates for registered staff have been met within the month. An increase in unregistered staffing fill rates particularly on nights, reflects the additional shifts that have been added to support the enhanced care and DOLS requirements.

11 red flags have been documented, showing that staff are responding to the Divisional awareness drive regarding the importance of completing safe care and the triangulation of staffing shortfalls, harm and explanation of temp spend

There have been no episodes of CDT this month. A 3-month action plan remains in place following the previous months CDT.

There has been a reduction in medicine administration errors from 5 to 1 in month. Focused work regarding the issues identified are being undertaken with the department's principal pharmacist. Clinical and educational support has been offered by the professional practice team for the difficulties with medicines management and IV competence completion within the international nurse workforce; it should be noted, however, that the medicine administration errors were largely relating to the domestic recruits. Additional study days have also been arranged to support this deficit.

There are currently no B5 vacancies due to the current reduction of the bed base to accommodate SAEC within Orrell ward. There is a small over establishment for Unregistered staff, which will balance out following formal workforce reviews.

SWINLEY WARD

Fill rates for registered and unregistered staff have been met within the month.

There have been 6 red flags documented.

There have been no reported patient harms in month.

Sickness is being appropriately managed utilising HR attendance management process. There is 1 x B5 vacancy which is being used to support the recruitment of a rotational position with the Women's Health Unit.

Summary and next steps

Fill rates for registered nurses within the Division have not always met the Trust required standard. Where this has occurred Ward Leaders have delivered clinical care. One ward leader is currently working across 2 inpatient areas. Recruitment to the vacant ward leader post is active.

Whilst inpatient vacancies remain low, there are considerable challenges across both Theatre and Critical Care areas. Vacancies within theatres remain a significant pressure for the division and have the potential to impact negatively on the elective recovery programme. An enhanced rate of pay has been agreed via NHSP to assist in the filling of staffing gaps and reduce the impact on patients through cancellations. IN recruitment of experienced ODP's is reaching maturity. It has been identified that there is a skills gap and insufficient training placements, despite an uplift being agreed with HEI's, to meet future work.

Recruitment remains ongoing within Critical Care as a consequence of the investment in the supervisory shift leader role required in the Critical Care Specifications. It should be noted that support to enhance the overall workforce to support the provision of 11 Level 3 beds was not supported.

Maternity Services

There are currently 13.58 WTE Registered Midwife (RM) vacancies across the service; 9.44 WTE will be in post in September/ October 2021, as they are all newly qualified and awaiting PIN numbers (6 are WWL trained Midwives and 4 from other organisations).

Maternity services have been allocated funding for staffing and training purposes to improve safety and quality of care, from the Ockenden funding bid that was submitted based on Birthrate+, Midwifery staffing reports, and training requirements. The funding has enabled recruitment to the current vacancies based on 2400 births per year.
In addition to the vacancies for RM's the service continues has experienced significant challenges with absences due to Covid, predominately these have been for self-isolation due to family members however in recent weeks there have been increasing numbers of staff testing Positive.

The short and long-term sickness in addition to the on-going vacancies is adversely affecting staffing levels across the service and many shifts are not staffed to the appropriate ratios, however it is anticipated that this will position will improve by the end of October / early November when the majority of the new staff in post will have completed their supernumerary period.

There has been 1 Maternity Divert in July associated with reduced staffing levels; no women were impacted by this divert.

All incidents continue to be reviewed and escalated appropriating through ESG, with additional local and regional oversight of all moderate and above incidents.
Training compliance remains on track with a robust training programme in place to meet the requirements of CNST and Saving Babies Lives recommendations.

Compliance was declared in July with all 10 Year 3 CNST Safety Actions, with 2 actions requiring an action plan which have also been submitted to NHSR and feedback is still awaited.

Summary and next steps

Recruitment has been undertaken to establishment required following the receipt of Ockenden funding.

A full staffing report is due to be presented in October 2021 to The Board, which will project the numbers of Midwives required going forward. To support this the service considered the age profile of the current headcount of qualified Midwives which may result in increased retirements over the next 5 years onwards.

International recruitment of RM's is being undertaken across GM to mitigate the staffing shortfalls across the region.

There have been no safety concerns raised within the service although it is noted that the unit was on divert on 1 occasion in July, as previously mentioned. No women were impacted because of the divert.

RAINBOW WARD

Fill rates for the month for Registered staff have been borderline. Additional shifts for registered staff were put out to support the dependency within the ward due to complex admissions but were not picked up so additional unregistered support was requested and has been provided as is reflective of the large over fill of unregistered staff for day shifts.

There have only been 6 red flags documented. This is an improvement from the previous month but still requires further attention given the acuity of the patients on the ward.

1 drug admin errors documented with no harm identified.

There are currently no vacancies on the ward, however, with the recent approval of 5 O & A beds and anticipated RSV surge, plans for recruitment are pending to support the anticipated increase in demand for inpatient beds.

Summary and Next Steps

There have been challenges within the clinical area in maintaining fill rates for registered staff which have been exacerbated by an increased dependency of children requiring care. This risk has been mitigated by an increased utilisation of unregistered staff to support observation of those children.

Vacancies

The Trust recruitment data currently indicates that WWL has 146.25 WTE nursing and midwifery vacancies in the recruitment phase. The stages in recruitment are detailed below alongside the AFC pay band. The information provided details vacant posts within the recruitment process in July 2021 and the posts authorised only. Those that have yet to be authorised are excluded from this report.

AFC Band	Authorised for Advert	Shortlisting	Interview	Offered in July 2021	Total
2	0	1.07	4.0	7.0	12.07
3	0	0	1.0	2.0	3.0
4	2.92	0	2.8	2.6	8.32
5	10.36	3.25	32.8	33.01	79.42
6	1.0	2.66	7.6	9.56	20.82
7	7.04	1.0	7.0	4.58	19.62
8a	1.0	1.0	0	1.0	3.0
Total	**22.32**	**8.98**	**55.2**	**59.75**	**146.25**

Where posts have been offered, these are aligned to the pertinent budget code and are therefore not regarded by finance as a vacancy, and the vacant hours are offered to NHSP/Agency through the current escalation processes.

17.0 WTE B5 vacancies in the interview process are part of the rolling programme for the domestic recruitment pipeline.

Further housekeeping is required within the clinical divisions to ensure TRAC and ESR are updated in a timely manner as the data is currently showing an additional 11.52 WTE who have been offered posts and have no start date assigned.

Areas of particular concern are District Nursing Services and Maternity Services. Detail relating to the concerns were provided in the appropriate divisional sections.

International Recruitment

Of the 185 IN's agreed within the original business case, 182 have now been placed within the divisions. There continues to be over-establishment within some inpatient areas and the Divisions are currently reviewing options for staff movement to bring clinical areas back within their budgeted establishments. There has been no associated reduction in bank spend within these areas as additional support is required during staff preceptorship periods.

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 continues to map the numbers of IN's required to maintain safe staffing requirements and supplement recruitment nationally.

A collaborative piece of work is currently being planned to map the 2nd and 3rd years of the recruitment programme aligned to the Earn, Learn and Return philosophy. Consideration of not disadvantaging internal newly qualified registrants by having a two-tier training/support scheme is being factored into the programme alongside the potential impact on clinical time associated with the uplift in funded establishment provided for training.

A business case proposing focussed recruitment of IN's in difficult to recruit to areas is to be submitted.

Bank and Agency Utilisation

Bank and agency utilisation continues to be higher than expected with an increase in overall demand from June to July of 1.9% (27.5k hours). The total spend for Nursing and Midwifery (N&M) in month is provided below.

Bank (£)	1,645,934
Agency (£)	93,024
Total (£)	**1,738,958**

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 below.

	A&E (£)	Standish (£)	Pulse Oximetry @ Home	Total (£)
Bank	188,568	51,533	34,646	274,747
Agency	14,236	2008		16244
				290,991

From the information above £290,911 of temporary spend is unavoidable as this is required to maintain IPCC patient flows and the provision of safe patient care.

Bank fill rate increased to 94.2% resulting in 366 unfilled shifts. Agency staffing accounted for only 3% of temporary staffing requests. 15% of booking requests were short notice requests, 40% of these were given the booking reason as vacancy; if this reason was accurate these shifts should have been forwarded to NHSP at the point of roster approval.

Healthcare Assistant shift requests increased by 5000 hours in month, 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.

The average lead in time for releasing shifts to NHSP was 23.3 days, a marginal improvement from the 23 days reported in June, against a target of 42 days. The top 3 reasons for requesting temporary staff remain escalation, vacancy, and sickness. Further work is required within clinical areas to ensure that all unfilled shifts at the point of roster approval are released to NHSP to improve opportunities to fill shifts and to ensure the correct booking reason is provided. Direct booking of agency shifts decreased to 1.9% with most direct bookings being initiated across Theatres and the Emergency Department.

NHSP set up stands over at Wrightington to attract more substantive workers to join the bank; 22 substantive staff signed up in total mostly from operating theatres. A further stand is planned on the RAEI site to improve visibility and to attract additional workers.

The community project aimed at attracting more staff to work on the bank has also gone live within month.

Roster Utilisation

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

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/

For July 2021 only 7 of the 40 rosters reported on had been approved 6 weeks in advance (17.5%); this delay means that staff within the clinical area are not able to view their roster to be worked remotely.

The auto roster function within E-Roster is only being utilised in 7 of the 40 areas; these areas are all within the community division. Utilising auto roster releases time for roster managers to complete other duties, however for this to be effective staff details and working patterns need to be maintained

within the system. There is evidence to suggest that increase in the requirement for ward managers to work clinically in response to staffing shortfalls/supervision of staff is negatively impacting on their ability to maintain administration responsibilities and therefore the system will require cleansing to enable this to be fully rolled out.

79.5% of unfilled shifts from available substantive staff had already been picked up via NHSP.

Overall annual leave allocation was 13% which is within the KPI range agreed within the e roster policy.

Staff Redeployment

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

With regards to data on SafeCare there have been 179 staff redeployments to other areas in response to patient acuity and short notice absence. The table below provides further divisional detail with regards to redeployment.

Division	Number of staff redeployed	Areas redeployed to
Specialist Services	37	1 to acute medical areas 36 within the division
Surgical Division	11	2 to acute medicine 9 within the surgical division
Medical Division	127	17 to surgical wards 1 to ICU 99 across the medical division
Community Division	1	To acute medical area

CHPPD

CHPPD data has not been refreshed on the Model Hospital since May 2021, therefore no new comparators can be drawn this month.

4.0 ACTIONS BEING TAKEN

- A Recruitment programme for the Wrightington site for theatre staff and to support the recovery programme is being devised
- Wellbeing support is being encouraged and facilitated by OD/staff engagement
- A Nurse education lead has been appointed within Specialist Services Division.
- Staff training continues around effective E-rostering completion within allotted timeframes, Safe care and red flag completion.
- Focused work is being undertaken with the ward leaders and NHSP. E-roster completion lead times remain below the targeted time frame of 42 days. The expectation of the meetings are that with increased scrutiny, there will be a greater understanding of for the need for timely roster completion, approval of and effective application of temporary spend to support staffing requirements.
- Increased focussed on rosters to be worked is being undertaken by the Divisional Directors of Nursing to provide assurance that rosters are safe and effective at the time they are produced.
- Recruitment to fixed term posts against allocated Winter monies within the Emergency Village
- Block bookings are being sent to NHSP for critical areas

- Mapping of IN nurse recruitment requirements with the domestic recruitment pipeline has been completed and mapping of age profiling is being undertaken to provide projected workforce requirements to the end of financial year 2025/26

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

July 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	127.9%	155.6%	4.6	143.7%	156.9%	6.7	6.7	5.65%	0.00%	2		0/6				
Astley	121.2%	148.7%	3.4	154.3%	196.6%	6.8	6.8	5.90%	0.00%		2	0/2				
Bryn North	95.0%	96.0%	8.5	135.3%	157.5%	16.7	16.7	Unable to report as this cost centre is not recorded on FBI or ESR		3		0/1		0/2		
Bryn South	0.0%	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				0/6				
Coronary Care Unit	175.5%	119.5%	10.9	182.4%		3.3	3.3	2.84%	3.40%							
Highfield	0.0%	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	154.0%	103.1%	4.0	140.7%	179.2%	5.4	5.4	8.57%	8.52%	1		0/5				
Pemberton	127.6%	100.0%	6.0	134.5%	132.1%	5.5	5.5	11.74%	0.00%			0/3				
Shevington	111.0%	96.8%	3.1	141.2%	153.1%	5.5	5.5	4.01%	0.00%	18	1	0/6		0/1		
Standish	104.1%	97.4%	2.9	165.9%	200.9%	6.8	6.8	1.37%	19.56%	7	1	0/4	1/0			
Winstanley	157.4%	150.7%	7.4	120.6%	140.3%	8.0	8.0	10.73%	0.00%	5			1/0			

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	97.7%	99.2%	33.0	86.5%	0.0%	4.3	4.65%	0.00%	0.00%				1/0			
Langtree	77.0%	88.6%	3.9	113.6%	174.2%	4.6	8.99%	2.10%	20.50%	29	2	0/5		0/1		
Orrell	104.0%	99.2%	3.1	115.6%	157.5%	5.3	2.96%	6.88%	8.80%	11		0/4		0/1		
Swinley	105.9%	109.8%	3.6	120.6%	167.0%	3.3	3.84%	0.00%	2.65%	6						
Maternity Critical Care / Delivery	88.7%	88.5%	0.0	1.7%	0.0%	0.0	2.90%	2.07%	2.07%							
Maternity Ward	105.3%	99.0%	2.4	138.8%	156.4%	3.1	18.72%	5.31%	5.31%							
Neonatal Unit	117.4%	122.0%	28.5	86.3%	0.0%	3.3	4.70%	0.00%	0.00%							
Rainbow	96.6%	94.0%	8.7	186.8%	103.5%	5.0	4.26%	4.85%	9.11%	6				0/1		

Division of Specialist Services

	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Vacancies (%) - Registered Nursing Band 5-8	Datix Incidents - related to staffing/Red Flags	CDT	Falls (Harm / No Harm)	PU (Grade 1&2 / Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the hospital staff did everything they could do to control your pain?	Have you been given the care you felt you required when you needed it most?
Aspull	100.0%	99.1%	3.3	125.0%	165.5%	5.60	17.86%	9.35%	19.73%	9	1	0/3		0/1		
Ward A	129.3%	97.9%	4.8	101.3%	101.4%	4.15	5.61%	5.07%	0.00%	1		0/2		0/1		
Ward B	125.6%	109.9%	4.2	96.2%	113.0%	4.03	10.45%	11.53%	0.00%	3	1	0/2		0/1		
JCW	0.0%	0.0%	0.0	0.0%	0.0%	0.0	4.66%	20.09%	23.19%	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	116.9%	126.9%		178.0%	261.4%		3.50%	7.20%	12.21%	0		0/3		0/2		
A&E Paeds	109.7%	104.2%					0.23%	0.98%	0.98%	0						
A&E NP's	80.5%	0.0%		25.8%	0.0%		3.41%	31.05%	19.28%							
CDW	81.3%	88.7%		102.3%	100.4%		8.06%	12.04%	19.57%			0/1				
Lowton	102.8%	95.3%		107.7%	159.4%		10.57%	9.05%	6.75%	2		0/3				
Medical Assessment Unit	91.2%	101.3%		98.3%	165.4%		4.12%	7.23%	6.88%	1		0/4		0/2		

Division of Community

	Average Fill Rates (%) & CHPPD						Staff Availability			Staff Experience	Nurse Sensitive Indicators				Patient Experience % (Number surveyed)	
	RN / RM			CSW												
Ward	Day shift (%)	Night shift (%)	CHPPD	Day shift (%)	Night shift (%)	CHPPD	Sickness (%)	Vacancies (%)	Vacancies (%) - Registered Nursing Band 5-8	Datix Incidents - related to staffing/Red Flags	CDT	Falls (Harm / No Harm)	PU (Grade 1&2 / Grade 3 & 4)	Drug Admin Errors (Harm / No Harm)	Do you think the hospital staff did everything they could do to control your pain?	Have you been given the care you felt you required when you needed it most?
Community Assessment Unit: RAEI	161.3%	100.5%	5.0	100.6%	138.8%	4.9	4.9%	0.00%	0.00%			1/3				

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

Appendix 2

	June 2021		July 2021	
No of areas	Red Metrics Registered Staff Days	Red Metrics Registered Staff Nights	Red Metrics Registered Staff Days	Red Metrics Registered Staff Nights
24	**3**	**0**	**2**	**0**

Table 1. Red Metrics in Inpatient Areas June/July 2021

Month	Registered WTE	Unregistered WTE
July	122.66	23.39

Table 2. Nurse Vacancies in the recruitment phase July 2021 Trust Wide)

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

Table 3. Nursing Red Flags May -July 2021

Red Flag Category	No. of Incidents May 2021	No. of Incidents June 2021	No. of Incidents July 2021
Unit on Divert			1
Co-Ordinator Unable to Remain Super-numerary	3		
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)			1

Red Flag Category	No. of Incidents May 2021	No. of Incidents June 2021	No. of Incidents July 2021
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**

Table 4. Maternity Red Flags March/July 2021.

CHPPD	Data period	Trust value	Peer median	National median	Chart	Actions
Care Hours per Patient Day - Total Nursing, Midwifery and AHP staff	May 2021	10.6	8.9	9.1		
Care Hours per Patient Day - Total Nursing and Midwifery staff	May 2021	10.6	8.9	9.1		
Care Hours per Patient Day - Total AHPs staff	May 2021	0.0	0.0	0.0		
Cost per Care Hour - Total Nursing and Midwifery staff	Q4 2018/19	£20.6	£25.3	£23.6		
Cost per Patient Day - Total Nursing and Midwifery staff	Q4 2018/19	£174.4	£186.7	£189.6		

Table 5. Use of Resources May 2021 (Source Model Hospital)

Title of report:	Performance Report
Presented to:	Board of Directors
On:	29 September 2021
Presented by:	Deputy Chief Executive
Prepared by:	Deputy Chief Executive, Director Operations, Data, Analytics and Assurance
Contact details:	BI.Performance.Report@wwl.nhs.uk

Executive summary:

Increasing NHSI/E scrutiny and assurance is mainly focused in two areas:

The first relates to Urgent and Emergency care, in particular pressures on the ambulance service, including handover delays in Accident and Emergency. Whilst some localities are seeing a return to pre covid pandemic levels this is not the case for Wigan, Increased demand at the front door, rising numbers of delays in discharge alongside staffing pressures caused by Post covid cohorting is creating unprecedented levels of pressure on the emergency floor Given on-going challenges patient safety remains the priority with the Trust forced to escalate several areas throughout September to ensure clinical safety.

However, the Executive team are cognizant of the impact escalating areas has on workforce, and of all the operational pressures on our staff, particularly clinical staff given recent tragic episodes concerning junior doctors. Staff have coped non-stop over the last 18 months and, despite many right interventions and initiatives being in place supporting staff, the operational pressure is relentless as we now move into a period of known increased demand for acute beds, whilst Community colleagues also respond to national vaccination directives.

At a recent meeting, the Executive team from the Trust met with their counterparts in Commissioning to review the many interventions and investments to date but to also explore how we work together to identify areas of focus outside of hospital which could help reduce pressure by reducing attendance and admission and by improving flow. The Emergency Care Improvement Support Team (ECIST) is supporting a locality led Discharge and Flow improvement programme in October. These programmes, along with others, will form part of the WWL' winter pressure response alongside the Locality Urgent care response and will link with the Greater Manchester Urgent Care Board.

Further additional demand is predicted in the coming Winter months due to the potential for an increase in Covid admissions, which we're already seeing, and an increase in non-covid respiratory admissions such as Flu. Although difficult to predict, the indicative forecasting undertaken by *Greater Manchester utilisation team* suggest WWL will potentially need 50 additional beds to meet winter demand. The Trust commenced the first of a series of winter pressure workshops led by Silver Command exploring where and how a further

50 beds can be sourced as part of the winter pressure modelling, and in particular a workforce plan to support the increase.

The second area of focus is elective recovery, 104+ week wait profiling. Responding to NHSI/E tight deadline, and as part of the Greater Manchester ICS recovery plan, WWL submitted a position based on high level modelling to provide as realistic a position as possible. The modelling shows that at best around 50% of the 1250 patients on the current waiting list forecasted to breach 104 weeks by 31st March 2022 would receive treatment beforehand. The Worse case being none of the patients due to breach 104 weeks by the end of March receive treatment, unless allocated a more urgent priority. The reality is the position will be somewhere in the middle, and although the directive is to have no patient waiting beyond 104 weeks by March 2022, the Trust's initial return is felt to be operationally grounded and reflects not just efficiency and transformation opportunity but also reflects the continued Covid, workforce and urgent care demands described above. We continue to develop a forecasting tool capable of responding to various scenarios to ensure all trajectories are as robust as possible.

In addition to the plans underpinning the Trust's good progress against its recovery plan, key actions to support treatment of long waiting patients are:

We continue to access Greater Manchester independent sector capacity for long waiting patients triaged as clinically suitable for specialties. The trust is confident this capacity will increase from October given on-going discussions with other sources.

As Wrightington has been named Bolton's partner organisation for orthopaedic elective surgery, and indeed Orthopaedic Elective Hub in Greater Manchester, Bolton has been named WWL's partner site for Paediatric Oral surgery with surgical lists starting at the end of September.

The Trust continues to explore ways of enhancing utilisation of the Leigh site both internally and as part of National Capital Elective Recovery Programme Bid. We are also working with partners at Christie to protect cancer capacity as we head into winter, however capacity created would be directed to Priority 2 (urgent cases) in the first instance.

Recommendation(s)

The Committed is asked to note the current potential risks to urgent care and elective recovery, the WWL approach to mitigate this risk outlined in this paper, in particular the further modelling required to inform the 104-week profiling, and the focus on the internal, locality and GM system wide plans which aim to support further unprecedented increases in urgent and emergency care and potential subsequent impact on elective recovery, those waiting the longest for treatment.

Link to strategy
Patient
Partnership
Workforce

Risks associated with this report and proposed mitigations

Patient Harm
Staff health and wellbeing
Complaints and litigation
Reputational damage

Mitigation:
Patient Clinical Prioritisation
Safety checklist
Staff well health and wellbeing as part of Staff engagement programme

Urgent and Emergency Care Board ownership and delivery of system wide winter plan
Winter planning
Elective Recovery Plan
Waiting list profiling

Scorecard:

	Month	ON/OFF Track	Why?	
A&E Performance (Single)	M05	Off Track	78.78% M05, 84.04% YTD; Target 95%	ACTIVITY & EFFECTIVENESS
Cancer Performance (Grouped)	M04	Off Track	3 / 7 in month, 3 / 7 YTD; Metrics Off Track	
RTT Performance (18 Weeks)	*M04*	*Off Track*	*63.26% M04, 62.27% YTD; Target 92%*	
RTT Performance (52 Weeks)	*M04*	*Off Track*	*2394 patients waiting 52+ weeks*	
Diagnostics Patients waiting under 6 weeks	*M04*	*Off Track*	*81.01% M04, 86.64 YTD; Target 99%*	
Recovery plan - NHS E/ I	M05	Off Track	2 out of 3 measures achieved	
Recovery plan - WWL	M05	On Track	107% of 2019 Activity; Target 90%	

Financial Position (£000s)	In Month Actual £000's	In Month Plan £000's	In Month Var £000's	Year to Date Actual £000's	Year to Date Plan £000's	Year to Date Var £000's	H1 Plan £000's	Full Year Plan £000's
Income	37,267	36,755	512	188,317	184,261	4,056	221,052	TBC
Expenditure	(35,484)	(35,004)	(479)	(182,719)	(178,821)	(3,898)	(213,908)	TBC
Surplus / Deficit	563	549	15	(496)	(572)	76	(70)	TBC
Cash Balance	42,313	36,069	6,244	42,313	36,069	6,244	34,321	TBC
Capital Spend	1,446	1,189	(257)	4,835	4,811	(24)	6,302	11,022

Reported position : M05

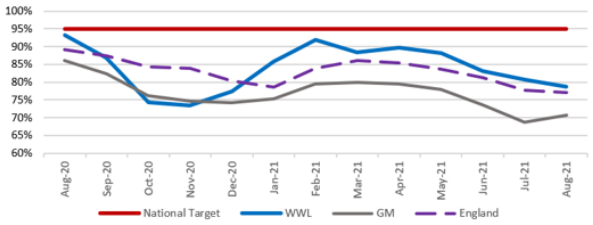
The plan has been updated to the NHSI/E submission made in October for the second half of the financial year.

FINANCE

Exception Reports:

Scorecard Exception Reporting

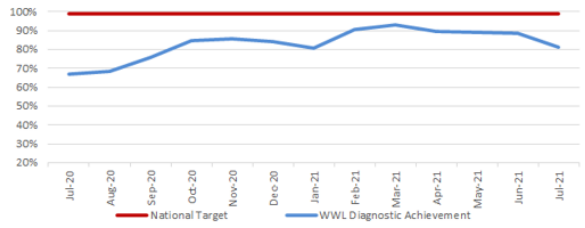
Metric : A&E Performance (Single)



Narrative and Planned Actions :

Current in month performance is 78.78%; performance remains challenging, however the number of attendances has started to decrease, with numbers in August dipping below 10,000 for the first time since April 2021
Nationally in August, WWL ranked 35th out of 109 Acute Trusts with published data, and remain above the national average of 77.0%. WWL retained first place in the GM rankings during the month.

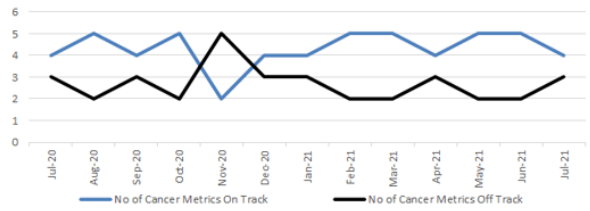
Metric :Diagnostics Patients waiting under 6 weeks



Narrative and Planned Actions :

Most diagnostic areas experienced a decline in performance during the Covid period but have seen improvements over the last few months. For July 21 our overall performance was 81.01% against a target of 99%, a marked reduction compared to June 2021 (88.63%).

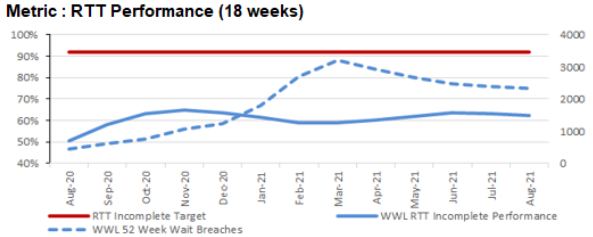
Metric : Cancer Performance : Grouped



Narrative and Planned Actions :

The chart to the left tracks the number of cancer metrics on and off track.
There were 3 failed Cancer metrics in July, a slight deterioration from 2 in June. The lowest was 1 in May 2020, the highest 5 in November 2020.
Two Week Wait For Symptomatic Breast Patients (Cancer Not Initially Suspected) - July 91.23%, against a target of 93%.
31 Day Standard (Diagnosis to First Definitive Treatment) - Performance during July 93.58%, against a target of 96%.
62 Day Standard (Urgent GP Referral to First Definitive Treatment) - Performance during July 80.29%, against a target of 85%.

Metric : RTT Performance (18 weeks)



Narrative and Planned Actions :

The Overall 18 Weeks Waiting List continues to grow. Despite this increase, the number of patients waiting over 52 weeks for treatment drop for the fifth consecutive month, a 27.6% reduction against the peak in March 2021.
This, combined with a 7% financial year-to-date decrease in the amount of Priority 2 patients waiting for treatment, shows that the Trust's current elective strategy is working and that the growth of the waiting list is due to an increase in new RTT referrals.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Monthly Trust Financial Report – Month 5 (August 2021)
Presented to:	Board of Directors
On:	29 September 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	37,267	36,755	512	188,317	184,261	4,056
Expenditure	(35,484)	(35,004)	(479)	(182,719)	(178,821)	(3,898)
Financial Performance	579	560	18	(471)	(514)	43
Cash Balance	42,313	36,069	6,244	42,313	36,069	6,244
Capital Spend	1,446	1,189	(257)	4,835	4,811	(24)

Key Messages:

- The Trust has agreed a balanced budget for the first half (H1) of 2021/22 with the Greater Manchester (GM) system and NHSE/I.
- The block contract and system top up funding arrangements have been extended for H1, as national tariff remains suspended.
- In month 5, the Trust reported a surplus of £0.6m, which was on plan. Year to date, the Trust is reporting a deficit of £0.5m which is on plan.

The WWL Way

- The Trust is forecasting a break-even position for the first half of the financial year.
- Cash is £42.3m at the end of Month 5.
- Capital spend is £1.4m in month and £4.8m year to date.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	2021 / 22 Transformation Plan – M5 status report
Presented to:	Board of Directors
On:	29th September 2021
Presented by:	Richard Mundon, Director of Strategy and Planning
Prepared by:	Karlyn Forrest, Director of Strategic Transformation Lucy Currie, Assistant Director of Transformation
Contact details:	**T:** Ext. 2283 **E:** lucy.currie@wwl.nhs.uk

Executive Summary

The Transformation Plan for 2021/22 sets out the priority large scale improvement programmes for the current year, contributing to both the delivery of *Our Strategy 2030* and responding to more immediate strategic and operational priorities, including the restoration and recovery from Covid-19. As presented to the Board of Directors in May 2021, the plan focusses on the four key themes and includes nine transformation programmes. The Transformation Plan also facilitates an alignment with both locality and system-wide transformation priorities and programmes of work.

The Transformation Board is responsible for overseeing the delivery of the Transformation Plan. Established at the start of the current financial year, this group meets monthly and is chaired by the Chief Executive Officer. Detailed programme delivery reports for each programme, including dashboards with the outcome metrics are presented by each Executive Director SRO at this forum to support the programmes deliver their expected benefit(s).

Aligned to the 4Ps, this paper provides an update on progress against agreed outcomes for all Transformation Programmes as at M5, including RAG ratings for performance against agreed improvement trajectories.

Link to strategy

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

Risks associated with this report and proposed mitigations

None to note

Financial implications

The 21/22 Transformation Plan is a one of the key mechanisms to support the delivery of financially sustainable and efficient services. As part of the holistic benefits realisation approach to Transformation, each programme has a full financial and productivity review and the identified benefits are tracked throughout the implementation and delivery of each scheme. The financial benefits from the programmes are transacted as part of Divisional / departmental efficiency plans.

Legal implications

None to note

People implications

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

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

Wider implications

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

Recommendation(s)

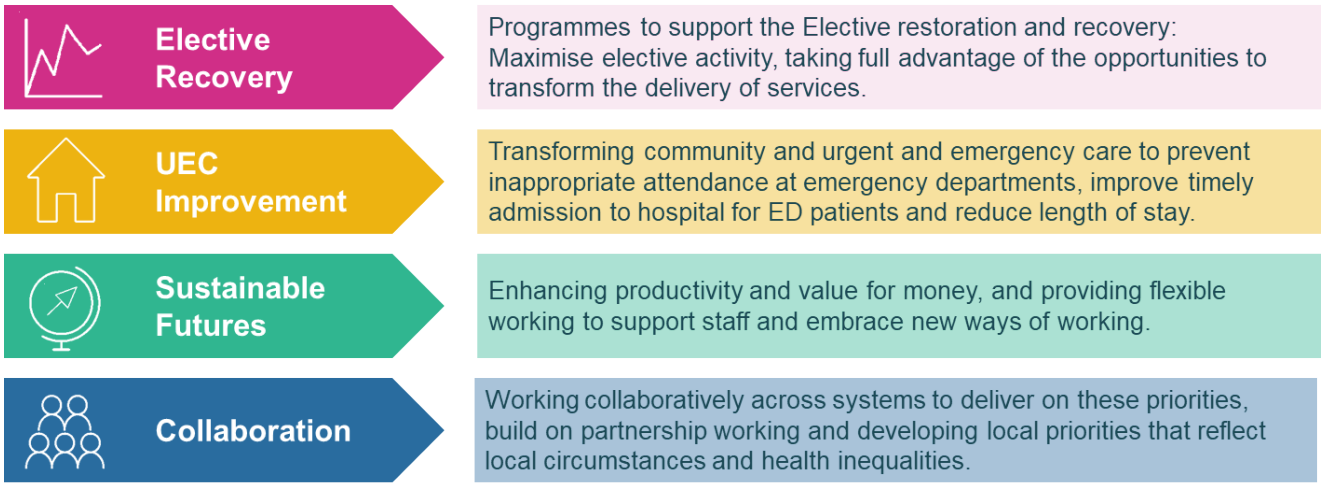
The Board is asked to note the key points in this paper and support the ongoing implementation of the complex change programmes within the Transformation Plan in order to achieve the improvement outcomes for our patients and people.

Report

Context

The Transformation Plan 2021/22

The Transformation Programmes for 21/22 all contribute to four main themes which align to WWL priority areas and the Operational Planning Guidance 21/22. These themes encourage us to focus on the high impact areas for improvement, also allowing the Transformation Plan to adapt to any new requirements throughout the year. This thematic approach allows WWL to ensure that any changes in focus remain aligned with the high impact areas that will deliver the greatest benefit to our population, as outlined below:



Within the four identified themes, there are nine individual programmes identified. Each programme has a Senior Responsible Officer (SRO) at Executive Director level and a number of the programmes have direct alignment to the HWP locality plan as highlighted in the summary:

Theme	Programmes	Executive SRO	Projects	Locality
Elective Recovery	Outpatient Reset	Dr Sanjay Arya	• PIFU • Virtual Clinics • Advice & Guidance • Digital Communications • Enhancing Primary & Community Care	✔
	Clinical Service Collaboration	Richard Mundon	• GM Specialist Care Pathways • Wrightington – Elective Recovery Hub	
Urgent & Emergency Care (UEC) Improvement	Protecting the front door	Mary Fleming	• NHS 111 • Crisis Response • CAS • UTC / WIC • MH Pathways	✔
	UEC Streaming		• SDEC / SAEC • Monitor @ Home • CAU • Direct referral	
	Discharge & Flow		• Better @ Home • Community Beds • Discharge 2 Assess	
Sustainable Futures	Agile Working	Ian Boyle	Collaborative project across Workforce, IM&T, E&F, & Transformation	✔
	Workforce Efficiencies	Alison Balson	• Rostering • Medical spend • Time to Hire • Business cases	
	HVLC (GIRFT)	Mary Fleming	• Day case rates • HVLC pathways • Theatre standards	
Collaboration	GM Collaboration Programmes	Richard Mundon	• GM Integrated PACS • Unified Hospital Pharmacy Supply Chain • GM Pathology Network improvements	

Performance as at M5

The Transformation Plan delivers a range of holistic benefits across all 4Ps: Patients, People, Partnerships and Performance. Each of the outcomes for the programmes above are therefore categorised into these areas along with current progress towards the agreed outcomes.

Programme	P	Outcome	Status	Why?	Key future actions
Outpatient Reset	Patients	A positive patient experience for those accessing virtual clinics; both phone and video	Green	84% of patients would use virtual clinics again – excellent verbal feedback from patient survey	
	Patients	Increase numbers of patients on Patient Initiated Follow Up lists in line with plan	Amber	7 specialties now live and uptake increasing, however, below the planned trajectory	Support is being provided to specialities to review the uptake of PIFU, identify barriers to uptake and the achievability of the trajectory
	Patients	Increase number of patient communications delivered electronically	Green	Over 50,000 letters accessed digitally by patients up to August 2021	
	Partnerships	Increased uptake of Advice & Guidance in Primary Care	Green	A&G uptake increasing above 2019/20 baseline of 350 contacts with over 500 contacts per month	
	Performance	Minimum 40% of all OP clinics are delivered virtually	Amber	Virtual clinics accounted for 37% of all outpatient attendances in August 2021	Review of uptake by speciality / clinician to identify variation and provide targeted support
	Performance	Reduction in outpatient expenditure by £330k FYE	Amber	Validated financial plan still to be agreed for virtual clinics. £20k for Digital Letters delivered YTD	Plan to be presented at the next Outpatient Reset Programme Board on the 6th October 21 with the detailed plan to realise efficiencies.
Agile Working	People	Improved well-being for staff through choice over working environment and patterns	Not due		
	People	Reduction in travel time for WWL staff	Green	Existing agile working practices have resulted in reduced travel time. Not yet quantified.	
	People	Accommodation pressures resolved & enabler to 40% outpatient appointments delivered virtually	Not due		
	Performance	Reduction in travel costs, carbon emissions and print costs	Green	Over £100k savings within CIP plan for travel. Carbon emissions impact to be reviewed	

GIRFT - Theatre Productivity	Performance	All specialities meet 85% national day case target	Amber	General surgery, gynaecology and urology under 85% target	Development of speciality specific improvement projects ongoing.
	Performance	Increase throughput in 29 speciality pathways	Not due		
UEC Streaming	Patients	Improvement in A&E quality & access standards	Red	4 hour performance declining	Range of internal and system actions ongoing to support unpreceded demands on A&E, including improved discharge and flow
	Performance	Reduction in acute admissions by 17 per day and G&A bed demand by 35 beds	Green	Above planned trajectory for Q1. Q2 figures available in October.	
	Performance	Increase in UEC Streaming activity & proportion of admissions on 0 day LoS pathways	Green	Medicine improvement 46% to 59% 0 Day LoS Surgery improvement 38% to 64% 0 Day LoS	
Clinical Services Collaboration	Partnerships	An increase in our out of area referrals to 10,000	Green	Currently on plan for out of area referrals	
	Partnerships	Greatest throughput of T&O activity in GM in 21/22	Green	WWL have delivered 3,643 cases - approx 65% more than the next highest trust in GM and 30% of all cases	
	Performance	Restored to 20 orthopaedic sessions per working day by 31/03/22	Amber	August average 17 sessions per day	Proactive recruitment underway to increase workforce capacity following successfully securing £800k for 2021/22 to develop the elective hub at Wrightington
	Performance	Achieve £250k financial contribution from out of area activity in 21/22	Amber	Currently on plan, however, financial plan is backloaded and significant value risk rated 'red'	As above.
Discharge and Flow	Patients	Increase % of people who are living in their own home 3 months post discharge (target 95%)	Red	Target not being achieved.	ECIST visit taking place 14th October 2021 to focus future improvement interventions
	Partnerships	No increase in long term residential and nursing home placements and POCs	Green	No increase seen.	
	Performance	95% of people (Pathway 1-4) are discharged from hospital within 24 hours of 'no longer has a right to reside'	Amber	Performance remains low at average 12%, but in line with plan. Trajectory set to improve from September onwards.	As above

Protecting the Front Door	Partnerships	Increase in % of patients using NHS111 to access UEC appointment slots	Amber	NHS111 appointment slots are now in place across some WWL services, but activity data unavailable	Weekly meetings being held and full support in place to resolve this issue
	Performance	Reduction in A&E attendances	Red	A&E attendances are exceeding 2019/20 baseline	Range of internal and system actions ongoing to support unpreceded demands on A&E, including improved discharge and flow
	Performance	Increase proportion of patients accessing UTC and WIC rather than A&E	Amber	Proportion has increase over Q1-2, however, has not improved above 2019/20 baseline	Investment and development of the UTC at RAEI underway, including expansion of UTC opening hours.
Workforce Efficiency	Performance	Reduction in temporary spend of a minimum £110k	Not due		
	People	Reduced unplanned sickness absence	Not due		
	People	85% Compliance with rate cards. 100% Compliance with roster timeframes.	Not due		
	People	Improve staff retention of those who leave within 12 months from 27% to 10%	Not due		
	People	Improve 'Your Voice' scores for specific metrics within the survey	Not due		

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

AUDIT COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

1.1. The Audit Committee ("the Committee") is constituted as a standing committee of the Foundation Trust's Board of Directors ("the Board"). Its constitution and terms of reference shall be as set out below, subject to consultation with the Council of Governors and amendment at future Board meetings.

1.2. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

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

2. MAIN PURPOSE

2.1. The Committee has primary responsibility for monitoring the integrity of the financial statements, assisting the Board in its oversight of risk management and the effectiveness of internal control, oversight of compliance with corporate governance standards and matters relating to the external and internal functions.

2.2. The Committee shall provide the Board with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Foundation Trust's activities both generally and in support of the annual governance statement.

2.3. The Board is responsible for ensuring effective financial decision-making, management and internal control including:

(a) Management of the Foundation Trust's activities in accordance with statute and regulations; and

(b) The establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought.

3. MEMBERSHIP

3.1. The Committee shall be composed of four (4) independent Non-Executive Directors and the Committee shall ensure that it has sufficient skills to discharge its responsibilities. At least one (1) member should have recent and relevant financial experience.

3.2. The Chair of the Foundation Trust shall not chair nor be a member of the Committee.

3.3. A quorum shall be formed on the attendance of three (3) Non-Executive Directors.

4. SECRETARY

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

5. ATTENDANCE

5.1. Only members of the Committee have the right to attend meetings of the Committee but the Chief Finance Officer, the Medical Director, the Counter-Fraud Specialist and the internal and external auditors shall generally be invited to attend routine meetings of the Committee.

5.2. Other executive directors and staff shall be invited to attend those meetings in which the Committee will consider areas of risk or operation that are their responsibility.

5.3. Other persons may be invited by the Committee to attend a meeting or part of a meeting so as to assist in deliberations.

6. FREQUENCY OF MEETINGS

6.1. Meetings shall be held at least four (4) times per year, with additional meetings being convened as necessary.

6.2. The external auditor shall be afforded the opportunity at least once per year to meet with the Committee without executive directors present.

7. DUTIES

7.1. With respect to the financial statements and the annual report:

(a) Monitor the integrity of the financial statements of the Foundation Trust, any other formal announcements relating to the Foundation Trust's financial performance and reviewing the significant financial reporting judgments contained in them;

(b) Review the annual statutory accounts before they are presented to the Board, in order determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

(i) the meaning and significance of the figures, notes and significant changes;

(ii) areas where judgment has been exercised;

(iii) adherence to accounting policies and practices;

(iv) explanation of estimates or provisions having material effect;

(v) the schedule of losses and special payments;

(vi) any unadjusted statements; and

(vii) any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

(c) Review the annual report and annual governance statement before they are submitted to the Board to determine completeness, objectivity, integrity and accuracy;

(d) Review each year the accounting policies of the Foundation Trust and make appropriate recommendations to the Board; and

(e) Review all accounting and reporting systems for reporting to the Board, including in respect of budgetary control.

7.2. With respect to internal control and risk management:

(a) Review the Foundation Trust's internal financial controls to ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance;

(b) Review and maintain an oversight of the Foundation Trust's general internal controls and risk management systems, liaising with the Risk and Environmental Management Group where necessary;

(c) Review processes to ensure appropriate information flows to the Committee from executive management and other committees in relation to the Foundation Trust's overall internal control and risk management position;

(d) Review the adequacy of the policies and procedures in respect of all counter-fraud work;

(e) Review the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks; and

(f) Review the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements.

7.3. With regard to corporate governance:

(a) Monitor corporate governance compliance (e.g. compliance with the terms of the licence, constitution, codes of conduct, Standing Orders, Standing Financial Instructions and maintenance of registers of interests).

7.4. With regard to internal audit:

(a) Monitor and review the effectiveness of the Foundation Trust's internal audit function, taking into consideration relevant UK professional and regulatory requirements;

(b) Review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation;

(c) Oversee on an ongoing basis the effective operation of internal audit in respect of:

(i) adequate resourcing;

(ii) its coordination with external audit;

(iii) meeting relevant internal audit standards;

(iv) providing adequate independence assurances; and

(v) it having appropriate standing within the Foundation Trust.

(d) Consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations; and

(e) Consider the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal of internal audit staff; and

7.5. With regard to external audit:

(a) Review and monitor the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements;

(b) The Council of Governors should take the lead in agreeing with the Committee the criteria for appointing, reappointing and removing external auditors. To support them in this task, the Committee should:

(i) provide information on the external auditor's performance, including details such as the quality and value of the work, the timeliness of reporting and fees;

(ii) make recommendations to the Council of Governors in respect of the appointment, reappointment and removal of an external auditor and related fees as applicable. To the extent that a recommendation is not adopted by the Council of Governors, this shall be included in the annual

report, along with the reasons that the recommendation was not adopted.

(c) Discuss with the external auditor, before the audit commences, the nature and scope of the audit;

(d) Assess the external auditor's work and fees each year and, based on this assessment, make the recommendation to the Council of Governors will respect to the reappointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards;

(e) Oversee the conduct of a market testing for the appointment of an auditor at least once every five (5) years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the auditor;

(f) Review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations; and

(g) Develop and implement a policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance.

7.6. With regard to Standing Financial Instructions:

(a) Review on behalf of the Board the operation of, and proposed changes to, the Standing Financial Instructions;

(b) Examine the circumstances of any significant departure from the requirements of Standing Financial Instructions; and

(c) Review the Scheme of Reservation and Delegation.

7.7. With regard to other matters:

(a) Review performance indicators relevant to the remit of the Committee;

(b) Examine any other matter referred to the Committee by the Board and initiate investigation as determined by the Committee;

(c) Develop and use an effective assurance framework to guide the Committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as to fulfil its functions in connection with these terms of reference;

(d) Review the work of all other foundation trust committees in connection with the Committee's assurance function; and

(e) Consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health sector and professional bodies with responsibilities that relate to staff performance and functions.

8. MINUTES AND REPORTING

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

8.2. The Committee will report to the Board after each meeting. The report shall include details of any matters in respect of which actions or improvements are needed.

8.3. The foundation trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities. The report shall include:

(a) the significant issues that the Committee considered in relation to financial statements, operations and compliance and how these were addressed;

(b) an explanation of how the Committee has assessed the effectiveness of the external audit process and the approach taken to the appointment or reappointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and

(c) if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.

9. PERFORMANCE EVALUATION

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

10. REVIEW

10.1. These terms of reference of the Committee shall, in consultation with the Council of Governors, be reviewed by the Board at least annually.

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

TERMS OF REFERENCE

1. AUTHORITY

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

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

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

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

2. MAIN PURPOSE

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

2.2. Its key duties are as follows:

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

(i) Approving the Research Strategic plan

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

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

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

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

(e) Overseeing establishment of the conditions for, and promoting, a patient-focused and ambitious culture for research and innovation.

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

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

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

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

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

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

3. MEMBERSHIP

3.1. The membership of the Committee shall consist of:

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

(b) Director of Strategy and Planning;

(c) Medical Director;

(d) Chief Nurse

(e) Director of Communications and Stakeholder Engagement

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

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

4. SECRETARY

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

5. ATTENDANCE

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

(a) Clinical Director for Research and Development

(b) Head of Research and Development

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

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

6. FREQUENCY OF MEETINGS

6.1. Four meetings per year will be scheduled.

7. MINUTES AND REPORTING

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

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

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

7.4. The following group shall report to the Committee:

(a) Research and Development Committee

8. PERFORMANCE EVALUATION

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

9. REVIEW

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

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Register of referrals received by the Clinical Ethics Group
Presented to:	Board of Directors
On:	29 September 2021
Presented by:	Not applicable – consent agenda
Prepared by:	Alison Jones, PA to Medical Director
Contact details:	T: 01942 822026 | E: alison.jones@wwl.nhs.uk

Executive summary

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

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

Link to strategy

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

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

There are no financial implications arising out of this report.

Legal implications

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

People implications

There are no people implications in this report.

Wider implications

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

Recommendation(s)

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

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

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

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Risk Management Framework
Presented to:	Board of Directors
On:	29 September 2021
Presented by:	N/A – consent agenda
Prepared by:	Head of Risk
Contact details:	E: John.Harrop@wwl.nhs.uk

The Risk Management Framework was reviewed by the Risk Management Group on 16 September 2021 and recommended to board for approval.

Underpinning the framework there are a number of policy and procedural documents that have been approved by RMG.

Recommendation

Board are recommended to review and approve the framework.

Report

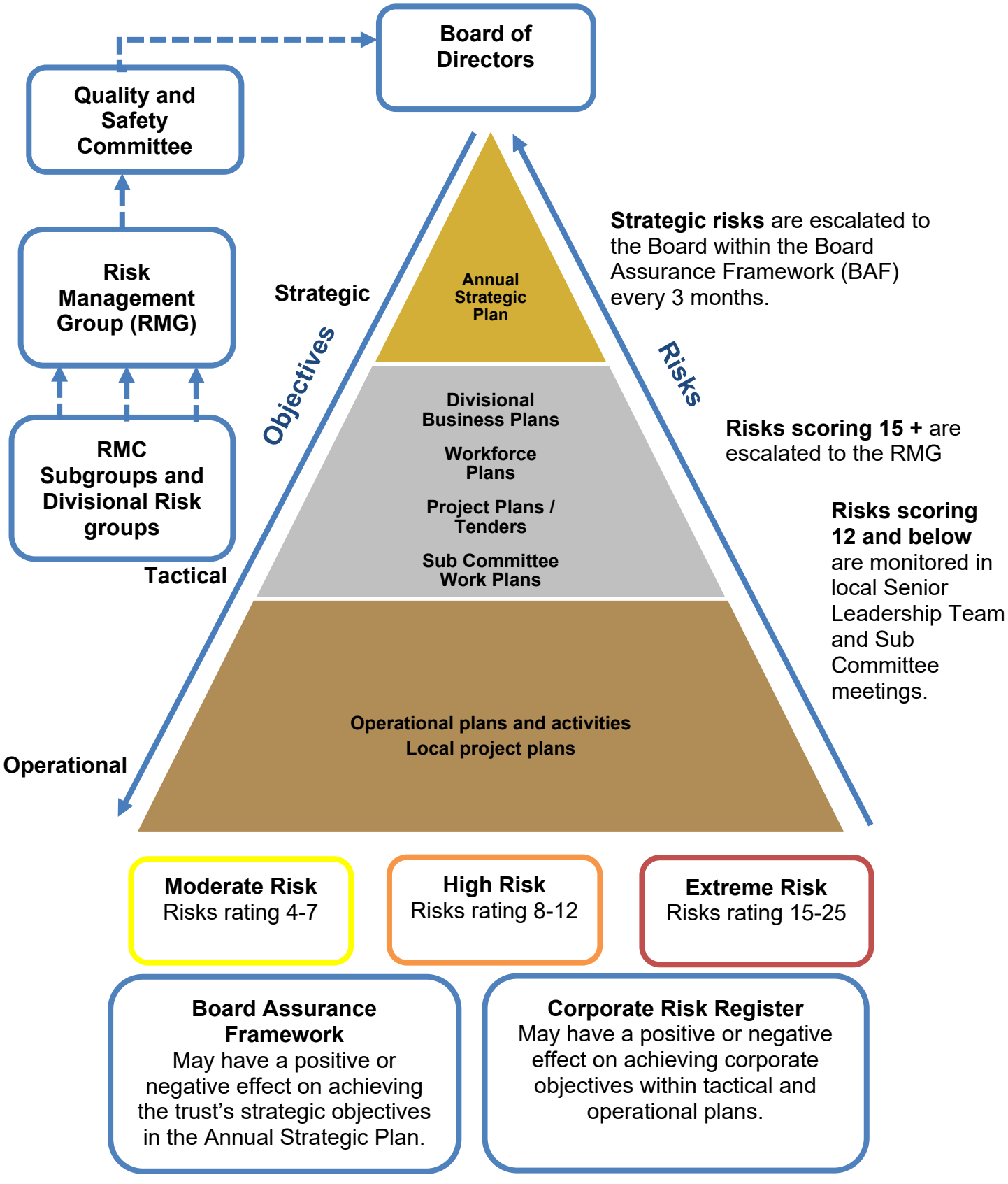
NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Strategy:	**Risk Management Framework 2021-2024**	
Policy Library Number:	**TW10-002**	
Version number :	**Version 15**	
Date this version approved:	**TBA**	
Approving committee:	**Board of Directors**	
Author(s) (job title)	**Head of Risk**	
Executive Director:	**Director of Corporate Affairs**	
Division/Directorate:	**Corporate**	
Trust Wide (Yes/No)	**Yes**	
Links to other Strategies, Policies, SOP's, etc.	**Risk Management Policy (TW18-002)** **Risk Management Process (TW10-002 SOP)**	
Date(s) previous version(s) approved: (if known)	**Version: 14.**	**Date : November 2016**
DATE OF NEXT REVIEW:	**April 2021, extended to July 2021**	
Manager responsible for review: (Job title)	**Head of Risk**	

The WWL Way

AT ALL TIMES, STAFF MUST TREAT EVERY INDIVIDUAL WITH RESPECT AND UPHOLD THEIR RIGHT TO PRIVACY AND DIGNITY

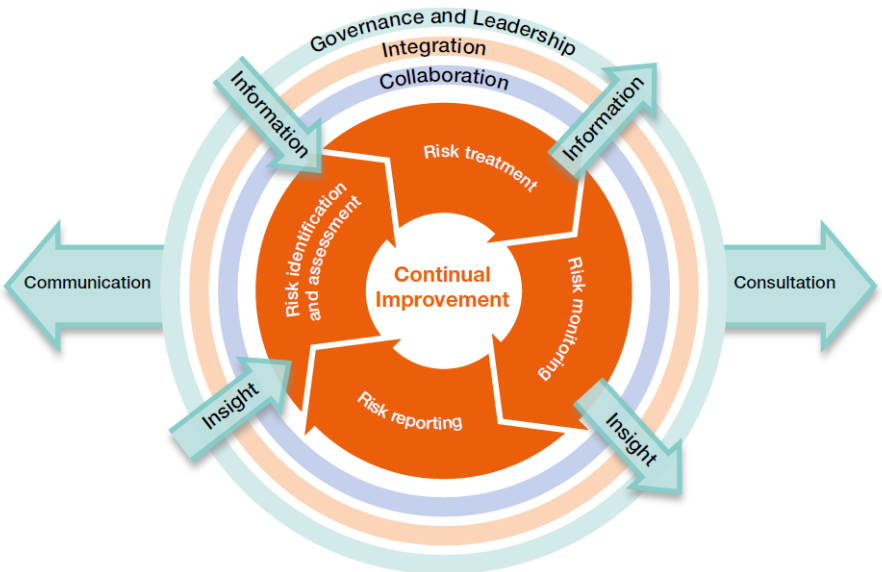
Risk Management Framework 2021-2024



1. INTRODUCTION

1.1 It is the vision of Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL) to be a provider of excellent health and care services for our patients and the local community. Underpinning delivery of our strategic ambitions are the five behaviours which we all seek to embody as WWL people: 4ward Thinking; Working Together; Accountable; Respectful and Demonstrate Compassion. To achieve our vision, we have three strategic priorities: improving, integrating, innovating and four ways to focus our objectives: Patients, People, Performance and Partnerships, which encapsulate the areas on which we want to focus our development and improvement. This ambition is set within the context of the external and internal environment and is underpinned by our annual strategic and corporate objectives. Implementing the Risk Management Framework ensures that we embed risk management in our trust activities and that we manage risks effectively and efficiently to deliver our vision.

2. SCOPE, CONTEXT AND CRITERIA



Risk Management Process (adapted from Gov: The Orange Book 2020 and ISO 31000:2018)

2.1 The Risk Management Framework supports the consistent and robust identification and management of opportunities and risks within desired levels across WWL, supporting openness, challenge, innovation and excellence in the achievement of objectives.

3. MAIN PRINCIPLE A: Risk management will be an essential part of governance and leadership, and fundamental to how the trust is directed, managed and controlled at all levels.

3.1 The Risk Management Policy sets out the respective duties and responsibilities for specific committees, groups and individual members of staff. The trust board is corporately accountable for ratifying, adhering to, and delivering the Risk Management Framework. The board will determine and continuously assess the nature and extent of the principal risks that the trust is exposed to and is willing to take to achieve its objectives - its risk appetite – and ensure that planning and decision-making reflects this assessment.

3.2 The accountable officer, supported by senior management, will demonstrate leadership and articulate their continual commitment to, and the value of, risk management through developing and communicating the Risk Management Framework to the trust and other partners, which will be periodically reviewed.

4. MAIN PRINCIPLE B: Risk management will be an integral part of all organisational activities to support decision-making in achieving objectives.

4.1 The Trust will:

4.1.1 be open and transparent about its understanding of the nature of risks and about the process it is following in handling them.
4.1.2 seek wide involvement of those concerned in decision-making processes.
4.1.3 act proportionately and consistently in dealing with risks.
4.1.4 base decisions for intervention on relevant evidence, including expert risk assessment; and
4.1.5 place responsibility for managing risks to those best able to control them.

5. MAIN PRINCIPLE C: Risk management will be collaborative and informed by the best available information and expertise.

5.1 Effective communication can only be achieved if there are channels up, down and across the trust, to receive, escalate, disseminate information specific to risks. These channels allow staff to participate in, or be effectively represented in, decisions about managing risk.

5.2 The trust will ensure that appropriate and effective methods of communication are in place including:

5.2.1 Accurate and clear information flows that are accessible to all.
5.2.2 Communication channels exist from Ward to Board.
5.2.3 Time is allocated to discuss, manage and challenge risks in line with the Risk Management SOP.
5.2.4 Plans are formulated by Divisions to ensure risks and safety critical messages are clear and cascaded to their wider team.
5.2.5 Staff are competent to contribute to their local risk management processes and encouraged to identify risks and formulate control measures.
5.2.6 By introducing key actions to improve communicating risks effectively, the understanding of risk appetite and tolerance will improve.
5.2.7 bring together different functions and areas of professional expertise in the management of risks.
5.2.8 ensure that different views are appropriately considered when defining risk criteria and when analysing risks
5.2.9 provide sufficient information and evidence to facilitate risk oversight and decision making; and
5.2.10 build a sense of inclusiveness and ownership among those affected by risk.

5.3 Subject matter leads will provide expert judgement to advise the trust's committees to:

5.3.1 set feasible and affordable strategies and plans.
5.3.2 evaluate and develop realistic programmes, projects and policy initiatives.
5.3.3 prioritise and direct resources and the development of capabilities.
5.3.4 identify and assess risks that can arise and impact the successful achievement of objectives.
5.3.5 determine the nature and extent of the risks that the trust is willing to take to achieve its objectives.
5.3.6 design and operate internal controls in line with good practice; and
5.3.7 drive innovation and incremental improvements.

6 MAIN PRINCIPLE D: Risk management processes will be structured to include:

6.1.1 **risk identification, analysis, and evaluation as part of a risk assessment** to determine and prioritise how the risks should be managed.

6.1.2 the selection, design and implementation of **risk treatment** options that support achievement of intended outcomes and manage risks to an acceptable level.

6.1.3 the design and operation of integrated, insightful and informative **risk monitoring and review**; and

6.1.4 timely, accurate and useful **risk recording and reporting** to enhance the quality of decision-making and to support management and oversight bodies in meeting their responsibilities.

6.2 RISK IDENTIFICATION AND ASSESSMENT

6.2.1 RISK IDENTIFICATION

6.2.1.1 Risk identification activities provide an integrated and holistic view of risks, organised into categories relating to the four principal objectives: patients, people, performance and partnerships.

6.2.1.2 The trust will establish risk management activities which cover all types and sources of risk.

6.2.1.3 The aim is to understand the trust's overall risk profile. The trust will use a range of techniques for identifying specific *risks* that may potentially impact on one or more objectives. Risk prioritisation is supported by risk assessment, which incorporates risk analysis and risk evaluation.

6.2.2 RISK ANALYSIS

6.2.2.1 The purpose of risk analysis is to support a detailed consideration of the nature and level of risk. The risk analysis process uses a common set of risk criteria to foster consistent interpretation and application in defining the level of risk, based on the assessment of the *likelihood* of the risk occurring and the *impact* should the *uncertain event* happen.

6.2.2.2 The level of risk will be determined at three stages:

1) **Risk appetite** is the level of risk with which the trust **aims** to operate.

2) The **current risk position** is the risk level at which the trust is currently operating. This level is tolerated by default, where cessation of activity is not an option. Risks are subject to management to drive activity into tolerance or appetite parameters.

3) **Risk tolerance** is the level of risk with which the trust is **willing** to operate, given current constraints.

6.2.3 RISK APPETITE AND RISK TOLERANCE

6.2.3.1 The success of the trust is a result of effectively managing our strategic and corporate risks, which in turn support the achievement of our objectives. The trust acknowledges that an element of risk exists in all activity it undertakes.

6.2.3.2 Risk appetite is defined as the level of risk with which the trust **aims** to operate. Too great a risk appetite can jeopardise a project or activity whilst too little could result in lost opportunity.

6.2.3.3 Risk tolerance is the level of risk with which the trust is **willing** to operate, given current constraints. This balances the funding position with the position outlined in trust's objectives. The tolerance position will shrink as the organisation optimises the risk position. Above this threshold, the trust will actively seek to manage risks and will prioritise time and resources to reducing, avoiding or mitigating these risks.

6.2.3.4 The Trust Board will agree the risk appetite and risk tolerance levels for the trust as part of the annual strategic planning process.

6.2.3.5 A risk leader from the Executive Management Team will be designated for each high-level risk on the Board Assurance Framework. Appropriate managers will be designated for all other risks. Risk leaders will ensure that their risk management plan addresses the risks identified and will be required to monitor the status of their risks through the relevant meetings.

6.2.4 RISK EVALUATION

Once the assessment of risk has been undertaken, an evaluation of the risk will be undertaken. The evaluation is to determine whether the risk level is within risk appetite, tolerable, or whether the risk requires further control measures to reduce its level, known as risk treatment. The evaluation process involves considering the level of risk and the time, cost and effort involved in reducing the risk rating further.

6.2.4.1 The aggregated risk appetite and risk tolerance levels for each of the trust's principal objectives will be set by the Board as part of the annual strategic planning process. Risks scoring 15 or above will be escalated to the Risk Management Group. The trust's willingness to accept a risk above the risk appetite or tolerance level will depend on which of the principal objectives is at risk and the positive or negative impact that the risk would have on objectives, should it materialise. Therefore, the risk evaluation referred to above must be completed by managers with sufficient knowledge and authority.

6.2.4.2 Those managers and groups that should be involved in deciding if a risk level is acceptable will be identified in the standard operating procedure to enable the trust to make an informed decision on accepting levels of risk.

6.3 RISK TREATMENT

6.3.1 Selecting the most appropriate risk treatment option(s) involves balancing the potential benefits derived in enhancing the achievement of objectives against the costs, efforts, or disadvantages of proposed actions. Justification for the design of risk treatments and the operation of *internal control* is broader than solely economic considerations and should consider all the trust's obligations, commitments and partner views.

6.3.2 As part of the selection and development of risk treatments, the trust will specify how the chosen option(s) will be implemented, so that arrangements are understood by those involved and effectiveness can be monitored. This will include:

6.3.2.1 the rationale for selection of the option(s), including the expected benefits to be gained.
6.3.2.2 the proposed actions.
6.3.2.3 those accountable and responsible for approving and implementing the option(s).
6.3.2.4 the resources required, including contingencies.
6.3.2.5 the key performance measures and control indicators, including early warning indicators.
6.3.2.6 the constraints.
6.3.2.7 when action(s) are expected to be undertaken and completed; and
6.3.2.8 the basis for routine reporting and monitoring.

6.3.3 Where appropriate, contingency, containment, crisis, incident and continuity management arrangements will be developed and communicated to support resilience and recovery if risks crystallise.

6.4 RISK MONITORING AND REVIEW

6.4.1 Monitoring will play a role before, during and after implementation of risk treatment. Ongoing and continuous monitoring will support understanding of whether and how the risk profile is changing and the extent to which internal controls are operating as intended to provide reasonable assurance over the management of risks to an acceptable level in the achievement of the trust's objectives.

6.4.2 The results of monitoring and review will be incorporated throughout the trust's wider performance management, measurement and reporting activities.

6.4.3 THREE LINES OF DEFENCE

6.4.3.1 The “three lines of defence” model sets out how these aspects will operate in an integrated way to manage risks, design and implement internal control and provide *assurance* through ongoing, regular, periodic and ad-hoc monitoring and review. Importantly, the accounting officer and the board should receive unbiased information about the trust’s principal risks and how management is responding to those risks.

6.5 RISK REPORTING

6.5.1 The Board, supported by the Audit Committee, will specify the nature, source, format and frequency of the information that it requires. Factors to consider for reporting include, but are not limited to:

6.5.1.1 differing partners and their specific information need and requirements.

6.5.1.2 cost, frequency and timeliness of reporting.

6.5.1.3 method of reporting; and

6.5.1.4 relevance of information to organisational objectives and decision-making.

6.5.2 The information will support the board to assess whether decisions are being made within its risk appetite to successfully achieve objectives, to review the adequacy and effectiveness of internal controls, and to decide whether any changes are required to re-assess strategy and objectives, revisit or change policies, reprioritise resources, improve controls, and/or alter their risk appetite.

6.5.3 Clear, informative, and useful reports or dashboards will promote key information for each principal risk to provide visibility over the risk, compare results against key performance/risk indicators, indicate whether these are within risk appetite, assess the effectiveness of key management actions and summarise the assurance information available. Reports will include qualitative and quantitative information, where appropriate, show trends and support early warning indicators. Understanding and decision-making will be supported through the presentation of information in summary form and the use of graphics and visualisation.

6.5.4 Principal risks will be subject to “deep dive” reviews by the board and the Audit Committee, with those responsible for the management of risks and with appropriate expertise present at an appropriate frequency depending on the nature of the risk and the performance reported.

7 MAIN PRINCIPLE E: Risk management shall be continually improved through learning and experience

7.1 The trust will continually monitor and adapt the risk management framework to address external and internal changes. The trust will also continually improve the suitability, adequacy and effectiveness of the risk management framework. This will be supported by the consideration of lessons based on experience and, at least annually, review of the risk management framework and the performance outcomes achieved.

7.2 All strategies, policies, programmes and projects will be subject to comprehensive but proportionate evaluation, where practicable to do so. As relevant gaps or improvement opportunities are identified, the trust will develop plans and tasks and assign them to those accountable for implementation. A risk management training programme will be developed to support continual improvement through learning and experience

COVID-19
Risk appetite statement

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Introduction

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

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

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

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

Underlying principles

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

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

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

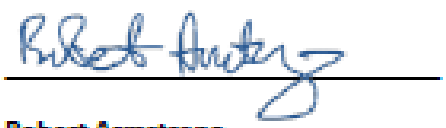
Our risk appetite

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

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

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

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



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

Appendix: Risk appetite matrix

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

Appendix 2

Risk Management Strategy 2021–2024 Implementation Plan

CORE ELEMENT:	WHERE WE WANT TO BE:	YEAR ONE PRIORITIES: FY 2021-22
GOVERNANCE AND LEADERSHIP	Risk management will be an essential part of governance and leadership, and fundamental to how the trust is directed, managed and controlled at all levels.	1. Effectiveness of Risk Management Group meetings will be reviewed, and changes implemented. 2. Frequency of Patient Safety Group meetings will be reviewed. 3. Risk register forms on Datix will be redesigned within 1 year. 4. Attendance at key meetings will be tracked 5. Meeting minutes will be shared with the group to provide assurance and escalation. 6. Review Terms of Reference for Risk Management Group.
	Risk Management Framework implemented	Framework, policy and procedure documents will be updated and amended to reflect best practice with consultation and approval by the Board of Directors.
	Risk Appetite and Tolerance Levels clearly defined for each principal risk to inform decision making.	1. The Board will be invited to develop a risk appetite statement, which details the Board's appetite and tolerance for risk taking and is mapped against the Strategic Objectives. 2. Risk Appetite and Tolerance indicators will be integrated into the Datix Risk Register
	Effective Board Assurance Framework (BAF)	The BAF will be reviewed and revised to reflect the core elements of this framework in preparation for 22/23 BAF.
	Clear Risk Management Oversight	1. Audit to provide assurance that Divisional Risk Assessments and Divisional Risk Registers are fit for purpose and align to the risk management process. 2. MIAA review of risk management on a Trust wide level.
INTEGRATION	Risk management will be an integral part of all organisational activities to support decision-making in achieving objectives	Types (categories) of risk will be updated to align with the Trust's Strategy: "The WWL Way 4wards": Patient, People, Performance, Partnerships.

CORE ELEMENT:	WHERE WE WANT TO BE:	YEAR ONE PRIORITIES: FY 2021-22
COLLABORATION AND BEST INFORMATION	Risk management will be collaborative and informed by the best available information and expertise.	1. Data quality issues identified with Datix will be resolved. 2. Risk management training and resources to be developed and delivered 3. The Board of Directors must allocate appropriate resources for training and the development of enhanced risk awareness for all 4. A suite of Risk Guides will be developed and issued.
RISK MANAGEMENT PROCESS	Risk management processes will be **structured** to include: a. **risk identification, analysis, and evaluation as part of a risk assessment** to determine and prioritise how the risks should be managed. b. the selection, design and implementation of **risk treatment** options that support achievement of intended outcomes and manage risks to an acceptable level. c. the design and operation of integrated, insightful and informative **risk monitoring and review**; and d. timely, accurate and useful **risk recording and reporting** to enhance the quality of decision-making and to support management and oversight bodies in meeting their responsibilities.	1. Review and update RISK 1 Form for reporting risks. 2. Review and update RISK 2 Form for recording risks. 3. Introduce standard method for describing risk and introduce control and assurance measures. 4. Update risk workflow 5. Delays in resolution of risk scores to be resolved.
CONTINUAL IMPROVEMENT	Risk management will be continually improved through learning and experience.	1. Review of corporate risk register at each RMG meeting. 2. Escalation and assurance of risks scoring 15 and above via the RMG. 3. Annual Corporate risk register to be presented to board. RMG minutes to be presented to committees. 4. Audit Committee to review register at each meeting including a bi-annual deep dive.

Title of report:	Appraisal & Revalidation Annual Report
Presented to:	Board of Directors
On:	29 September 2021
Presented by:	Dr Sanjay Arya
Prepared by:	Kathryn Heffernan
Contact details:	T: x2637 E: kathryn.heffernan@wwl.nhs.uk

Executive summary

This report covers the period of 1st April 2020 – 31 March 2021.

The template format of the report has been provided by the NHS England Revalidation Team. All Trusts have been requested to use the template and submit the full report which includes the Compliance Statement to NHS England before 30 September 2021.

The purpose of this report is to provide assurance that appraisal systems are robust, support revalidation and are operating effectively, whilst acknowledging that there are further improvements to be made. The report forms part of the Medical Director's duties as Responsible Officer.

On 31 March 2021 there were a total of 376 doctors who had a prescribed connection to Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust.

The People's Committee is asked to note the contents of this paper for submission to the Trust Board for approval of compliance in Section 7 of this report.

Link to strategy

Patients – We continue to ensure our medical appraisal and revalidation process is a key part of assuring our patients of the safety and effectiveness of medical professionals. Whilst medical revalidation aims to give confidence to the public that doctors are well supported and monitored and that there is a system for responding to concerns about a doctor's practice.

People – to ensure that all doctors have an annual appraisal to ensure they are up to date and fit to practice.

Performance - Appraisal provides key information to the responsible officer on the fitness to practise of each doctor and their commitment to remaining up to date. The recommendations that responsible officer make to the GMC on doctors' fitness to practise are made using outputs from appraisal and other information available to them from local clinical governance systems.

Partnerships – we continue to engage with all our partners associated with appraisal and revalidation our doctors, appraisers and associated departments within WWL; NHS England and GMC.

Risks associated with this report and proposed mitigations
None to report.

Financial implications
None to report.

Legal implications
Not applicable

People implications
Without the additional licenses we will not be able to support our staff members with annual appraisal.

Wider implications
Staff and patient safety will be affected. If our doctors are unable to complete appraisal we will be unable to demonstrate to our patients that our doctors are up to date and fit to practise.

Staff will be unable to revalidate with the GMC due to them being unable to evidence that they are up to date and fit to practise with their whole scope of work.

Recommendation(s)
Purchase the additional licenses required and ensure the licenses are included in the contract renewal with Clarity in 16 months' time.

Report

Wrightington, Wigan & Leigh Teaching Hospitals NHS FT Annual Board Report

Section 1 – General:

1. **An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.**

Action from 2020/2021
Not applicable

Comments: Dr Naqvi was the RO for the period of this report.
Due to the pandemic, RO network meetings were delivered remotely, but the RO and Medical Appraisal & Revalidation Manager attended the events when scheduled.

Action for 2021/2022
Continue to attend RO network meetings either remotely or in person when sessions confirmed by NHS England for the remainder of 2021 and 2022.

2. **The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.**

Action from 2020/2021
An additional 124 licenses from Clarity were purchased for the duration of our contract. This enables all doctors whether fixed term or permanent to use the same platform within WWL and assist appraisers with the same format and consistency for all doctors.

Comments: Dr Naqvi retired as the Responsible Officer on 15th August 2021 and Dr Sanjay Arya is the Responsible Officer effective from 16th August 2021.
The designated body during the 2020/2021 period has provided sufficient funds for the RO to carry out his responsibilities.

Action for 2021/2022
Appraisal system contract with Clarity is due for renewal in January 2022. Cost for 374 licenses and 50 multi-source patient survey packs will be approximately £49,700 for a 3-year contract (allocated in budget).
Continued support for the RO with a Medical Appraisal Lead, MCh/ITF Appraisal Lead and Appraisal & Revalidation Manager

3. **An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.**
The Appraisal & Revalidation Manager monitors and updates the connection list with all starters and leavers and monitors all new connections.
All inappropriate or incorrect connections are reviewed and where appropriate declined by the A & R Manager. Any issues identified and referred to the GMC Connect if clarification is required.

Action from 2020/2021
None

Action for 2021/2022
Appraisal & Revalidation Manager will continue to monitor the prescribed connections in line with the RO Regulations. A & R Manager will request transfer of information from previous designated bodies where appropriate.

4. **All policies in place to support medical revalidation are actively monitored and regularly reviewed.**

Action from 2020/2021
None

Comments: Appraisal & Revalidation Policy is not due for renewal until Oct 2022

Action for 2021/2022
Start reviewing Appraisal & Revalidation Policy in April 2022.

5. **A peer review has been undertaken of this organisation's appraisal and revalidation processes.**

Action from 2020/2021
None

Comments: Last peer review was carried out in 21 Sept 2015 by NHS England.

Action for 2021/2022
None required

7. **A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.**

Action from 2020/2021
N/A

Comments: When notified the Appraisal & Revalidation contacts all locum or short-term placement doctors to make them aware of the appraisal process and requirements. All are invited to meet with the A & R Manager for training on appraisals.
For those with a prescribed connection to WWL as their designated body, the doctors will undertake an annual appraisal and be supported through revalidation by the Trust. For those doctors without a prescribed connection, we offer any support required for revalidation this varies on a case-by-case basis.

Action for 2021/2022
A & R Manager will continue to meet with all new starters (if required) to inform and train on the requirements of appraisal and revalidation.

Section 2 – Effective Appraisal

1. **All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.**

Action from 2020/2021
None

Comments: All doctors employed by WWL have an appraisal which covers their whole scope of practice and includes information about complaints, litigation and significant events. The Appraisal & Revalidation Manager reviews outstanding appraisals on a monthly basis and highlights the doctors who have not completed the appraisal within the required timeframe. The Appraisal & Revalidation Manager reviews all consultant appraisals scope of work section for private practice declarations and ensures they are up to date.

Action for2021/2022
To continue to actively review all doctors' appraisals.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from 2020/2021
We had 3 consultants who did not complete their appraisals in this last cycle. One doctor on sick leave; two are expected to complete by end of Sept 21.

Comments: The Appraisal & Revalidation Manager and the Appraisal Lead meet on a regular basis to review overdue appraisals. The Appraisal & Revalidation Manager and the Appraisal Lead will speak to or meet with individual doctors who may have problems or issues with completing their appraisal.

Action for 2021/2022
To continue to actively encourage all doctors to complete their appraisals on time and provide support if required.

3. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from 2020/2021
Three new appraisers recruited this past year.

Comments: There are currently 87 appraisers across WWL.
Due to the pandemic no Appraiser Update Training was carried out in 2020.
An update was carried out in May 2021 with appraisers attending remotely via Teams.
All our appraisers have met the requirements of attending one per year.

Action for 2021/2022
To continue to recruit new appraisers across all specialities, but especially required in medicine. Further Appraiser Update Meetings to be carried out in December 2021 and May 2022.

4. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from 2020/2021
None

Comments: Each year the Appraisal Lead and the Appraisal & Revalidation Manager run two Appraiser Update sessions. Attendance at these sessions is monitored. Each appraiser must attend one session per year to ensure they are up to date with their role. Appraisers who are unable to attend are provided with the content of the presentation.
The Quality Assurance of appraisal summaries has been undertaken, 2 appraisals per appraiser are reviewed. The Appraisal & Revalidation Manager collates this feedback from the quality assurance process and uploads this into the individual appraiser's appraisal under supporting information.

Action for 2021/2022
Continue with Appraiser Update Meetings x 2 per year and quality assurance process.
Further Appraiser Update Meetings to be carried out in December 2021 and May 2022.

5. **The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.**

Action from 2020/2021
None

Comments: The appraisal system includes a feedback questionnaire for doctors and appraisers to complete at the end of each appraisal. In addition, as noted in point 4 all appraisers receive feedback on their appraisals.

An Annual Organisational Audit is submitted every year to the People's Committee then to the Trust Board

Action for 2021/2022
Continue providing QA feedback to individual appraisers. Include any areas of improvement required in the Appraiser Update Meetings.

Section 3 – Recommendations to the GMC

1. **Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.**

Action from 2020/2021
None

Comments: All recommendations are monitored by the Appraisal & Revalidation Manager and any submission delays are documented with full explanation under the doctor's revalidation folder.

In March 2020, the GMC issued guidance that doctors with a due date before end of September 2020 would have their revalidation date deferred for one year. This was further updated to include doctors with revalidation dates between 1 October 2020 and 16 March 2021 who would also have their dates moved back by one year.

In 2020/2021, 8 doctors had positive recommendations submitted, no deferments.

Action for 2021/2022
To continue to monitor GMC submission dates and document with full explanation any deferments.

2. **Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.**

Action from 2020/2021
None

Comments: The Appraisal & Revalidation Manager ensures all doctors are kept fully up to date with their revalidation recommendation and ensures they are aware of what is required if deferment has been submitted.

Action for 2021/2022
Ensure all revalidation recommendations are processed in a timely manner.

Section 4 – Medical governance

1. **This organisation creates an environment which delivers effective clinical governance for doctors.**

Action from 2020/2021
None

Comments: WWL operates an open and honest environment that ensures effective clinical governance for doctors.

Action for 2021/2022
None

2. **Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.**

Action from 2020/2021
None

Comments: The Medical Director/RO and the Appraisal & Revalidation Manager have regular meetings with the GMC ELA. If required, discussions are held with the Practitioner Professional Advice Service (part of NHS Resolutions) to discuss individual cases. All doctors are requested to add relevant information in their appraisal.

Action for 2021/2022
Continue with current process.

3. **There is a process established for responding to concerns about any licensed medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.**

Action from 2020/2021
None

Comments: The Trust has a Maintaining High Professional Standards policy which provides a process around all steps and considerations for when a concern arises in relation to a medical practitioner.

Action for 2021/2022
MD/RO has organised MHPS training through NHS Resolutions for DMDs and CDs on 9 & 10 November 2021. 24 doctors have registered for this training.

4. **The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors**.

Action from 2020/2021
None

Comments: During the last year there has been one external departmental review (Surgery) following concerns raised. A Royal College review has been undertaken in surgery and concluded.

Action for 2021/2022
The recommendations from the Royal College of Surgeon's Review are to be actioned by the department.

5. **There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.**

Action from 2020/2021

None

Comments: RO to RO communication is completed via the Medical Practice Information Transfer (MPiT) form via email.

Action for 2021/2022

Continue to respond to requests for Transfer of Information.

6. **Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).**

Action from 2020/2021
None

Comments: All cases where a concern has been raised a doctor's practice are reviewed by the Responsible Officer, Divisional HR Business Support Manager and the Divisional Medical Director with external advice from the practitioner performance advisory service, if required. If a formal investigation is undertaken a case manager and independent case investigator with HR support are appointed.

Action for 2021/2022
Manchester Foundation Trust is currently auditing the surgical departments clinical governance processes due to a concern raised internally.

Section 5 – Employment Checks

1. **A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.**

Action from 2020/2021
None

Comments: Pre-employment checks are carried out by Medical HR Dept. All doctors are recruited to the Trust (whether substantive or fixed term) are subject to the same pre-employment checks as defined by NHS Employment Check Standards. All references are reviewed by the Associate Medical Director.
References for the MCh/ITF doctors are reviewed by the GTEC team.

Action for 2021/2022
Medical HR to continue to carry out all pre-employment checks.

Section 6 – Summary of comments, and overall conclusion

The Trust is compliant in all areas for appraisal and revalidation over the 2020/2021 appraisal cycle.

The Annual Organisation Audit submission was cancelled by NHS England due to the Covid Pandemic, but an overview of the status of appraisals has been included in this report.

General review of last year's actions from the last Board Report which have been implemented are:

- Recruitment of 3 new appraisers.
- Purchase of 124 additional appraisal licenses taking our total up to 374.

Actions for the coming year include:

- New Responsible Officer in position as of 16 August 2021.
- Purchase of a further 3-year contract with Clarity for renewal of our electronic appraisal system
- Recruit additional appraisers in the medicine division
- Review Medical & Appraisal Revalidation Policy, requires update by Apr 2022

Overall conclusion - Appraisal:

Appraisal figures 1 April 2020 – 31 March 2021; figures impacted during this period **due to the suspension of appraisals by NHS England from 1 April 2020 – 30 September 2020 due to the Covid pandemic.**

	2020/2021	2019/2020	2018/2019	2017/2018	2016/2017
Number of Doctors	376	374	371	371	321
Consultants	155/198 (78%)	183/191 (96%)	175/177 (99%)	175/176 (99.4%)	161/171 (94.2%)
Staff Grade/ Associate Specialists/ Speciality Doctor	27/36 (75%)	36/39 (92.3%)	39/40 (97.5%)	33/37 (89.2%)	33/37 (89.2%)
Temp, short term contract	56/142 (39%)	97/144 (67.4%)	126/154 (81.2%)	89/158 (56.3%)	69/113 (61.1%)

Overall Conclusion – Revalidation:

Revalidation is the process by which licensed doctors demonstrate to the GMC that they are up to date and fit to practise. One cornerstone of the revalidation process is that doctors will participate in annual medical appraisal. On the basis of this and other information available to the responsible officer from local clinical governance systems, the responsible officer will make a recommendation to the GMC, normally every five years, about the doctor's revalidation. The GMC will consider the responsible officer's recommendation and decide whether to continue the doctor's licence to practise.

Number of recommendations between 1 April 2020 – 31 March 2021 = 8

Positive recommendations = 8

Deferrals requests = 0

Non engagement notifications = 0

Section 7 – Statement of Compliance:

The Board of Wrightington, Wigan and Leigh NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of designated body:

Wrightington, Wigan & Leigh Teaching Hospitals NHS FT

Name: Mr Silas Nicholls Signed: _____

Role: Chief Executive Date: _____