Board of Directors Public Meeting

Wed 07 December 2022, 14:00 - 16:15

Boardroom, Trust Headquarters

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Agenda

14:00 - 14:01
1 min

17. Declarations of Interest

Information *Mark Jones*

Verbal item

14:01 - 14:02
1 min

18. Minutes of Previous Meeting

Approval *Mark Jones*

- 18. Minutes_Board of Directors - Public Meeting_051022 (1).pdf (6 pages)
- 18a. Public Board Action Log - October 2022.pdf (1 pages)

14:02 - 14:12
10 min

19. Chair's Opening remarks

Information *Mark Jones*

Verbal Item

14:12 - 14:32
20 min

20. Chief Executive's report

Information *Silas Nicholls*

- 20. Board Report_CEO_December 2022_FINAL UPDATED .pdf (3 pages)

14:32 - 15:07
35 min

21. Committee chairs' reports

Information *NEDs*

21.1. Audit

Ian Haythornthwaite

- 21. AAA Audit - Nov 2022.pdf (1 pages)

21.2. Finance and Performance

Rhona Bradley

Report to follow due to proximity of the F&P meeting

21.3. People

Lynne Lobley

- 21. AAA _ People - 18 Oct 2022 2.pdf (2 pages)

21.4. Quality and Safety

Francine Thorpe

21. AAA QS - Oct 22.pdf (2 pages)

15:07 - 15:17
10 min

22. Board assurance framework

Decision *Paul Howard*

22. BAF Report December 2022 Board Meeting.pdf (28 pages)

15:17 - 15:32
15 min

Break

15:32 - 15:47
15 min

23. Integrated performance report

Discussion *Alison Balson/Martin Farrier/Mary Fleming/Rabina Tindale*

23. Board of Directors M7 2223 Scorecard_v1.pdf (5 pages)

15:47 - 16:02
15 min

24. Finance Report

Discussion *Kelly Knowles*

24. Trust Financial Report 22-23 October month 7 Board.pdf (10 pages)

16:02 - 16:12
10 min

25. Findings from East Kent investigaton

Discussion *Rabina Tindale*

25. East Kent Paper for Dec Trust Board Final.pdf (9 pages)

16:12 - 16:15
3 min

26. Consent Agenda

Information

26.1. IPC Board Assurance Framework

26.1. FINAL IPC BAF v1.11. November 2022.pdf (37 pages)

26.2. Guardian of Safe Working report

26.2. BoD cover report - guardian of safe working Dec 2022.pdf (2 pages)
26.2a. Quarter 1 Report GoSWH Sept 2022.pdf (8 pages)

26.3. Freedom to speak Up Guardian report

26.3.FTSU - December 2022.pdf (11 pages)

26.4. Review of well-led action plan

Approval

26.4. Well-led action plan - Dec 202.pdf (15 pages)

26.5. EPRR Core standards

- 26.5. EPRR Core Standards Board Report 2022 V2.pdf (5 pages)
- 26.5a. 2022 EPRR Core Standards Action Plan V2.pdf (3 pages)
- 26.5b. 2022 Core Standards V3 26-10-2022.pdf (17 pages)

16:15 - 16:15
0 min

27. Date, time and venue of next meeting

Information *Mark Jones*

01 February 2023, Boardroom, Trust Headquarters, 1:15pm - 4:15pm

Board of Directors - Public Meeting

Wed 05 October 2022, 13:30 - 16:45

Boardroom, Trust Headquarters

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Attendees

Present:	Mr M Jones	Chair (in the Chair)
	Prof C Austin	Non-Executive Director
	Mrs A Balson	Director of Workforce
	Mr I Boyle	Chief Finance Officer
	Lady R Bradley	Non-Executive Director
	Dr S Elliot	Non-Executive Director (up to item 137 only)
	Ms M Fleming	Deputy Chief Executive
	Mr P Howard	Director of Corporate Affairs
	Mrs L Lobley	Non-Executive Director
	Ms R Tindale	Chief Nurse
	Mrs AM Miller	Director of Communications and Stakeholder Engagement
	Mr S Nicholls	Chief Executive
	Mrs F Thorpe	Non-Executive Director
	Mrs A Tumilty	Non-Executive Director
In attendance:	Ms D Alicehajic-Becic	Shadow Board Member (observer)
	Dr M Farrier	Associate Medical Director
	Mrs N Guymer	Deputy Company Secretary (minutes)
	Mr A Haworth	Public Governor
	Ms K Knowles	Shadow Board Member (observer)
	Ms K Stevenson	CQC
	Ms H Shelton	Shadow Board Member (observer)
	Ms A Wainwright	CQC

Meeting minutes

132. Declarations of Interest

Information
Mark Jones

pertinenthair of a Safeguarding Adults Board in another organisation.

133. Minutes of Previous Meeting

Approval
Mark Jones

The minutes of the previous meeting were **APPROVED** as a true and accurate record.

11. Minutes - Public Board - 3 Aug 2022 v1.pdf

134. Chair's Opening remarks

Information
Mark Jones

The Chair provided an update on various activities that he had undertaken since the last meeting, highlighting the Trust's headline sponsorship of the Wigan Pride Parade, in which he had marched with other Board members and colleagues. He noted that he had also recently met local leaders of partnership organisations and had positive discussions around the changes which would follow the introduction of the Integrated Care System (ICS). He recalled that the most recent governor workshop had focused on the resulting change to the governor role and how they would change the way that they work as a result.

He recalled that he had joined the Trust around one year ago and that since then, many challenging pandemic related issues have arisen and been effectively dealt with. He noted the determination of the Trust to tackle issues as they arise, to analyse learning and overall to strive for improvement.

The Board received and noted the update.

135. Chief Executive's report

Information
Silas Nicholls

The Chief Executive presented the report which had been circulated in advance of the meeting.

The Board received and noted the update.

13. Board Report_CEO_October 2022_APPROVED.pdf

136. Committee chairs' reports

Information
NEDs

136.1. Audit

No additional verbal update was provided in addition to the written report.

The Board received and noted the update.

14.1. AAA Audit - Sept 2022.pdf

136.2. Finance and Performance

Alison Tumilty

Mrs A Tumilty presented the report which had been circulated following the main bundle, due to the proximity of the two meetings.

Mr S Eliott noted that cancer referrals are rising and queried why and whether this is happening across the board.

The Deputy Chief Executive advised that this is the case, and that this is linked to the waiting times for routine referrals and that WWL are committing to the forecast that 2019-20 waiting list levels will be achieved by the end of the year, heavily caveated that this can only be achieved if the associated transformation work described in the report delivers as projected.

Lady R Bradley queried the Trust's position on energy and further, asked whether, should they become of relevance in terms of workforce vacancies and recruitment, how the effects of the cost of living crisis on staff are being addressed.

The Chief Finance Director noted that the Trust are protected in terms of the current rate, which will be maintained through the current deal, until the end of the financial year. However, he noted that the variable would be how cold of a winter is seen this year and that the Trust would need to secure a new rate during the next financial year.

The Chief People Officer responded to the latter question to note the difficulties experienced by many NHS trusts, since the cost of living increase has resulted in more competition than usual from the hospitality and private sector. She advised however, that the impact on the NHS is being considered holistically as winter approaches and is aligned to financial planning and the modelling through of recruitment activities built in to planning model moving forwards. She advised that WWL are acting consistently with other organisations.

AAA F&P - Sept 2022 AT IB.pdf

136.3. People

Lynne Lobley

Mrs L Lobley presented the report which had been circulated following the main bundle, due to the proximity of the two meetings.

Mrs F Thorpe queried the plans in place to ensure that allied health professionals (AHPs) are included in the workforce efficiencies program.

The Chief Nurse and Chief People Officer described various pieces of work ongoing in this respect, including work done by the Chief AHP, at system level and also by the Trust's Workforce Efficiency Group, to both include these staff in the plans being formulated and to put in support mechanisms to facilitate these professionals to operate independently in roles which they may not have held previously.

Lady R Bradley queried how staff's concerns around presenteeism manifest practically, expressing concern that these incidents may hinder staffs' career progression, as is the case in other sectors.

The Chief People Officer advised that a both qualitative and quantitative assessment identifies the extent of an individual's personal position, so that steps can be put in place to allow them to continue to work effectively in their role. She triangulated this with the staff story and how the staff member had described that support provided by the IDVA team had allowed her to continue to attend work safely and provided assurance to the Committee around the process in place to tackle presenteeism.

14.3. AAA _ People - 5 Sept 2022 NG AB LL.pdf

136.4. Research

Clare Austin

Prof C Austin presented the report which had been circulated in advance of the meeting.

No further assurance was sought by the Board.

14.4. AAA - Research - Sept 2022.pdf

136.5. Quality and Safety

Francine Thorpe

Mrs F Thorpe presented the report which had been circulated in advance of the meeting.

Prof C Austin queried whether the number of complaints and the key themes have remained static or are fluctuating and asked what work is done to improve complaint response rates.

The Chief Nurse advised that work is ongoing to put an infrastructure in place to remove inefficiencies within the team which have resulted previously in response rates not being maintained, as well as training for staff and a rota system for who is responding to which complaints and how. Staff have also now begun to contact patients by phone which has allowed for faster response times and proven effective in closing complaints quickly. She noted that the 85% rate is targeted to be reached by the end of March 2022, with hopes to reduce the response time frame further than the current 60 days.

The Board received and noted the updates provided.

14.5. AAA QS - Aug22.pdf

137. Board assurance framework (BAF)

Information
Paul Howard

The Director of Corporate Affairs reminded the Board that the document provided addresses risk to the delivery of corporate objectives. He noted that the organisation's operational risks are reviewed by the Risk Management Group, which is chaired by the Chief Executive and reports after each meeting to the Executive Team. Further, the Audit Committee conducts deep dives in to the organisation's highest scoring operational risks biannually and at their last meeting, noted assurance around the processes in place in that respect, per the AAA report contained within the papers.

Mrs L Lobley queried how the delivery of the new Leigh community diagnostics centre (CDC), links to the objectives set out in the service strategy.

The Director of Strategy and Planning noted that the CDC aligns to the element of the strategy which pledges to increase diagnostic services.

Prof C Austin queried the moderate risk rating of risk PR2 around avoidable pressure ulcers, to delivery of CO3, around delivery of harm free care, noting that substantial assurance had been provided through the recent internal audit result in respect of the handling of pressure ulcers and asked why the risk is therefore not reduced.

Mrs F Thorpe highlighted that the corporate objective here requires achievement of various different performance indicators and that safe care is multifactoral, beyond pressure ulcers alone. She noted that given the current pressures across so many services, it would not feel right to reduce this risk.

A discussion ensued around the fact that the BAF is a live document and it was noted that all Board members have access to the systems in place for viewing both this and the balanced scorecard at any time.

The Board received and noted the update provided.

Dr S Elliot left the meeting.

15. BAF Report October 2022 Board Meeting.pdf

138. Infection prevention control (IPC) board assurance framework

Information
Rabina Tindale

The Chief Nurse provided a summary of the paper which was circulated in advance of the meeting.

In response to a query from Mrs A Tumilty around how the risk to staffing within the microbiology service is being managed, the Director of Strategy and Planning noted that the Trust do not have a permanent appointment but that a retiree has agreed to do some work for the Trust and that locums are also being utilised. He conceded that this was not sustainable or cost effective and that therefore the Trust have several schemes in place to address this. The first is a mutual aid arrangement with Northern Care Alliance, who have agreed to support WWL where staffing levels reduce; that an external provider would be contracted with to provide the specialist support required in respect of orthopaedic microbiology and that in the longer term, a shared service model will be explored.

Mrs L Lobley expressed concerns around depleted staffing within the IPC team.

The Chief Nurse noted that there is a shortage of nurses in this professional group nationally following the pandemic and in response, advised that WWL now have training opportunities in place to encourage, in particular, those who are in the early stage of their career to join the speciality.

The Board **APPROVED** the implementation of the actions outline in the paper.

17. IPC BAF Report at 16 September 2022. 25.9.2022.pdf

139. Safeguarding annual report

Information
Rabina Tindale

The Chief Nurse provided a summary of the paper which was circulated in advance of the meeting. She clarified that in terms of ongoing reporting around safeguarding, that the Safeguarding Effectiveness Group review monthly safeguarding reports and that the report provided has also been reviewed by the Quality and Safety Committee.

Mrs F Thorpe complimented how thorough the report was and queried where issues manifesting through safeguarding adult reviews would be mapped against serious incidents.

The Chief Nurse clarified that this would be done by the Quality and Safety Committee.

The Board received and noted the report.

18. WWLTH Safeguarding Annual Report 2021 FINAL.pdf

140. Winter Planning

Information
Mary Fleming

The Deputy Chief Executive provided a summary of the report provided, highlighting that the WWL's winter plan requires support from partners across the borough as well as the wider system, if it is to be effective. She noted that it is due to be signed off in mid October 2022 and would be well socialised across the Trust and all Trust sites.

The Chief Executive added that he had met with Anne Ford, Head of Regional Compliance at the CQC to ensure that she is well sighted on the Trust's plans and has the opportunities to raise any queries at an early stage.

The Chief People Officer highlighted the potential for industrial action and that both weekly updates to ETM and at Greater Manchester Health and Social Care Partnership (GM) level give consideration to a consistent approach in respect of what protected services will be and what will happen should the plan need to be enacted during a period of industrial action.

Mrs L Lobley noted the current struggle with reducing the number of 'no right to reside' patients and felt that the ICS should be more involved in helping to tackle this. She further queried whether there is any work going on with the ambulance to escalate patients who start to deteriorate in the care of that service.

The Chief Executive advised that they are involved but highlighted the struggles of local partners in identifying additional workforce to aid this. He noted the need for collective decisions to be made by NHS Trusts around how to move forwards, including blended solutions in terms of social care, noting that ten director of adult social services have agreed that this should be taken forwards, although he noted that this was a longer term plan.

The Deputy Chief Executive noted that WWL have ambulance liaison officers who will assist to get patients out of ambulances and in to the hospital, even if this results in them receiving care on corridors. She noted that standard operating procedures are in place for the management of these patients but was clear that the need for utilising this is increasing and must be reduced so that it is not viewed as the norm.

Mr F Thorpe asked how the Trust will communicate with the public around care options during winter.

The Chief Executive advised that trusts are guided by NHSI/E in terms of what messages they are permitted to put out. A GM wide approach is being taken to ensure consistency and a more positive tone will be taken to help people prepare for winter at an early stage, rather than deterring them from using services. Further, rather than commercial networks such as radio, he noted the aim to utilise community champions and to get messages out to large community groups, for example through places of worship.

The Board received and noted the report.

19. Winter Planning Sep TB.pdf

141. Integrated performance report

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

The Director of Strategy and Planning introduced the new format report, highlighting that it is a ward to Board report and that the same metrics are discussed regularly at ward level.

The Deputy Chief Executive provided an update on the performance element of the scorecard; the Chief Nurse and Associate Medical Director provided an update on the quality and safety element of the scorecard and the Chief People Officer provided an update on the people element of the scorecard.

Mrs A Tumilty asked for an update on the progress made with rostering timeliness.

The Chief People Officer advised around the significant progress made due to changes in reporting and advised that every area aside from theatres are now expected to meet trajectory this month.

The Chief Finance Officer would address the finance element of the scorecard in tandem with the finance report.

The Board received and noted the report.

20. Board of Directors M5 2223 Integrated Performance Report.pdf

142. University hospital escalation

Information
Richard Mundon

The Director of Strategy and Planning presented the paper which had been circulated in advance of the meeting, noting the Trust's difficulty in attaining university status. He queried the appetite of the Board to continue to pursue this and to therefore lobby for the University Hospital Association to change their criteria.

Mrs L Lobley queried the status of the University Hospital Association and where the lobbying would be aimed at.

The Director of Strategy and Planning advised that this is unclear but that the University Hospital Association have not responded positively to lobbying thus far and that therefore lobbying would now be directed at the Department of Health.

The Board **AGREED** that the Trust should continue to lobby to ascertain this status.

21. UHS Board Update Paper September 2022 v5.pdf

143. Finance Report

Discussion
Ian Boyle

The Chief Finance Officer presented the report which had been circulated in advance of the meeting. He added that the Health Service Journal has recently reported that two thirds of Integrated Care Boards are currently off plan financially.

A discussion ensued around the success that the 'rapid review' process has had in supporting the divisions to focus on cost saving and improving their financial position.

Mrs L Lobley queried the plan for the cost improvement program in the following year.

The Chief Finance Officer advised that this plan would be considered prior to the planning guidance released in December 2022 and that it would be likely that a 4% saving would need to be made.

The Board received and noted the report.

22. Trust Financial Report 22-23 August month 5 Board.pdf

144. Consent Agenda

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

144.1. Review of well-led action plan

Information/Decision
Paul Howard

To **APPROVE** the changes set out in the report.

23.1. FINAL Well-led action plan - Oct 2022.pdf

144.2. Equality, diversity and inclusion annual report 2021/22

Approval
Alison Balson

To **APPROVE** the report for publication on the Trust's website and note the changes to the 2022/23 reporting cycle.

23.2 EDI Annual Report 2021-22.pdf

145. Date, time and venue of next meeting

Information
Mark Jones

Wednesday 7 December, 12:15 - 4:15pm, Boardroom, Trust Headquarters

Action log

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
8 Jun 2022	76/22(a)	Staff story	Consider whether a forum exists, or should be established, for Advanced Nurse Practitioners and Physicians Associates, if likely to benefit this group	Medical Director and Chief Nurse	5 Oct 2022	Deferred from August 2022. No update provided.
3 Aug 2022	115/22	Board Assurance Framework	Discuss with the Risk Manager the amendment of CO15 to take account of the importance of partnership working for urgent care and how this affects delivery of CO12.	Deputy Chief Executive	5 Oct 2022	The two met and updated ID3533 urgent and emergency care and ID3289 elective services waiting list with reference to working closely with colleagues in the Wigan locality to reduce no right to reside by 20% and reduce 12 hour waits. **Action complete.**

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	07/12/22
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

There are reference links to the organisational strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

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

Legal implications

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

People implications

There are no people risks associated with 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

Our Emergency Department continues to face significant challenges and has been consistently running above capacity levels for some time now. The pressure has only continued to grow since our last Board meeting in October, with attendance figures sitting above the Northwest and Greater Manchester average, and the gap is unfortunately increasing. Staff within the department, the teams who work side-by-side with Emergency Department colleagues, and those services who work to try and help relieve the pressures being experienced, continue to do everything they can to provide safe and effective care to our patients. We have a robust winter plan in place, with a dedicated framework to help us manage these pressures, and it is paramount that we work together with our partners within the Wigan Borough and Greater Manchester to do so.

Additional measures we have recently put in place to help reduce some the pressures includes increasing the opening hours and staffing levels within our Same Day Emergency Care unit, as well as working closely with our colleagues in the local authority to implement a number of agreed measures. This includes basing a multidisciplinary team from both social care and the voluntary sector on WWL premises. The team will focus on the more complex discharges to agree the best way to discharge those patients quickly, with the right support, and to the most appropriate place.

One of the key things the Trust continues to have a strong focus on is the number of in-patients who are considered medically fit to leave hospital, but who do not yet have anywhere to go, often because they are waiting for further support either at home or a placement elsewhere. We are constantly monitoring the flow of patients through our services and the discharge of patients from our hospitals, which involves services from outside the hospital sites themselves helping with admission avoidance and helping to place patients in appropriate health and care settings to ease the pressures created. Our pioneering Virtual Ward continues to go from strength-to-strength, providing care for patients outside of our hospital walls, making a big difference to the number of patients who would otherwise require a hospital bed if they could not access this type of remote monitoring. WWL's community teams play a very important role in admission avoidance, something which has been highlighted in the local news recently with the Health Outreach and Inclusion Team's spot as finalists at the first ever Best of Wigan Awards. Members of the team were nominated in the Health Hero category, which highlights the extraordinary efforts of healthcare support workers who care for and empower vulnerable people. The Health Outreach and Inclusion Team tackle health inequalities within the most vulnerable communities in society with the main function of supporting individuals and families, particularly from disadvantaged groups who often have difficulties accessing services. By offering services such as screening, health advice and onward signposting and referrals, the team are actively helping people to find the most appropriate healthcare options for their needs.

Alongside the steps we are taking internally and externally to manage the challenges created in urgent and emergency care, and with patient flow through our hospitals, protecting our elective surgery services is essential. Particularly at our surgical hub at Wrightington Hospital, so that we can continue to address waiting times for patients, all of which has been built into our plans for the coming months. At the same time, work has already started on expanding our current services and increasing our capacity at Leigh Infirmary. As part of a £130.3million regional surgical hub scheme, WWL has secured funding to build additional theatre capacity at our Leigh site, which will help to reduce the backlog caused by COVID-19 and offer patients quicker access to vital procedures. The new development is just one part of the Trust's programme of investment at the Leigh site, alongside the Community Diagnostic Centre, which all help towards the aim of creating a modern 'one stop shop' diagnostics and healthcare facility, and potentially see WWL treating approximately 40,000 additional patients per year.

Despite the challenges we are facing and will continue to face, as well as balancing our priorities to keep patient safety at the forefront of everything we do, the Trust continues to make significant progress in providing innovative healthcare solutions in many specialties. Since our last Board meeting, WWL became the first Trust in Greater Manchester to launch a new pilot in breast screening technology, the Mammography Intelligent Assessment (Mia), which is a breakthrough in

artificial intelligence, allowing our breast screening service to review mammograms electronically following assessment by two specialists, helping our radiologists to reach a faster and more accurate diagnosis. It is expected that 150 patients per day will be reviewed using the software at WWL's Thomas Linacre Outpatients Centre and at various mobile breast screening unit locations across the Wigan Borough.

Over the course of an eight-week period from September to the end of November, colleagues across WWL have been encouraged to complete the NHS Staff Survey, which is an annual opportunity for our staff to provide their feedback on all aspects of working life at WWL. It is vitally important we hear the views of our staff so that we can celebrate the things we do well as a Trust, make changes to continue to improve and be a recommended place to work and receive treatment. Our uptake has improved significantly from 2021 and I would like to thank everyone who took part. As a Trust we continue to offer regular opportunities for staff to share their thoughts in order to drive change, including through our All Staff Team Brief sessions, Leaders' Forum and in regular meetings between divisions and teams. In January our listening activities will continue with the Your Voice survey, a local approach to gather feedback driven by our Staff Engagement Team. One of the ways we have listened and acted upon staff feedback is through implementing a number of support offers to assist with the cost of living crisis and the impact this is having on staff across the Trust. Useful resources, advice and information regarding financial support have been made available, a winter coat swap will be taking place to make it easier for staff to donate, share and swap second hand coats this winter, and a free confidential helpline is in place which staff can access 24/7 for additional support with any issues or problems they may be having, as well as signposts to additional support offers available outside of the Trust.

Last month, WWL came together to pay respects to those who have lost their lives in armed forces service, with a Service of Remembrance held in the Chapel at Royal Albert Edward Infirmary, led by WWL's Director of Corporate Affairs Paul Howard and the Trust's Chaplaincy and Spiritual Care Team. The service came at the end of a week of celebration, recognition and commemoration as part of WWL's Armed Forces Focus Week, which was used by staff to show their appreciation to current serving personnel, veterans and those who have fallen in service. As a Veteran Aware Trust, WWL is committed to supporting patients and staff who have served in the armed forces, and their families. As part of this accreditation, a one-year review recently looked into the improvements and advances we have made to support our armed forces community. The feedback from this review by the Veterans Covenant Healthcare Alliance was of an excellent standard, and the work carried out by our Armed Forces Healthcare Team is due to be used as evidence to inform other organisations who are undertaking accreditation.

More of the Trust's excellent practice has received praise over the past two months, with our nursing colleagues included as finalists at the Nursing Times Workforce Summit and Awards in the UK Best Employer of the Year for Nursing category. Our achievements in research recruitment have also been highly commended nationally and internationally, with our Oncology Research Team's efforts to help the OPTIMA (Optimal Personalised Treatment of Breast Cancer using Multiparameter Analysis) reach 3,000 participants recently celebrated, whilst WWL's Research Delivery Team recently recruited the first global patient to the RAPSODI-UK (reverse or anatomical replacement for painful shoulder osteoarthritis, differences between interventions) trial.

I would like to end my report by wishing Alison Balson, our Chief People Officer, and Ian Boyle, Chief Finance Officer, all the very best for the future, with Alison due to leave the Trust this month to take up the position of Chief People Officer at University Hospitals of Morecambe Bay NHS Foundation Trust, whilst Ian has joined the Northern Care Alliance NHS Foundation Trust as Chief Finance Officer. In line with all Board appointments, we have commenced the robust recruitment process for the permanent Chief People Officer position, whilst the recruitment process has just been completed for our Chief Finance Officer position, which will be announced shortly.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Audit Committee
Date of meeting:	23 November 2022
Chair:	Ian Haythornthwaite

Key discussion points and matters to be escalated from the discussion at the meeting:

ALERT
▪ The Committee does not wish to alert the Board in respect of any issues.
ASSURE
▪ The executive team have now signed off a business case for investment in the overseas billing team which will strengthen the process around collection of overseas debt. ▪ The Committee took assurance from the reviewed and redrafted SFIs. These now include a non-compliance matrix, in respect of which the staff side and the Local Negotiating Committee were consulted with, to ensure that measures taken in respect of breaches are fair. WWL's approach has now been brought in line with that taken more widely by the Greater Manchester Integrated Care System. ▪ The Committee received assurance that the process around losses and special payments has now been considered and reformed by a task and finish group. ▪ The Committee was assured by the counter fraud report that the correct processes are in place to tackle fraud. ▪ The Committee took substantial assurance from the internal audit report in respect of two audits and moderate assurance on another audit. They were assured by the internal auditors that all remaining audits in their plan will be conducted within this financial year. ▪ The external auditors gave assurance that they have all appropriate resources in place to conduct the year end audit in a satisfactory manner.
ADVISE
▪ The Committee received the Three Wishes Charity report, accounts, letter of representation and letter of comment. They recommended to the Charitable Trust Board that these should be approved and the letter signed by the Chair of that Board. ▪ The Committee noted and received the waiver report and requested some further information and detail to be provided and the next meeting.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
▪ No new risks were identified.

Committee report

Report from:	People Committee
Date of meeting:	18 October 2022
Chair:	Lynne Lobley

Key discussion points and matters to be escalated from the discussion at the meeting:

ALERT
▪ The Committee wish to alert the Board in respect of the two lowest scoring areas of the General Medical Council (GMC) survey, being handover and rota design, which both scored under 50%. However, it did note that the Trainee Medical Education Group will have responsibility for requesting formal action plans to be put in place in respect of these negative outliers and monitoring delivery of these plans. ▪ The Committee received an update on the three key workforce efficiency programs and suggested that going forward, reports should set out the impact that the programs are having, in terms of run rate and cost savings. It noted that this is being built in to the divisional and Trust wide forecast and that by the next meeting, divisional positions will be established and able to be reported.
ASSURE
▪ The People Dashboard was well received and noted to be effectively addressing the Committee's requirements. ▪ The Board are asked to note that the GMC survey provided assurance that WWL are moving in the right direction with doctors' training and are performing well across the Greater Manchester (GM) region. ▪ The education exception report was noted and received and it was acknowledged that WWL have complied with the requirements of the 2016 contract by reporting exceptions to the Committee. ▪ The equality, diversity and inclusion (ED&I) deep dive presented showed that following collection of the data in respect of staffs' protected characteristics, the Trust have identified and recommended clear actions required in order to make the improvements required in this area. ▪ The Committee observed a clearer understanding of the make up of the Allied Health Professional (AHP) workforce and how the AHP workforce supply project will aid development of the Trust's related strategy. ▪ WWL's vaccination programme was noted to be running successfully. ▪ The plan to increase engagement in the upcoming staff survey including the communications already issued was noted. ▪ The library annual report provided positive assurance around library services. ▪ The Freedom to Speak Up report provided good assurance around the progress made with the service since it had been outsourced.

ADVISE
▪ Implementation of the workforce efficiencies plan and the work done with the finance team to progress these programs of work was positively received although it was noted that the required savings are yet to be seen. ▪ Similarly, good progress is being made with recruitment and retention and a reduction in vacancies was noted, although there is further work to be done. ▪ The work plan is proving effective in tracking which items the Committee has reviewed and which it is due to review, hence maintaining good governance. ▪ The Committee noted an increase in positive GM wide collaboration between trusts.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
▪ Risks were discussed in the context of the corporate objectives, as per those outlined through the Board Assurance Framework.

Committee report

Report from:	Quality and Safety Committee
Date of meeting:	10th August 2022
Chair:	Francine Thorpe

Key discussion points and matters to be escalated from the discussion at the meeting:

ALERT

- A thematic review of serious incidents reported over the last 3 years involving treatment delays highlighted a number of areas for improvement and 6 recommendations for action including:
  - Strengthening the use of the Datix system
  - Promoting and embedding shared learning across the organisation
  - Training for staff on SMART action planning with effective challenge and oversight
  - Audits identified to be registered with the Audit Department for tracking

Updates to be scheduled for future meetings to ensure that actions have been implemented

- The deep dive into treatment delays highlighted a potential safety concern in relation to acting upon radiology reports. The Radiology service has implemented a number of actions and the committee requested an update for the October meeting to gain further assurance.
- 49% of complaints are being responded to within the agreed timescales, this is an improvement from Q1 and will continue to be monitored to ensure 85% is achieved by the end of Q4
- Aspire accreditation visits highlighted 5 key areas for Trust-wide improvement work, these are being regularly audited and reported to the Committee.

ASSURE

- The workplan for the committee for the next 12 months was approved
- Aspire accreditation programme continues to highlight progress in a range of safety and patient experience measures. Of particular note is the positive feedback from patients and staff about the visits
- Response rates to patient feedback have improved during Q1. The Patient Experience report provided examples of actions taken as a result of feedback and a new strategy for 2022/2025 is in development. Progress will be monitored through regular reports to Q&S
- Information from the Safe Staffing report highlighted:
  - Matrons meeting a minimum of twice daily to review staffing shortfalls and patient acuity to mitigate risk of harm to patients

- 52% of ward leaders currently supernumerary. It is anticipated that this will be 100% by the end of September.
- No direct correlation of patient harm to reduced staffing levels

- The IPC Report highlighted a reduction in the number of Clostridium Difficile cases in Q1 compared to 2021/22 data. A new process for individual case review has been established.
- The Trust has implemented the National Standards of Healthcare Cleanliness as evidenced by the appropriate auditing of the clinical areas.
- The Committee reviewed a detailed paper from maternity services outlining progression towards CNST compliance and Ockenden recommendations. No areas of concern were identified
- The Committee received a verbal update on measures in place to maintain patient safety within the A&E department that included:
  - Escalation and prioritisation of deteriorating patients
  - Provision of appropriate care to patients having to wait in corridors
  - Safe staffing escalation policy

The Committee asked for regular updates to retain oversight of this key area

- Trust Standardised Hospital Mortality Ratio (SHMI) position has worsened slightly but remains within the expected range. Benchmarking with other organisations indicates that this picture is a national trend. The reasons for this are currently being investigated and will be included in the next mortality report
- The Committee receive a comprehensive Health & Safety Annual Report

ADVISE

- There has been a slight delay in gathering baseline data relating to the Trust objective C02 *We will increase the % of patients who die in their Preferred Place of Death* A working group has now been established to progress this and the Committee will receive regular reports on progress.
- The Division of Surgery (excluding maternity and child health) provided a spotlight report on their key challenges and highlights in relation to quality and safety that included:
  - Strengthening their governance arrangements to address backlogs in a number of areas
  - A range of quality improvement projects linked to Trust-wide challenges
  - Positive progress in complaints handling achieving 78% response time and improvement work to resolve concerns informally
- The Harm Free Care Report highlighted:
  - A slight increase in grade 2 pressure ulcers in Q1 compared to Q4 however fewer lapses in care were identified
  - A slight increase in falls across the Trust in Q1 compared to Q4
  - Data relating to Catheter Acquired Urinary Tract Infections is now being tracked

The metrics outlines within this report will continue to be closely monitored through Q&S

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- 3 risks have been reviewed and closed since the meeting in May
- 3 risks have been de-escalated since the meeting in May
- Risks relating to the BAF objectives for 2022/23 have been reviewed and updated

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Board Assurance Framework (BAF) Report
Presented to:	Board
On:	7 December 2022
Presented by:	Director of Corporate Affairs
Prepared by:	Head of Risk Director of Corporate Affairs
Contact details:	T: 01942 822027 E: paul.howard@wwl.nhs.uk

Executive summary

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

Link to strategy

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

Risks associated with this report and proposed mitigations

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

Financial implications

There are no financial implications associated with this report.

Legal implications

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

People implications

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

Wider implications

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

Recommendation(s)

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

1. Introduction

1.1 Our Board Assurance Framework (BAF) provides a robust foundation to support our understanding and management of the risks that may impact the delivery of Our Strategy 2030 and the annual corporate objectives 2022/23.

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

1.3 Each risk within the BAF has a designated Executive Director lead, whose role includes routinely reviewing and updating the risks:

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

2. Risk Rating Matrix

2.1 Each risk in the BAF is rated at an inherent, current and target risk level using the following matrix:

RISK RATING (LIKELIHOOD x IMPACT)

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

Table 1

2.2 The inherent risk score indicates the level of risk prior to the application of control measures or if current controls fail. The current risk score indicates the current level of risk considering the application of controls, assurances and progress made since the last review. The target risk score indicates the level of risk once identified risk treatments have been actioned. There are five categories of risk treatment – terminate, transfer, treat, tolerate or take the opportunity.

3. BAF Review

3.1 The latest assessment of the Trust's key strategic risks is presented here for the Board's review and approval. The BAF is included in this report with detailed drill-down reports into all individual risks.

3.2 The current risk assessment incorporates the outcomes of Lead Executive reviews of their designated risks, which took place in November 2022.

4. New Risks Recommended for Inclusion in the BAF

4.1 Current risks have been reviewed and updated in line with the 2022/23 corporate objectives.

4.2 No new risks have been escalated to the BAF since the last Board meeting in October 2022:

5. Risks Accepted and De-escalated from the BAF since October 2022

5.1 No risks have de-escalated or accepted and closed from the BAF since October 2022.

6. Review Date

6.1 The next scheduled review of all risks on the BAF is February 2023.

7. Recommendations

7.1 The Board are asked to:

- Review the risks and confirm that they are an accurate representation of the current significant risks to the delivery of the Trust's strategic objectives.

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Board assurance framework

2022/23

The content of this report was last reviewed as follows:

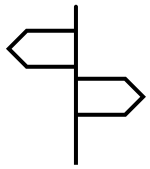
Quality and Safety Committee:	October 2022
Finance and Performance Committee:	November 2022
People Committee:	December 2022
Audit Committee:	November 2022
Executive Team:	November 2022

“ **assurance** (/əˈʃɔːrəns/) *noun*

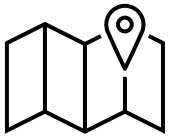
(In relation to board assurance) Providing confidence, evidence or certainty that what needs to be happening is actually happening in practice ”

Definition based on guidance jointly provided by NHS Providers and Baker Tilly

How the Board Assurance Framework fits in

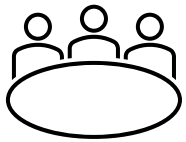


Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how 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.

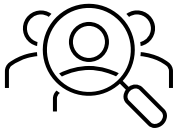


Corporate objectives: Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives 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.

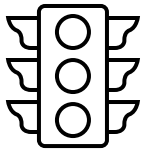
Board Assurance Framework: The board assurance framework provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains risks that are most likely to materialise and those that are likely to have the greatest adverse impact on delivering the strategy.



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 ambitions, each is allocated to one specific strategic ambition for the purposes of monitoring. Each strategic ambition is allocated to a monitoring body who will seek assurance on behalf of, and report back to, the Board of Directors.



Accountability: Each strategic risk has an allocated director who is responsible for leading on delivery. In practice, many of the strategic risks 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 to highlight overall assurance. Red indicates items with low assurance, amber shows items with medium assurance and green shows items with high assurance.

Understanding the Board Assurance Framework

RISK RATING MATRIX (LIKELIHOOD x IMPACT)

	Impact →				
Likelihood ↓	**Insignificant 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Critical 5**
Almost certain 5	5 Moderate	10 High	15 Significant	20 Significant	25 Significant
Likely 4	4 Moderate	8 High	12 High	16 Significant	20 Significant
Possible 3	3 Low	6 Moderate	9 High	12 High	15 Significant
Unlikely 2	2 Low	4 Moderate	6 Moderate	8 High	10 High
Rare 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	CPO:	Chief People Officer
CN:	Chief Nurse	MD:	Medical Director
DCSE:	Director of Communications and Stakeholder Engagement		

DEFINITIONS	
Strategic ambition:	The strategic ambition that the corporate objective has been aligned to – one of the 4 Ps (patients, people, performance or partnerships)
Strategic risk:	Principal risks that populate the BAF; defined by the Board and managed through Lead Committees and Directors.
Linked risks:	The key risks from the operational risk register which 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 impact and assist to secure delivery of the strategic objective
Gaps in controls:	Areas that require attention to ensure that systems and processes are in place to mitigate the strategic risk
Assurances:	The three lines of defence, and external assurance, in place which provide confirmation that the controls are working effectively. 1st Line functions that own and manage the risks, 2nd line functions that oversee or specialise in compliance or management of risk, 3rd line function that provides independent assurance.
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
Risk Treatment:	Actions required to close the gap(s) in controls or assurance, with timescales and identified owners. Five T's - Terminate, Transfer, Tolerate, Treat, Take the Opportunity.
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

4WARD THINKING | WORKING TOGETHER | ACCOUNTABLE | RESPECTFUL | DEMONSTRATE COMPASSION

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

FY022/23 Corporate Objectives

Patients

We will…
- Improve the safety and quality of clinical services
- Ensure patients and their families receive personalised care in the last days of life
- Improve the delivery of harm-free care
- Improve the quality of care for our patients
- Listening to our patients to improve their experience

People

We will…
- Make working at WWL a positive experience, where everyone has a voice that matters
- Support the health and wellbeing of our colleagues
- Ensure inclusion and belonging for all – ED&I
- Creating an environment where we always learn and everyone flourishes

Performance

We will…
- Deliver our financial plan, providing value for money services
- Minimise harm to patients through delivery of our elective recovery plan
- Improve the responsiveness of urgent and emergency care
- Progress towards becoming a Net Zero healthcare provider

Partnerships

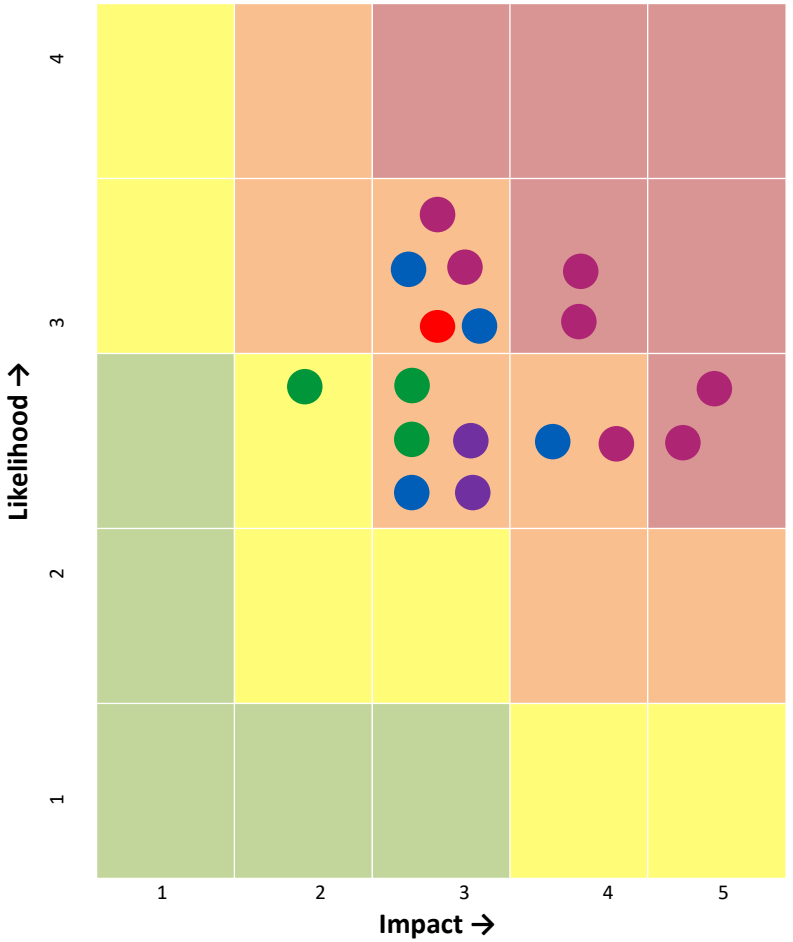
We will…
- Positively impact on the social and economic factors of our Borough
- Develop effective relationships within Wigan Borough and Greater Manchester for the benefit of our patients
- Make progress towards becoming a University Teaching Hospital

Risk management

Our risk appetite position is summarised in the following table:

Risk category and link to principal objective	Threat		Opportunity	
	Optimal	Tolerable	Optimal	Tolerable
Safety, quality of services and patient experience	≤ 3 Minimal	4 - 6 Minimal	≤ 6 Cautious	≤ 8 Cautious
Data and information management	≤ 3 Minimal	4 - 6 Minimal	≤ 6 Cautious	≤ 8 Cautious
Governance and regulatory standards	≤ 3 Minimal	4 - 6 Minimal	≤ 6 Cautious	≤ 8 Cautious
Staff capacity and capability	≤ 6 Cautious	≤ 8 Cautious	≤ 8 Open	10 - 12 Open
Staff experience	≤ 6 Cautious	≤ 8 Cautious	≤ 16 Eager	≤ 12 Eager
Staff wellbeing	≤ 6 Cautious	≤ 8 Cautious	≤ 16 Eager	≤ 12 Eager
Estates management	≤ 6 Cautious	≤ 8 Cautious	≤ 8 Open	10 - 12 Open
Financial Duties	≤ 3 Minimal	4 - 6 Minimal	≤ 6 Cautious	≤ 8 Cautious
Performance Targets	≤ 6 Cautious	≤ 8 Cautious	≤ 8 Open	10 - 12 Open
Sustainability / Net Zero	≤ 6 Cautious	≤ 8 Cautious	≤ 8 Open	10 - 12 Open
Technology	≤ 6 Cautious	≤ 8 Cautious	≤ 8 Open	10 - 12 Open
Adverse publicity	≤ 3 Minimal	4 - 6 Minimal	≤ 6 Cautious	≤ 8 Cautious
Contracts and demands	≤ 3 Minimal	4 - 6 Minimal	≤ 6 Cautious	≤ 8 Cautious
Strategy	≤ 6 Cautious	≤ 8 Cautious	≤ 8 Open	10 - 12 Open
Transformation	≤ 6 Cautious	≤ 8 Cautious	≤ 16 Eager	≤ 12 Eager

The heat map below shows the distribution of all 16 strategic risks based on their current scores:



Green: patients | Blue: people | Pink: performance | Purple: performance | Red: average risk score

Patients

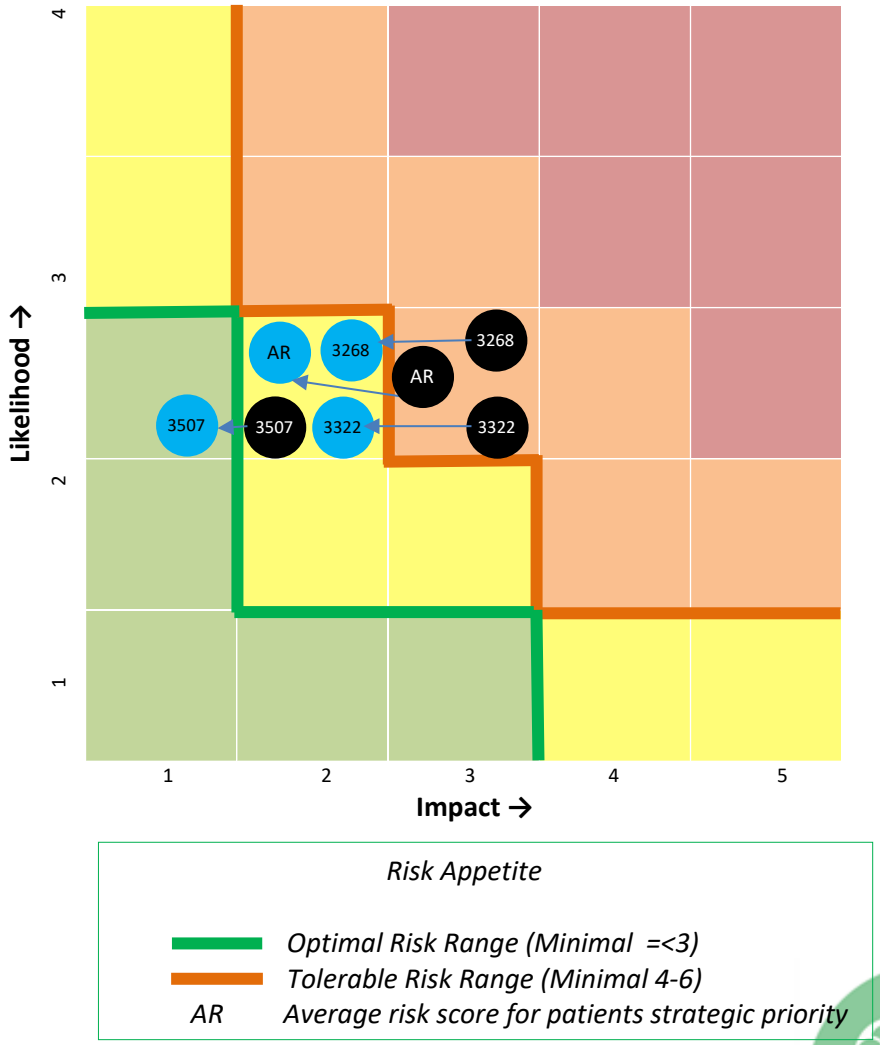
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

Monitoring: Quality and Safety Committee

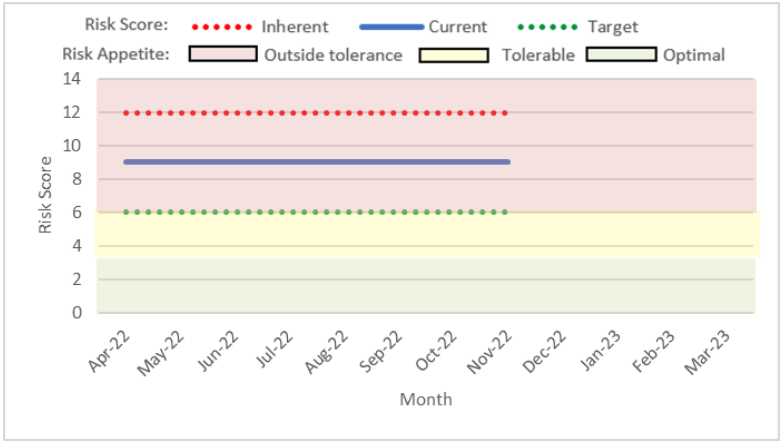
The following corporate objectives are aligned to the **patients** strategic priority:

Ref.	Headline objective
CO1	We will improve the safety and quality of our clinical services by achieving a 25% reduction in mortality related to sepsis by 31st March 2023 and sustain the improvement in mortality relating to AKI achieved during 2021/22.
CO2	We will increase the % of patients who die in their Preferred Place of Death, with a target for improvement to be set following completion of a baseline audit in the first quarter of 2022/23. **No risks currently identified*. *Working Group (Acute Trust, Community, Hospice and Primary Care) meeting.*
CO3	We will improve the safety and delivery of harm-free care by achieving a zero preventable category 3 and 4 pressure ulcers in both the hospital and community setting. 100% of NEWS, PEWS and MEWS will be recorded accurately reducing the risk of failure to recognise a deteriorating patient by 31st March 2023. As an enabler to this objective 400 of clinical staff will have received human factors training by the 31st March 2023.
CO4	We will improve the quality of care delivered through pursuing our journey of excellence through our accreditation programme. Seven in-patient wards will progress to achieving the silver rating in our accreditation programme, with the remaining wards maintaining their bronze rating. Additionally, the accreditation programme will be extended to see some other clinical and non-ward areas achieve the bronze rating by the 31st March 2023.
CO5	We will improve our complaint response rates by ensuring 85% of complaints received are responded to and acted upon within our agreed timeframes by the 31st March 2023. **No risks currently identified*.

The heat map below sets out the current risk score (black shading) and the target risk score (blue shading) for these risks:

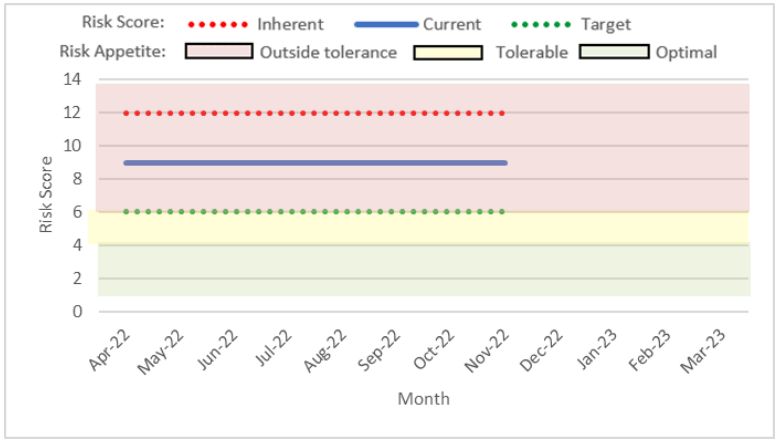


Corporate Objective: **CO1** Improve the safety and quality of clinical services							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 1: Clinical Services - Recognition, screening and treatment of the deteriorating patient**						
	Risk Statement:	There is a risk that patients who are deteriorating are not appropriately clinically escalated due to non-identification of sepsis, AKI or baseline observations resulting in mortality related to sepsis and AKI.						
Lead Committee	**Quality and Safety**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal	
Lead Director	**MD**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Safety, quality of services & patient exp.	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	3270	
Date of last review	**22.11.22**	**Risk Rating**	12. High	9. High	6. Moderate	**Risk treatment**	Treat	



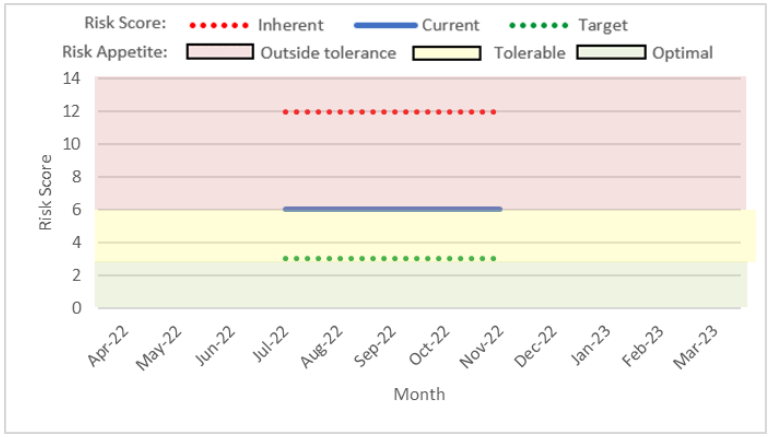
Strategic Opportunity / Threat Linked Risk	**Existing controls**	**Gaps in existing controls**	**Assurances (and date last seen)**	**Gap in assurances**	**Risk Treatment**	**Due Date / By Whom**
Threat: **(ID 3268)** 3270 – Consultant cross cover from SRFT for AKI service	• This is a dedicated corporate objective for FY2022/23. • Rapid Improvement Group. • Sepsis QI group. • Sepsis Improvement Plan. • Sepsis live in HIS. • Visibility of AKI and Sepsis Nurse in clinical areas • AKI and sepsis audits undertaken. • Themed SIRI panel on sepsis in Sept 2021 focused on improvement work and highlighted achievements to date. • Improved AKI pathways to ensure that there is no avoidable harm caused by WWL.	• Workload demands for AKI and Sepsis nurses. • AKI Improvement Plan needs to be developed.	**2nd Line:** • Quality & Safety Committee October 2022.	• No gaps currently identified.	1. Deteriorating Patient Improvement Group continues to meet monthly.	Monthly

Corporate Objective: **CO3** Improve the delivery of harm free care								**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 2: Harm Free Care - Avoidable Pressure ulcers**							
	Risk Statement:	There is a risk that our systems and processes, coupled with challenged staffing, may not facilitate the swift identification of potentially avoidable pressure ulcers resulting in harm to our patients.							
Lead Committee	**Quality and Safety**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal		
Lead Director	**CN**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Safety, quality of services & patient exp.		
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	3323		
Date of last review	**22.11.22**	**Risk Rating**	12. High	9. High	6. Moderate	**Risk treatment**	Treat		



Strategic Opportunity / Threat Linked risk	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3322)** 3323 – Tissue viability team capacity	• Pressure ulcer link nurses trained within areas. • Introduced human factors training with over 330 staff trained so far. • Grade 2/DTI Pressure ulcer Panels in place. • Grade 3/4 & Unstageable Pressure ulcer panels in place. • New pressure ulcer rapid Review template launched for pressure ulcers. • New Pressure ulcer policy and procedure. • Datix improvements started to better capture pressure ulcer management. • Reduced number of pressure ulcers identified as lapses in care by WWL.	• Staff being able to be released to undergo training. • Junior workforce. • Investigation of developed ulcers are not investigated to a level to allow for full identification of learning. • Equipment issues. • Beds owned by individual Divisions. • Under resourcing of Tissue Viability Team.	**2nd Line:** • Quality & Safety Committee October 2022	• No gaps currently identified.	1. Harm Free Care Business Case to be drafted. 2. Continue to accurately record NEWS, PEWS and MEWS. 3. Continue the roll out of human factor training.	December 2022 CN March 2023 CN March 2023 CN

Corporate Objective: **CO4** Improve the quality of care for our patients								**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 3: Ward accreditation programme**							
	Risk Statement:	There is a risk that future waves of covid may affect the supernumerary status of ward leaders, due to the impact of covid on staffing levels in clinical areas, challenging the achievement of silver accreditation level. This is a single person service with paper based scoring and reporting which may also influence the speed of the roll out.							
Lead Committee	**Quality and Safety**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal		
Lead Director	**CN**	**Likelihood**	4. Likely	2. Unlikely	1. Rare	**Risk category**	Safety, quality of services & patient exp.		
Date risk opened	**20.07.22**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	-		
Date of last review	**22.11.22**	**Risk Rating**	12. High	6. Moderate	3. Low	**Risk treatment**	Treat		



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3507)**	• Introduced the ASPIRE ward accreditation programme and have already accredited 6 wards as SILVER status.	• Accreditation project plan to be developed.	**2nd Line:** • Quality & Safety Committee October 2022	**2nd Line:** • Project plan to go to NMAHP, NMALT and new Quality Assurance Group.	1. Accreditation project plan to be developed by Clinical Quality Lead and service transformation lead.	December 2022 CN

People

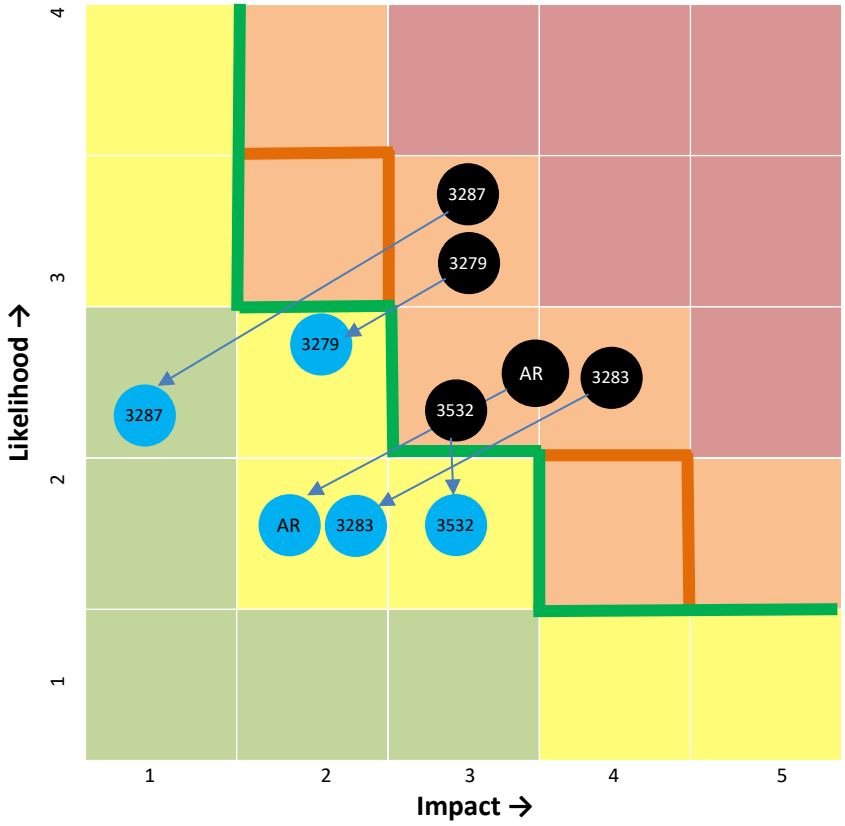
To create an inclusive and people-centred experience at work that enables our WWL family to flourish

Monitoring: People Committee

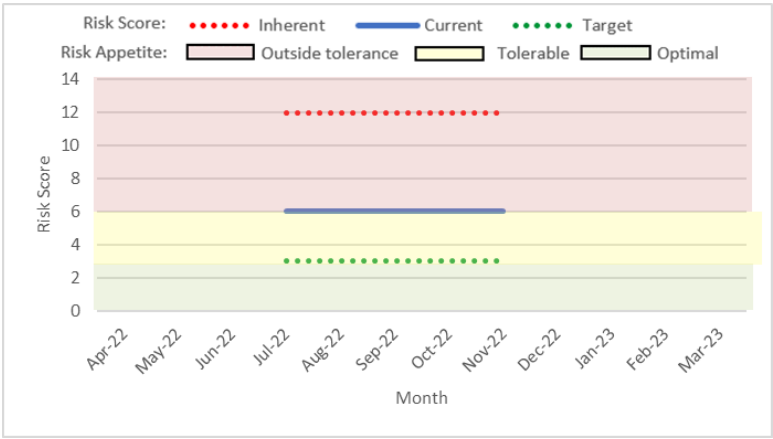
The following corporate objectives are aligned to the **people** strategic priority:

Ref.	Detailed objectives
CO6	We will advance and embed the implementation of our just and learning culture programme through leadership development, civility and team development / culture programmes that improve experience of work in a sustainable way and encourage our people to speak up.
CO7	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, supported by real time and accurate absence data.
CO8	We will improve the equality, diversity and inclusion of our Trust by increasing diversity and accessibility, reducing inequality and improving the experience of protected groups.
CO9	We will prioritise personal and professional development to enable our people to flourish, making full use of all available funding sources by aligning our programmes to the learning needs analysis and strategic aspirations such as university teaching hospital status.

The heat map below sets out the current risk score (black shading) and the target risk score (blue shading) for these risks:

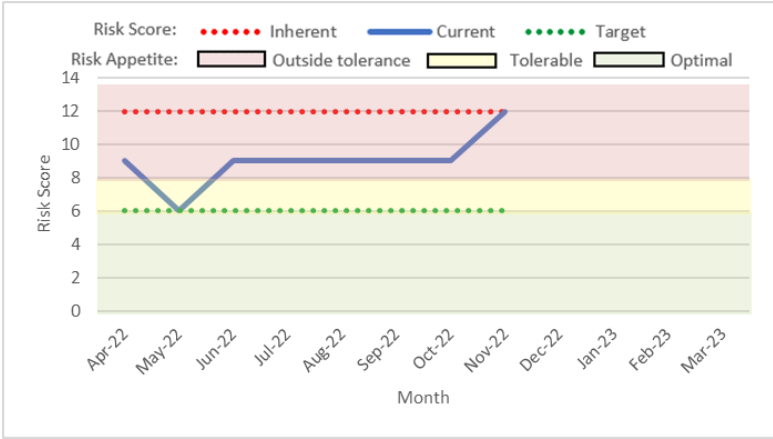


Corporate Objective: CO6 Make working at WWL a positive experience, where everyone has a voice that matters							**Overall Assurance Level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 4: Person centred people management**						
	Risk Statement:	There is a risk, given the significant culture shift required, that leaders may not have the capacity and capability to embed our just and learning culture through compassionate and person-centred people management, resulting in lower engagement levels, potential for increased turnover and a poor industrial relations climate.						
Lead Committee	**People**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**CPO**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Staff Experience	
Date risk opened	**19.08.22**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	-	
Date of last review	**18.11.22**	**Risk Rating**	12. High	9. High	6. Moderate	**Risk treatment**	Treat	



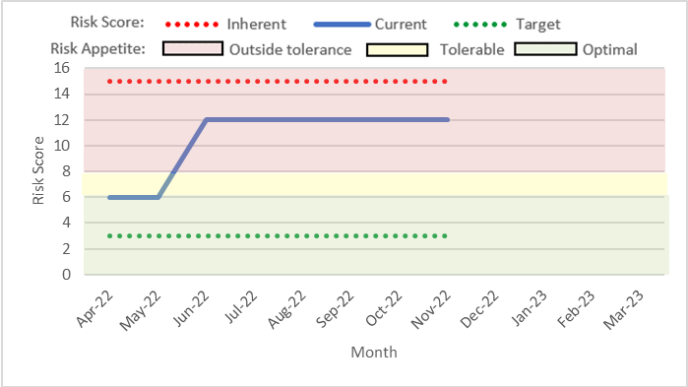
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **ID 3532**	• Civility and behaviour framework • Just & learning culture protocol • Divisional HR support • Disciplinary triage panel	• HR policy review – person centred policies • Full line manager & HR training programme – people centred people management.	• Feedback from line manager listening sessions (July) • ETM paper (August) – people management training proposal • Just culture & civility training programme place allocation (ETM September 2022) • Verbal update on just & learning culture training roll out – Our FFF Culture Group (October 2022) • Our FFF culture group (November 2022) - highlighting how culture programme learning is being embedded into day to day activities.	None identified.	1. WWL HR policy handbook development (completed in partnership) 2. NW well-being and attendance management policy 3. NW well-being and attendance management leadership development 4. Development of WWL training programme – HR team, staff side & line managers for roll out in 2023/24 5. Agree delivery methodology for the roll out of just & learning culture training (as part of people leaders training and at induction) 6. Corporate induction review and departments to develop comprehensive and supportive local induction packages, based on learning from positive and negative experiences	1. March 2023 – Strategic HR Lead 2. January 2023 – NW HRDs 3. January 2023 – NW HRDs 4. March 2023 – Strategic HR Lead 5. January 2024 – Associate Director of Employee experience & well-being 6. March 2023 – Associate Director of staff experience & departmental leads

Corporate Objective: CO7 Support the health and wellbeing of our colleagues							**Overall Assurance Level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 5: Participation in preventative and restorative wellbeing activities**						
	Risk Statement:	There is a risk that sufficient time may not be available for staff to participate in preventative and restorative wellbeing activities within working hours, due to workload pressures and vacancies, resulting in lower engagement levels and evidence suggests this will reduce the success of the programme.						
Lead Committee	**People**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**CPO**	**Likelihood**	4. Likely	4. Likely	2. Unlikely	**Risk category**	Staff Wellbeing	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	-	
Date of last review	**18.11.22**	**Risk Rating**	12. High	12. High	6. Moderate	**Risk treatment**	Treat	



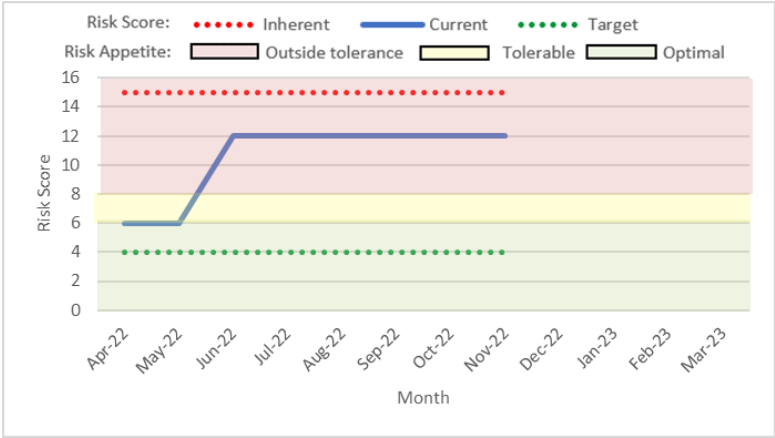
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **ID 3279**	• Your Voice Survey – well-being score. • Steps 4 Wellness Service enhancements. • Targeted in-reach activities in high-risk areas. • Wellbeing walkabouts. • Re-prioritisation and amendment of offers.	• Commitment to roster time for people to be released as needed. • Recruitment & retention update (People Committee June 2022 & September) • Increasing operational pressures impacting on release	**2nd Line:** • All staff Team Brief session (July 2022) • Team stress management pilot completion (evaluation at People Committee September) • Well-being update (staff engagement steering group September 2022) • Divisional well-being plan pilot completed in Medicine (November) – roll out to other Divisions commences w/c 21/11 • Divisional assurance meetings (October & November) sickness absence levels • People dashboard (ETM) and Our FFF (November) – issues of turnover in Band 2/3 roles associated with working conditions and pay level competition – deep dive using Guardian Service and task & finish group	None identified.	1. Strategic needs assessment to be completed working with divisional teams. 2. Divisional well-being plans that are prioritised and implementation monitored through divisional assurance reviews. 3. Recruitment to B5 Nursing & HCA vacancies (including international recruitment) – performance against trajectory. 4. Develop additional offers associated to cost of living support and upskilling of S4W Champions to provide additional support in departments and in real time	1.January 2023 - Consultant clinical Psychologist 2.December 2022 – Divisional Triumvirate & S4W team 3.March 2023 – DCN & DCPO (+ recruiting managers) 4. December 2022 - S4W & Senior Clinical Psychologist

Corporate Objective: **CO8** Ensure inclusion and belonging for all –ED&I							**Overall Assurance Level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 6: Fairness and compassion - workforce EDI expertise and supporting infrastructure**						
	Risk Statement:	There is a risk that EDI may not be embedded in everything we do, due to a lack of sufficient workforce awareness about EDI and we do not have substantive Workforce EDI resource, resulting in failure to deliver the EDI objectives, strategy and our statutory duties under the Equality Act.						
Lead Committee	**People**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**CPO**	**Likelihood**	5. Almost certain	4. Likely	1. Rare	**Risk category**	Staff Capacity and Capability	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	3231	
Date of last review	**18.11.22**	**Risk Rating**	15. Significant	12. High	3. Low	**Risk treatment**	Treat	



Strategic Opportunity / Threat	**Existing controls**	**Gaps in existing controls**	**Assurances (and date)**	**Gap in assurances**	**Risk Treatment**	**Due Date / By Whom**
Threat: **ID 3287** 3231- Culture of psychological safety, civility and compassionate leadership	• Workforce EDI specialist recruited (fixed term contract until January 2023). • EDI strategy approved. • Expanded staff networks supported. Training in place for network sponsors and EDI Champions. • Three independently assessed schemes approved for implementation – Rainbow Badge, Disability Confident & Race Equality Standard.	• No ongoing funding commitment	• EDI report to People Committee June 2022. • Workforce EDI objectives (People Committee – June 2022). • EDI workshop - October 2022 • EDI ER deep dive report (People Committee October 2022) • EDI workshop for leadership (31/11/22) • Trust Board EDI training (2/11/22) • EDI strategy implementation plan (ETM 17/11/2022) **3rd line** Messenger review – highlights the need to improve EDI awareness and to increase diversity (June 2022).	• No substantive EDI workforce resource to support delivery against strategic aims set out in the strategy. • Workforce and leadership awareness of EDI and associated responsibilities	1. Embed colleague diversity networks. 2. Gap analyses and action plans from the three assessments. 3. Review shadow running of EDS 3 (2022) process in 2022-23. 4. Awareness and engagement programme for all (with specific focus on leadership EDI responsibilities) – Board training & senior leaders workshop. 5. EDI workforce objectives delivery. 6. Business case / business planning process regarding Workforce EDI specialist role. 7. EDI corporate objective cascade to all senior leaders.	1. Complete 2. Complete 3. Complete 4. Complete 5. Workforce EDI lead -March 2023 In year resolved. 6. Substantive business case CPO –October 2022 _ completed. Subject to approval in business planning (December 2022 / January 2023) 7. Workshop & board training complete – divisional objectives to be determined

Corporate Objective: CO9 Create an environment where we are always learning, and everyone flourishes								**Overall Assurance Level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 7: Personal Development**							
	Risk Statement:	There is a risk that the prioritised learning needs analysis cannot be delivered due to funding constraints and / or inability to release staff for training, resulting in increased turnover and / or a lack of continued professional development for colleagues.							
Lead Committee	**People**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious		
Lead Director	**CPO**	**Likelihood**	5. Almost Certain	4. Likely	2. Unlikely	**Risk category**	Staff Capacity & Capability		
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	2. Minor	**Linked risks**	-		
Date of last review	**18.11 .22**	**Risk Rating**	15. Significant	12. High	4. Moderate	**Risk treatment**	Treat		



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **ID 3283**	• Full LNA completed and prioritised. • Mandatory and job specific training requirements reviewed and updated. • Agreed principles of apprenticeship and HEE funding allocations first.	• Ability to roll forward HEE funding allocations. • Ability to release staff due to vacancies / workload pressures. • Recurrent budget for training & development aligned to LNA.	**2nd Line:** • ETM review and in principle (LNA and apprenticeship plan) – May 2022 • People Committee report – June 2022 • HEE CPD investment schedule (Education Governance -July) • 2022/23 LNA business case (ETM September)	None identified.	1. Business case to deliver 2022-23 LNA.- further analysis with finance and staff group and divisional leads – build into business planning 2. Benchmarking review of nurse staffing establishment uplift to cover time for training. 3. Recurrent budget setting principles to be agreed as part of annual business planning round.	1.December 2022 / January 2023 (aligned to business planning timeline) – CPO 2.TBC – CNO 3. December 2022 / January 2023 (aligned to business planning timeline

Performance

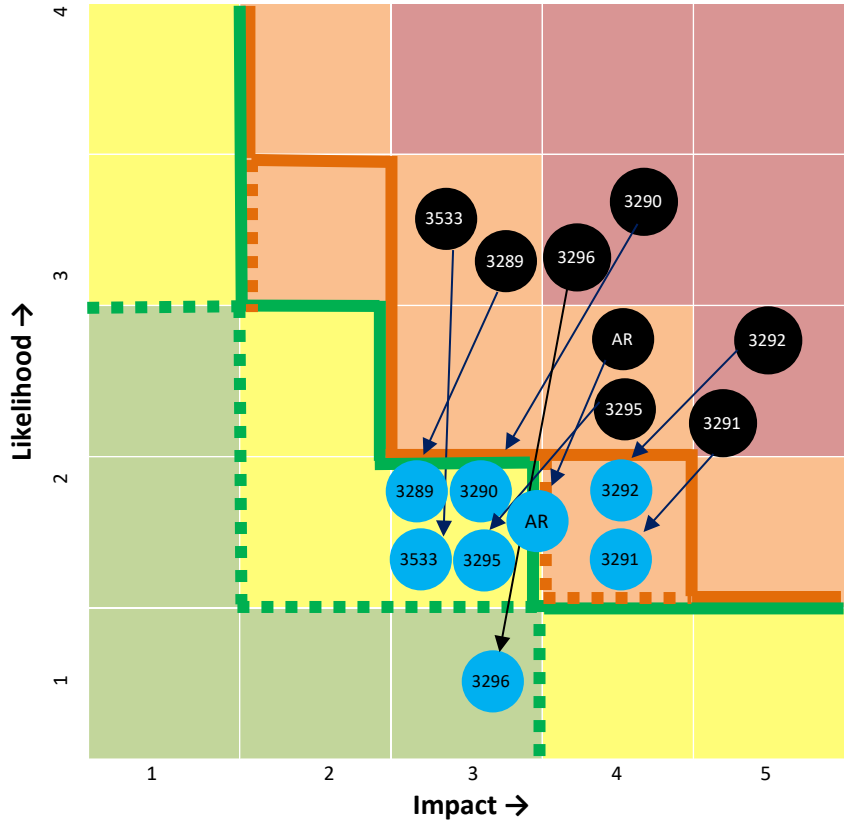
Our ambition is to consistently deliver efficient, effective and equitable patient care

Monitoring: Finance and Performance Committee

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

Ref.	Detailed objectives
CO10	We will deliver our financial plan for 2022/23, demonstrated through meeting the agreed I&E position, delivery of planned efficiencies and delivery of agreed capital investments in line with the capital plan.
CO11	We will minimise harm to patients in recovering and restoring our elective services in line with national recommendations by identifying and treating patients most at risk to by the 31st March 2023: • Eradicating 104 week waits by the end of June 2022 (unless patients have chosen to wait longer). *Action Completed.* • Eliminate 78 weeks wait by end of March 2023 • Increase elective activity delivered to 110% of the 2019/20 baseline (104% by value). Trust plan to deliver 103% baseline activity • Sustainably reduce the number of patients on a 62-day that are waiting 63 days or more to pre-pandemic levels.
CO12	We will deliver improvements to community and urgent emergency care services and pathways alongside our locality partners, demonstrated by 12 hour waits in the Emergency Department being no more than 2% of all attendances and the number of no right to reside patients returning to pre-pandemic levels (39 patients in total with no more than 15 on the acute site) by the 31st March 2023.
CO13	We will bring our recently approved Green Plan to life, integrating it within our governance structures to inform better decision making and creating a green social movement, making it everyone's responsibility to deliver on the year one actions identified within the Green Plan.

The heat map below sets out the current risk score (black shading) and the target risk score (blue shading) for these risks:



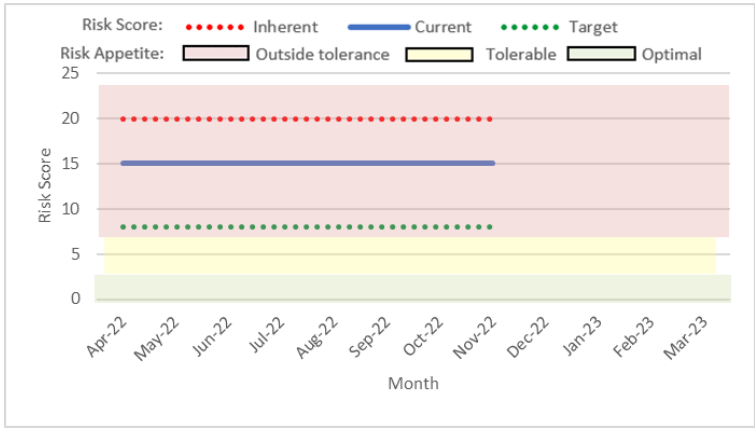
Risk Appetite

Optimal Risk Range (Financial Duties: Minimal = <3) (Other: Cautious = <6)

Tolerable Risk Range (Minimal 4-6, Cautious =<8)

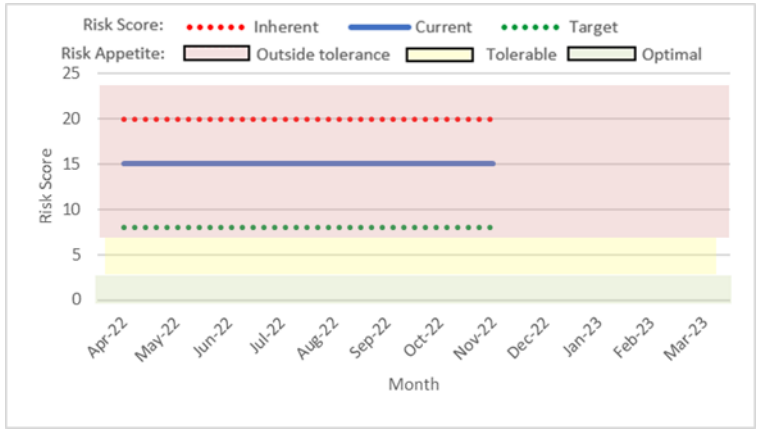
AR Average risk score for performance strategic priority

Corporate Objective: **C10** Deliver our financial plan, providing value for money services								**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 8: Financial Performance: Failure to meet the agreed I&E position**							
	Risk Statement:	There is a risk that the Trust may fail to fully mitigate in year pressures to deliver key finance statutory duties resulting in the Trust receiving significantly less income than the previous financial year.							
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current**	**Target Risk**	**Risk Tolerance**	Minimal		
Lead Director	**CFO**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Financial Duties		
Date risk opened	**19.10.21**	**Impact**	5. Critical	5. Critical	4. Major	**Linked risks**	-		
Date of last review	**18.11.22**	**Risk Rating**	20. Significant	15. Significant	8. High	**Risk treatment**	Treat		



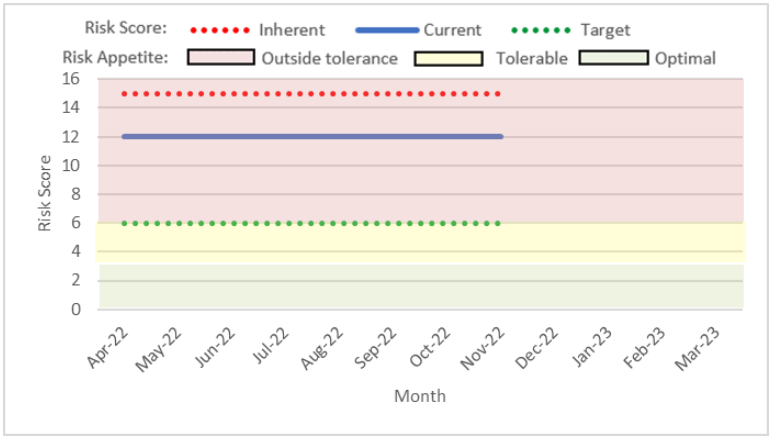
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3292)**	• Final plan signed off by Board and submitted to NHSEI - 20th June 2022 • CIP target agreed with programme for delivery and actions. • Continued lobbying via Greater Manchester in respect of additional funding which is appropriate for current clinical capacity and operational and inflationary pressures (Ext.) • Robust forecasting including scenario planning for worst, most likely and best case • Executive oversight and challenge of CIP & Financial performance through RAPID & Divisional Assurance Meeting • Pay control group established with scrutiny and rigour over agency spend in line with national agency controls • Stringent business case criteria to ensure only business critical investments are approved	• System and locality reporting in infancy • Covid and winter spend is above plan and funding received • Awaiting operational planning guidance for 23/24	**1st Line:** Monthly RAPID meetings for applicable divisions **2nd Line:** Finance & Performance Committee November 2022	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Financial Recovery Plan to be approved by Board 2. Forecast for covid spend to be signed off through Divisional Assurance Meetings with budget adjusted to reflect improvements 3. HFMA Financial Sustainability: Getting the Basics Right review to be independently assessed by MIAA	December 2022 CFO Q3 CFO/DCEO Q3 CFO

Corporate Objective: **C10** Deliver our financial plan, providing value for money services							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 9: Financial Sustainability: Efficiency targets & Balance Sheet**						
	Risk Statement:	There is a risk that efficiency targets will not be achieved, resulting in a significant overspend and that there is insufficient balance sheet flexibility, including cash balances, to mitigate financial problems.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current**	**Target Risk**	**Risk Tolerance**	Minimal	
Lead Director	**CFO**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Financial Duties	
Date risk opened	**19.10.21**	**Impact**	5. Critical	5. Critical	4. Major	**Linked risks**	-	
Date of last review	**18.11.22**	**Risk Rating**	20. Significant	15. Significant	8. High	**Risk treatment**	Treat	



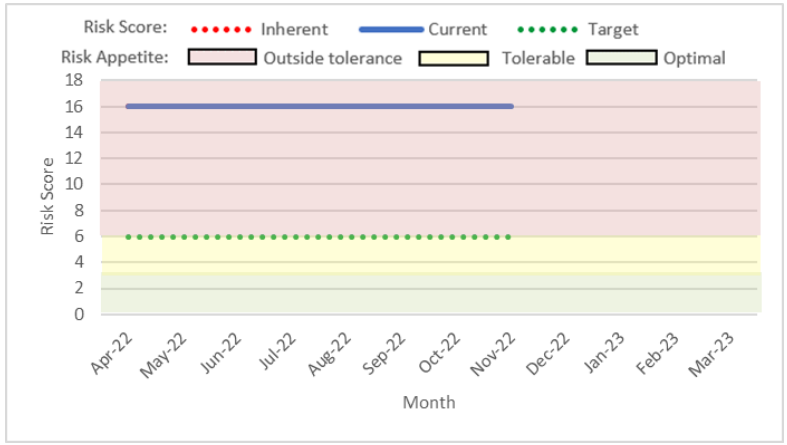
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3291)**	• Revised CIP delivery approach following review by Mersey Internal Audit Agency. • Monitored via Divisional Assurance Meetings, with additional escalation through RAPID if Divisional delivery is off plan. • Further oversight at Executive Team, F&P Committee and Board of Directors. • Work is ongoing across the GM system on developing a joint approach to productivity and cross cutting efficiency (Ext). • Transformation Board input & oversight of strategic programmes. • Effective credit control including monitoring debtor and creditor days and liquidity with oversight through SFT. • Effective monthly cash flow forecasting reviewed through SFT	• Level of unidentified CIP • High proportion of CIP is non recurrent and non cash releasing • High proportion of CIP is transactional • Mechanisms to facilitate delivery of system wide savings	**1st Line:** Monthly RAPID meetings for applicable divisions **2nd Line:** Finance & Performance Committee November 2022	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Financial Recovery Plan to be approved by Board 2. RAPID recovery meetings held with specific divisions as applicable based on agreed metrics. 3. Monthly updates on CIP presented to Executive Team, with regular updates at Trust Management Committee. 4. Engagement in GM Efficiency Programme work including productivity workstream co-chaired by WWL Deputy CEO (Ext)	December 2022 CFO March 2023 CFO/DCEO March 2023 CFO/DCEO March 2023 CFO/DCEO

Corporate Objective: C10 Deliver our financial plan, providing value for money services							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 10: Estates Strategy - Capital Funding**						
	Risk Statement:	There is a risk that there is inadequate capital funding to enable priority schemes to progress. Due to uncertainties around capital funding arrangements the strategy may assume that more investment can be made than is available.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal	
Lead Director	**CFO**	**Likelihood**	3. Possible	3. Possible	2. Rare	**Risk category**	Financial Duties	
Date risk opened	**19.10.21**	**Impact**	5. Critical	4. Major	3. Moderate	**Linked risks**	-	
Date of last review	**18.11.22**	**Risk Rating**	15. Significant	12. High	6. Moderate	**Risk treatment**	Treat	



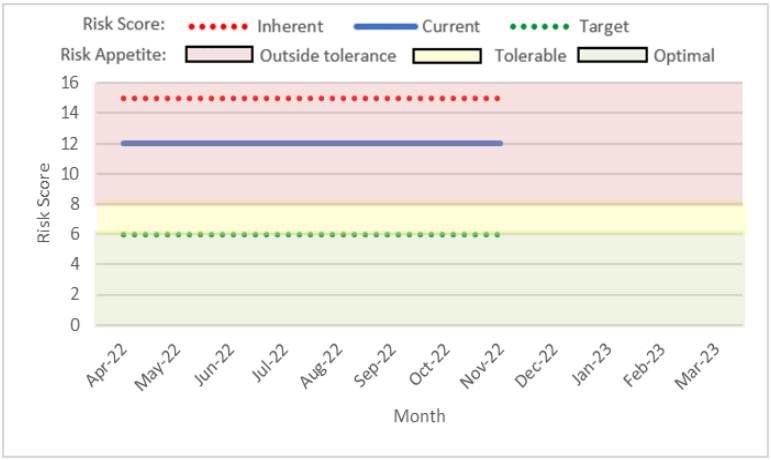
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3295)**	• Lobbying via Greater Manchester (Ext). • Capital Priorities agreed by Executive Team & Trust Board. • Cash for Capital investments identified. • Bids formally approved for centrally funded Community Diagnostic Centre and TIF Additional theatre at Leigh Hospital and MOU's received. • Reprioritisation of additional capital schemes to ensure the capital programme is reflective of organisational priorities • 3 year capital allocations available to inform more longer term system planning • Strategic capital group established with oversight of full capital programme • Capital plan forecast to deliver in full • Programme Boards established for major capital schemes – CDC & Leigh Theatre.	• Impact of cost of living rise in terms of project costs and timescales • GM overcommitment of capital programme • Delays in receiving MOU for Frontline Digitalisation	**1st Line:** • Monthly Capital Strategy Group **2nd Line:** • Finance & Performance Committee November 2022	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Close monitoring of Capital spend in line with trajectory 2. Development of capital reporting through the refreshed DFM App	March 2023 CFO Q4 CFO

Corporate Objective: C10 Deliver our financial plan, providing value for money services							Overall Assurance level	Medium
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 11: Activity not in line with the funding available**						
	Risk Statement:	There is a risk that the cost of delivering 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. If the activity plan is not achieved it could result in clawback of ERF monies already received.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current**	**Target Risk**	**Risk Tolerance**	Minimal	
Lead Director	**CFO**	**Likelihood**	4. Likely	4. Likely	2. Unlikely	**Risk category**	Financial Duties	
Date risk opened	**19.10.21**	**Impact**	4. Major	4. Major	3. Moderate	3. Moderate	-	
Date of last review	**18.11.22**	**Risk Rating**	16. Significant	16. Significant	6. Moderate	**Risk treatment**	Treat	



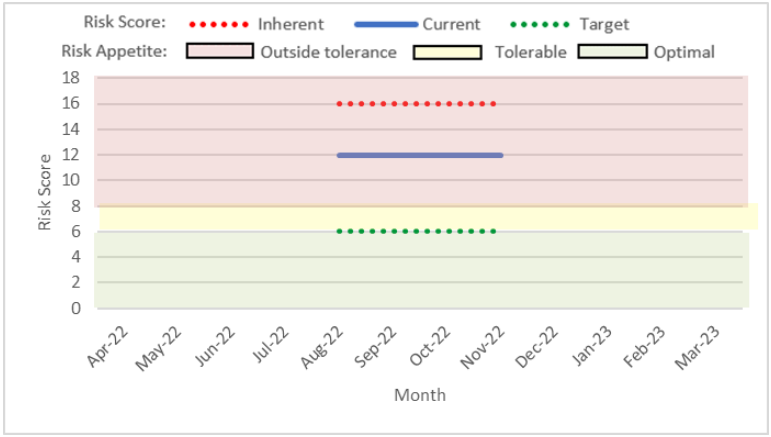
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3290)**	• The financial plan agreed triangulates with the activity plan. • GM Elective Recovery Reform Group in place with two programmes of work; (1) capacity and demand across GM and (2) reform. Deputy Chief Executive attends for WWL. (Ext.) • Continuing to access independent provider capacity. • Financial reporting webinar (M6) stated there is no intention for NHSE to clawback ERF from ICB's	•Activity is below plan - no formal confirmation that there will be no clawback of ERF for underachievement of the electivity activity plan	**2nd Line:** • Finance & Performance Committee November 2022	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Follow the national guidance to assume no clawback of ERF funding unless told otherwise.	March 2023 CFO

Corporate Objective: **CO11** To minimise harm to patients through delivery of our elective recovery plan							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 12: Elective services - Waiting List**						
	Risk Statement:	There is a risk that demand for elective care may increase beyond the Trust's capacity to treat patients in a timely manner, due to challenges of restoring services presented by covid, workforce and IPC measures, increase in cancer referrals, no right to resides backlog and late repatriations from the independent sector, resulting in potentially poor patient experience, deteriorating health, more severe illness and late cancer diagnosis.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**DCE**	**Likelihood**	5.Almost Certain	4. Likely	2. Unlikely	**Risk category**	Performance Targets	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks IDs**	3136,3432, 3020,3360	
Date of last review	**09.11.22**	**Risk Rating**	15. Significant	12. High	6. Moderate	**Risk treatment**	Treat	



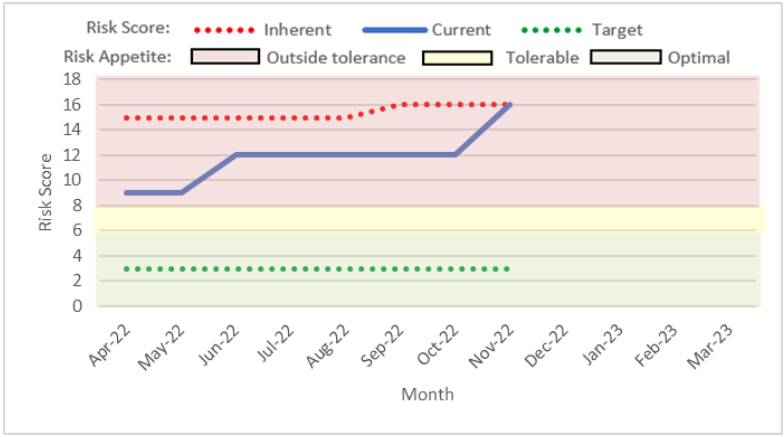
Opportunity / Threat Linked Risks	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3289)** **3136** Symptomatic breast imaging waiting times **3432**Counselling waiting times **3020** Waiting list Dermatology **3360** children with hearing loss waiting list	• Robust winter plan in place • Working with partners in the Wigan Borough to tackle pressures. • Achieved 104 weeks by June 2022 and we are on track to deliver 78 weeks by March 2023. • Elective Recovery Plan excelling at Wrightington site. • £1.6 million investment into Wrightington Hospital. • £10 million Community Diagnostic Centre at Leigh Infirmary. • Currently on track for cancer waiting times. • National waiting list guidance - Text reminder service switched on with digital facility to electronically validate appointments.	• 78 week wait to be addressed. • Increase in cancer referral rate. • Lack of capacity to undertake reviews of allocated risk stratification across all specialties. • Meeting new care demands such as increasing cancer referral rates and reduced bed capacity due to covid admissions and no right to reside. • Addressing care backlogs as a direct consequence of the pandemic, specifically the increase in the backlog of patients on follow up waiting lists, DNAs and patient cancellations. • Late repatriations from the independent sector. • National IPC guidance to open up capacity.	**2nd Line:** • Finance & Performance Committee November 2022. • WWL Winter Plan session August 2022	• No gaps in assurance currently identified.	1. Continue with existing controls applied to 104 week wait to identify the most clinically at risk patients and eliminate 78 weeks wait. 2. Continue with actions applied to improve 52 week position. 3. Monitor number of P2 on the waiting list through Financial and Performance Report 4.Monitor number of people of no right to reside - see PR6: Urgent and Emergency Care – Winter Pressures	March 2023 DCE March 2023 DCE Bi-monthly DCE

Corporate Objective: CO12 Improve the responsiveness of urgent and emergency care							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 13: Urgent and Emergency Care – Winter Pressures**						
	Risk Statement:	There is a risk to urgent and emergency care delivery over the winter period, due to the nursing and care home sector being unable to accept patients, resulting in the number of no right to reside patients substantially increasing, lack of capacity, longer waits, delayed ambulances and reduced patient flow.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current**	**Target Risk**	**Risk Tolerance**	Cautious	
Lead Director	**DCE**	**Likelihood**	4. Likely	4. Likely	2. Unlikely	**Risk category**	Performance Targets	
Date risk opened	**05.09.22**	**Impact**	4. Major	3. Moderate	3. Moderate	**Linked risks IDs**	3500, 3423	
Date of last review	**09.11.22**	**Risk Rating**	16. Significant	12. High	6. Moderate	**Risk treatment**	Treat	



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3533)** **3500** Prolonged stay in the ED waiting room **3423** ED – Increase in attendances and insufficient patient flow	• **Worst Case Scenario Planning** - Risk stratification – treating in clinical priority order and long waits. • Winter plan signed off with desktop exercises planned. • **Additional Capacity** – Healthier Wigan Partners capital monies for 24 more beds to address the backlog in no right to resides. • **Admission avoidance** - £2.3 million for virtual hub confirmed, same day emergency care (SDEC), falls pilot with NWAS. • Sequential use of every bed. • Delayed discharge Wigan. • Part of national only discharge programme. • Safe havens to safely de-escalate A&E • GMMH – urgent care centre due to be commissioned in January 2023. • Fortnightly A&E drop in sessions. • Wellbeing and resilience - 150 dedicated wellbeing champions delivering Steps4Wellness programme.	• 12 hour wait not improving. • Delayed ambulance turnover times. • Increase in gynaecological referrals.	**1st Line:** • Sickness and turnover monitored at divisional assurance meetings. • Safe staffing reports. **2nd Line:** • WWL Winter Plan session – August 2022 • Finance & Performance Committee November 22	• No gaps in assurance currently identified.	1. Work closely with colleagues in Wigan locality to reduce no right to reside by 20% and reduce 12 hour waits. 2. Communicate Winter Plan focussing on risk stratification, additional capacity and admission avoidance to reduce 12 hour waits in the Emergency Department.	March 2023 DCE December 2022 DCE

Corporate Objective: C13 Progress towards becoming a Net Zero healthcare provider							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 14: Estate Strategy - net carbon zero requirements**						
	Risk Statement:	There is a risk that Net Zero may not be delivered, due to investment not being available, resulting in failure to deliver the Green Plan and legislative requirements						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**CPO**	**Likelihood**	4. Likely	4. Likely	1. Rare	**Risk category**	Sustainability /Net Zero	
Date risk opened	**19.10.21**	**Impact**	4. Major	4. Major	3. Moderate	**Linked risks**	-	
Date of last review	**25.11.22**	**Risk Rating**	16. Significant	16. Significant	3. Low	**Risk treatment**	Treat	



Strategic Opportunity /Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3296)**	• Sustainability Manager in post. Recruited band 4 support (not yet in post). • Greener WWL comms commenced, supported by recruiting to the Ambassadors programme. • Third party commissioned to complete baseline assessment, develop prioritised investment plan, Net Zero Strategy and update the Trust's Green Plan. • Net Zero and sustainability e-learning programme. • Bidding strategy has been developed with a view to securing Public Sector Decarbonisation Scheme (PSDS) funding.	• Baseline emissions assessment • Prioritised action and investment plan • Climate Change Adaptation plan • Sustainable Travel Plan • Comms and Engagement strategy • Sustainability Impact Assessment • Capital funds should PSDS not be secured	**2nd Line:** • Finance & Performance Committee November 2022. • Surgery Audit Day based around sustainability Bid submitted to Salix Low Carbon Skills Fund 14/06/22 to enable bid to PSDS. • Ricardo progress briefing (ETM Sept 2022) • Business planning process commenced • Net Zero oversight group – high level Ricardo outputs (November 2022).	• No substantive sustainability workforce resource to support delivery against strategic aims set out in the Net Zero NHS guidance document. • Investment schedule aligned to capital programme (based on Ricardo outputs)	1. Complete baseline assessment. 2. Supply chain Net Zero review (national, regional & local). 3. Green prescribing plan. 4. Sustainability and Net zero to be included in business planning process for 2023-24. 5. Estates Net Zero High level Investment Plan to be shared at ETM for prioritisation discussion	1 Ricardo – December 2022 - complete 2 Associate Director of Procurement – TBC awaiting national direction 3 Chief Pharmacist – TBC awaiting national direction 4 Director of Strategy – December 2022 - complete 5 Net Zero Lead – January 2022

Partnerships

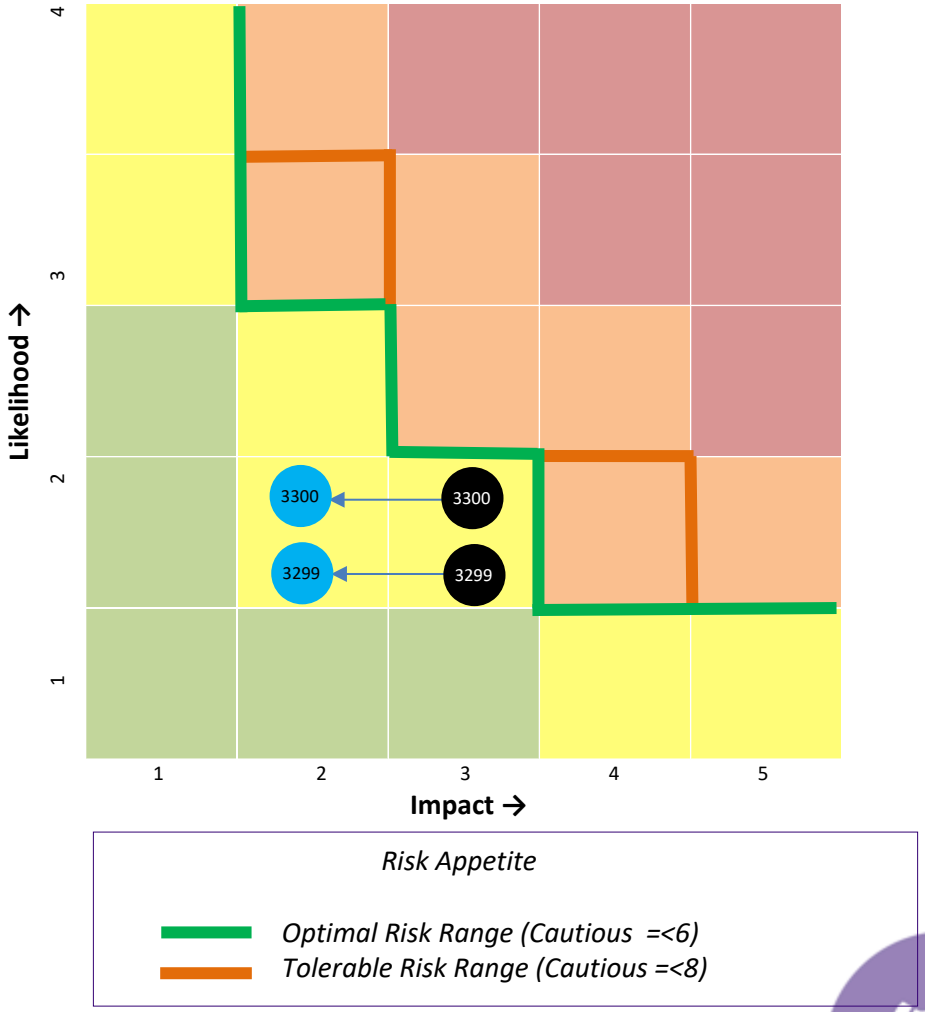
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

Monitoring: Board of Directors

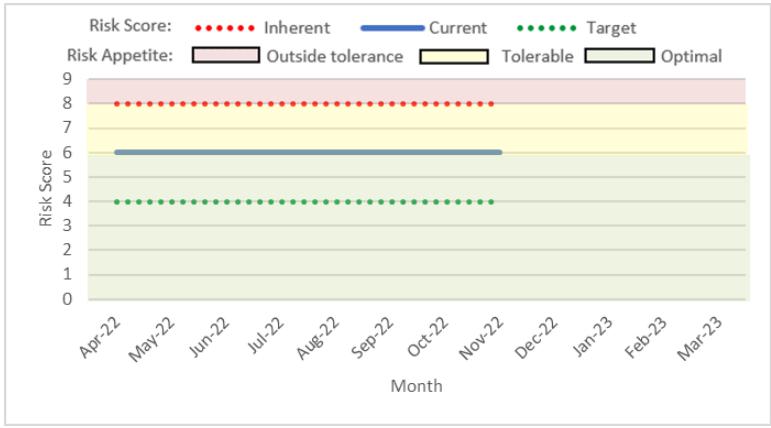
The following objectives are aligned to the **partnerships** strategic priority:

Ref.	Detailed objectives
CO14	We will develop our role as an anchor institution within the Borough through active participation in community wealth building groups with the aim of increasing the number of people employed who have a Wigan postcode and increasing the value of non-pay spend with local suppliers. **No risks currently identified.*
CO15	We will continue to develop effective relationships across the Wigan locality and wider Greater Manchester ICB to positively contribute and influence locality and ICB workplans, ensuring these align to our priorities and programmes of work and benefit WWL and the patients that we serve.
CO16	We will deliver all milestones and outcomes due within 2022/23 from our development and delivery plan for achieving the criteria required to become a University Teaching Hospital organisation in a maximum of four years' time.

The heat map below sets out the current risk score (black shading) and the target risk score (blue shading) for these risks:

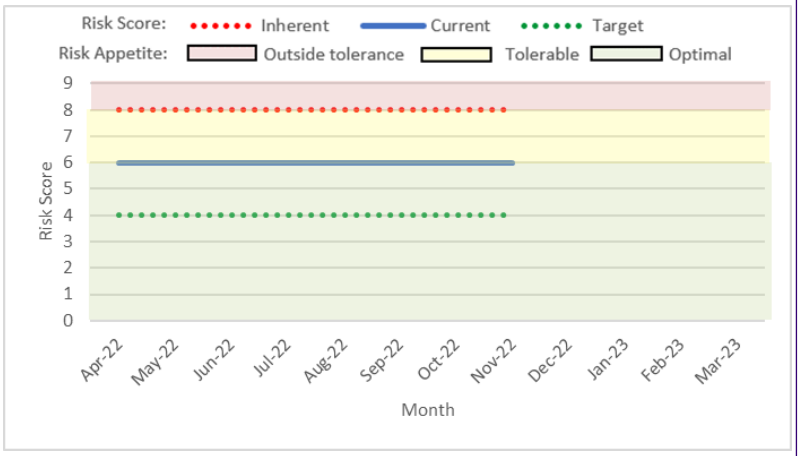


Corporate Objective: **CO15** Develop effective relationships within Wigan Borough and Greater Manchester for the benefit of our patients							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic	**Risk Title:**	**PR 15: Partnership working - CCG changes**						
	Risk Statement:	There is a risk that staff with local knowledge and understanding may be lost given the changes anticipated with CCGs.						
Lead Committee	**Board of Directors**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**DSP**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Strategy	
Date risk opened	**19.10.21**	**Impact**	2. Minor	2. Minor	2. Minor	**Linked risks**	-	
Date of last review	**22.09.22**	**Risk Rating**	8. High	6. Moderate	4. Moderate	**Risk treatment**	Treat	



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3300)**	• Locality meeting structures in place to support lasting corporate knowledge.	• No gaps currently identified.	**2nd Line:** • Board of Directors August 22	• No gaps currently identified.	1. No further actions currently identified.	

Corporate Objective: **CO16** Make progress towards becoming a University Teaching Hospital								**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 16: University Teaching Hospital - University Hospital Association criteria**							
	Risk Statement:	There is a risk that all the criteria that the University Hospital Association have specified may not be met, due to two key areas which we may find difficult to achieve, resulting in a potential obstacle towards our ambition to be a University Teaching Hospital.							
Lead Committee	**Board of Directors**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious		
Lead Director	**MD**	**Likelihood**	4. Possible	3. Likely	2. Unlikely	**Risk category**	Strategy		
Date risk opened	**19.10.21**	**Impact**	2. Minor	2. Minor	2. Minor	**Linked risks**	-		
Date of last review	**08.11.22**	**Risk Rating**	8. High	6. Moderate	4. Moderate	**Risk treatment**	Treat		



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3299)**	• Project documentation including action log in place.	•A core number of university principal investigators. There must be a minimum of twenty consultant staff with substantive contracts of employment with the university with a medical or dental school which provides a non-executive director to the Trust Board. These individuals must have an honorary contract with the Trust in question. •For Trusts in England, an average Research Capability Funding allocation of at least £200k average p.a. over the previous two years.	**2nd Line:** • Board of Directors • University Hospital Group – October 2022.	• No gaps currently identified.	1. The key actions for key principle investigators are for the Head of Research to provide a list of those we currently have and the research and HR teams are going to look at contractual options with a view to increasing the number of PIs that we have. 2. For RCF Funding of £200k – the Head of Research has advised that it will be 2024/2025 when we achieve the £200k average that is required. Regular updates will be provided on levels of funding and there is a plan in place to encourage increases in research participation at WWL.	MD January 2023 MD January 2023

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	WWL M7 Balanced Scorecard
Presented to:	Board of Directors
On:	7 December 2022
Presented by:	Director of Strategy & Planning
Prepared by:	Data, Analytics and Assurance Team
Contact details:	BI.Performance.Report@wwl.nhs.uk

The WWL Way

Executive summary

The current iteration of the Trust's New Balanced Scorecard is presented to the Board of Directors for the second time.

This version is not yet available to view at Divisional or Specialty levels, which will be available in a future release. The Scorecard remains mostly manually populated monthly and therefore not real-time, except for 3 Key Performance Indicators (KPIs) in the Performance quadrant which have been automated and refresh daily.

As the Data Warehouse (DW) continues to migrate to the cloud, KPIs will continue to be developed using the new DW and will replace the need to populate them manually.

The interactive version on the Balanced Scorecard is available and allows you to view trend, Statistical Process Control (SPC) and year on year comparison (where data available) charts for each KPI. This functionality will be refined over the next few months.

The Scorecard can be accessed via this link (when connected to the Trust's WiFi or VPN :
http://wwlqliksense3.xwwl.nhs.uk/sense/app/7a161be3-c0ae-4dbd-9746-5556f04c1369
Or
Via the Qlik Cloud (when accessing on a mobile devices or when off site) :
https://wwl.eu.qlikcloud.com/sense/app/7a161be3-c0ae-4dbd-9746-5556f04c1369

The DAA team can offer group or 1-1 sessions on the Scorecard and getting up and running if anyone has any problems or queries.

Finally, we would like to thank the Balanced Scorecard Project Board and ETM for their input and continued support to date.

Link to strategy
Patient
Partnership
Workforce
Site and Service

Risks associated with this report and proposed mitigations
There is some capital funding that has been allocated to the Data Warehouse Cloud migration project which should ultimately expediate our transition and therefore should positively impact on the Balance Scorecard project timescales.

Financial implications
None currently highlighted.

Legal implications
None identified.

People implications
None identified.

Wider implications

Recommendation(s)
The committee is recommended to receive the report, note the content, and provide feedback / advise of future requirements.

Report: M7 WWL Balanced Scorecard: October 2022

Quality & Safety (Chief Nurse & Medical Director)

ID	KPI Title	Period Covered	Total	Target	On Target	Trend
1	Never Events	Oct-22	0	0	●	▻
2	Number of Serious Incidents	Oct-22	4	0	●	▼
3	Sepsis - Screening and Antibiotic Treatment (IN DEV)	-	-	-		-
4	STEIS Reportable Category 3, 4 & Unstageable Pressure Ulcers	Oct-22	1	0	●	▻
5	STEIS Reportable Serious Falls	Oct-22	1	0	●	▻
7	Complaints Responses	Oct-22	50.00%	90%	●	▲
9	Patient Experience (FFT)	Oct-22	85.18%	TBC		▲
52	Methicillin-Resistant Staphylococcus Aureus (MRSA)	Oct-22	0	0	●	▻
53	Methicillin-Susceptible Staphylococcus Aureus (MSSA)	Oct-22	2	0	●	▲
54	Clostridium Difficile (CDT)	Oct-22	9	0	●	▼
78	SHMI Rolling 12 Months	Apr-22	114	100	●	▼

People (Chief People Officer)

ID	KPI Title	Period Covered	Total	Target	On Target	Trend
10	Vacancy rate	Oct-22	8.79%	5%	●	▼
13	Rate card adherence (Medical)	Oct-22	55.27%	80%	●	▲
14	Rostering timeliness	Oct-22	70.27%	75%	●	▲
15	% Turnover Rate	Oct-22	10.25%	10%	●	▼
16	Your Voice Score (QTR) - Engagement score	Jun-22	3.94	4	●	▼
18	Your Voice Score (QTR) - Well-being score	Jun-22	3.35	3.5	●	▼
19	Mandatory training compliance	Oct-22	92.15%	95%	●	▲
21	Sickness - %age time lost	Oct-22	6.56%	4%	●	▲
50	Usefulness of Trust wide communication	Apr-22	82.00%	70%	●	▼
51	Leaders Forum Reach	Oct-22	136	110	●	▲
62	Number of outputs per month (LF, ASTB, Executive Vlogs, CEO Vlog / Blog)	Oct-22	6	6	●	▼
63	FTSU contacts	Oct-22	9	n/a		-
64	Your Voice Score (QTR) - Psychological Safety	Jun-22	3.71	3.75	●	▼
65	Appraisal	Oct-22	79.13%	90%	●	▲
66	Empactis coverage (% of staff)	Oct-22	36.68%	50%	●	▻

Performance (Deputy Chief Executive)

ID	KPI Title	Period Covered	Total	Target	On Target	Trend
60	Ambulance handovers 60+ minutes delay	Oct-22	378	0	●	▲
59	Ambulance handovers under 30 minutes	Oct-22	59.57%	95%	●	▼
58	Ambulance handovers under 15 minutes	Oct-22	40.15%	65%	●	▼
32	Reduce 12-hour waits in EDs	Oct-22	15.61%	10%	●	▲
25	G&A Bed Occupancy - Acute Adult Inpatient Wards	Oct-22	98.62%	95%	●	▲
33	No Right to Reside Patients (excluding Discharges)	Oct-22	142	50	●	▻
75	Cancer Referrals - 115% of pre -covid averages	Oct-22	1,594	1310	●	▼
31	Cancer - waits longer than 62 days	Oct-22	91	87	●	▼
24	Patients waiting over 104+ weeks (except patient choice & clinically complex)	Oct-22	0	0	●	▼
42	Patients waiting over 78 weeks (except patient choice)	Oct-22	220	214	●	▼
28	Outpatient Utilisation (IN DEV)	-	-	-		-
68	Outpatient DNA Rates	Oct-22	10.10%	6%	●	▼
67	Virtual Outpatient Consultations	Oct-22	26.20%	25%	●	▼
23	Elective Theatre Utilisation	Oct-22	80.53%	85%	●	▲
41	Elective Recovery Plan	Oct-22	91.79%	100%	●	▲
76	Total Waiting List - RTT position	Oct-22	45,194	-	●	▼

Finance (Chief Finance Officer)

ID	KPI Title	Period Covered	Total	Target	On Target	Trend
34	Surplus / Deficit	Oct-22	-753	-726	●	▼
35	Capital Expenditure	Oct-22	467	1650	●	▼
36	Cash	Oct-22	30,717	33642	●	▲
39	Agency Expenditure	Oct-22	1,230	692	●	▲
47	Cost Improvement Programme (CIP)	Oct-22	1,608	1992	●	▼
48	Better Payment Practice Code (BPPC)	Oct-22	92.70%	95%	●	▲

M7 WWL Balanced Scorecard Commentary: October 22

Quality & Safety (Chief Nurse & Medical Director)

Latest Commentary - **Oct-22**

Patient Safety
1 falls incident was reported in October 2022. Early learning from this incident was that the falls risk assessments were not fully complete and could have identified further interventions to reduce the risk of fall.
1 serious pressure was also reported within this period from the District Nursing service. Early learning was that the patient could have been placed on an air mattress sooner and this could have reduced the risk of the ulcer deteriorating.
In total, 4 incidents were escalated to StEIS which is a reduction from last month.
The total number of incidents reported continues to increase, with a focus on no and low harm, therefore the number of StEIS reported incidents relative to this increase shows a decrease, contributing evidence that the Trust has a good safety culture.

Complaints
Whilst complaints responses has increased to 50%, it is recognised that further work is being done to improve this figure. It should be noted that there has been at least a 20% increase in the number of complaints received since last financial year and this figure is increasing every quarter. The increase can be seen to be attributed to the increase in attendances and waiting times. Clinical treatment, communication and patient care are the top three categories of complaints made. Values and behaviours training conducted by the complaints team continues and this is being streamlined to ensure that more staff can receive this training. In addition, investment within the complaints team will allow the PAL service to be more proactive within the Emergency Village and support frontline services in managing concerns at source rather than escalation to the formal complaints process.

People (Chief People Officer)

Latest Commentary - **Oct-22**

Wellbeing:
Cost of living group established now with representation from across divisions, people services and staff side. Schemes under development including increasing salary sacrifice limits, staff public transport season tickets, coat swap scheme, reduced cost meals and homework clubs. Wellness at Work Lounge activities include mindfulness taster sessions, reiki, spirituality and wellbeing sessions, menopause cafes.
Leadership & teams:
Establishment control data available in ESR by November, representing a more accurate vacancy picture for safe staffing and vacancy forecast purposes. Vacancy forecast will be used to project best and worse case scenarios, will support workforce efficiency savings, and the identification of local trends at divisional level.
Recruitment process improvements in place: electronic right to work check system to reduce time and improve applicant experience (October), shortened MS Teams application form used for domestic, catering and mass recruitment events, and for all honorary appointments.
Culture: New exit interview process has been in for 5 months and reporting themes have been produced to inform committee and divisional reporting. Stay conversation proposal under development; pulling together career development, wellbeing and support routes for staff, with the FTSU guardian the point of contact for a stay conversation. EDI session delivered for Heads of and Divisional Senior Leads providing staff stories around lived experience and introduction to Equality Impact Assessments. NSS - approx 20 days until survey closes. Trust response rate - 29%. Response rate for comparator Acute and Community Trusts are: highest - 58%, Lowest - 21%, average - 34%
Comms and visibility: Positive feedback at Leaders' Forum. 96% found September's ASTB extremely useful (64%) or very useful (32%). Use of Idea Boards continues to help encourage feedback/engagement - become a key mechanism in providing local insight, to support delivery of Trust objectives
Personal development:
Leadership Development and Talent: Health & Wellbeing Conversation training aimed at Wellbeing Champions and Leaders - sessions available across all sites. Talent Programme - engaging with key stakeholders across the trust to understand how we identify and develop talent across WWL to inform the development of the programme.
Learning Hub: Improvements to how Safeguarding training is tracked using inter-collegiate model of recording CPD. Review of locally mandated training for Doctors. Compliance - Nationally Mandated Training is 92.2%, and Locally Mandated Training is 85.4%

Performance (Deputy Chief Executive)

Latest Commentary - **Oct-22**

There were 4 patients waiting beyond 104 weeks at the end of October - 3 of these were patient choice and the other very clinically complex as agreed with the national team. A trajectory for 78 week clearance was submitted to GM in early October - plan for October was 214 patients and the actual position was 220. There remains a residual risk of approximately 95 gynae patients, although a mutual aid agreement is in progress with MFT, in exchange for WWL accepting ENT, Orthopaedic and Oral Surgery patients.

During October, 91.79% of the 22/23 elective recovery plan volume was delivered - it is not possible to translate this into income value due to the amount of uncoded activity, however the Apr-September value of income was 94% of the 19/20 baseline, against a target of 104%. Theatre utilisation increased to 80% against a model hospital target of 85%.

Cancer referrals remain above the planning assumption of 110-115% of 19/20 levels, although they reduced slightly between September and October. The conversion rate from cancer referrals to diagnosis reduced from 6% in 19/20 to 4.9% in 22/23 which suggests inappropriate 2ww referrals. The total number of patients on a cancer pathway beyond day 62 was 91 at the end of October, against a plan of 87 - however 62 day performance for confirmed cancer patients improved by 3% between September and October.

DNA rates remained at almost 10%, however text reminders were re-enabled on 7th November, with rollout to all specialties by w/c 21st November, therefore a significant improvement should be seen in December.

The overall RTT waiting list has plateaued since August, with a slight reduction of 132 patients last month to a total of 45,194.

Finance (Chief Finance Officer)

Latest Commentary - **Oct-22**

Surplus/Deficit
In month 7 (Oct 2022), the Trust has reported an actual deficit of £0.8m which is in line with plan. The year to date position is an actual deficit of £7.5m, which is £3.3m adverse to the planned deficit of £4.2m.
Capital Expenditure
Capital expenditure is £0.5m in month 7 which is £0.8m below plan. Year to date, capital spend is £4.1m which is £1.5m below the planned expenditure of £5.6m. Of which, £0.1m relates to internal CDEL backed capital spend and £1.4m relates to external PDC funded schemes pending formal funding approval.
Cash
The cash balance at the end of the period totalled £30.7m. Cash balances have decreased since March due to a timing delay of settlement of debtor and creditor invoices (including £11m capital relating to 2021/22) and financing the year to date deficit. There is also a timing difference associated with the additional funding for the pay award.
Agency Expenditure
Agency spend in month 7 is £1.2m, an increase of £0.2m from last month and £0.5m higher than the same month last year. The Trust is yet to see financial impact of some of the measures put in place to reduce temp spend, specifically in medical staffing. Year to date, Agency expenditure is £3.1m higher than this time last financial year (2022/23 £8.2m; 2021/22 £5.1m).
Cost Improvement Programme (CIP)
In month 7, CIP of £1.6m was transacted which is £0.4m away from the £2.0m plan. This is split £0.6m divisional CIP and £1.0m Corporate CIP. There is a reduction in divisional CIP compared to previous months. Year to date £10.0m has been transacted which is £4.0m adverse to £14.0m plan.
Better Payment Practice Code (BPPC)
BPPC in month is 92.7% compared to the target of 95%. Year to date, BPPC is 91.8% by volume and 93.5% by value. Performance has improved from previous months due to the work by SBS, financial services and procurement teams. This work is ongoing, and a training plan is under development to address the root causes.

Agenda item: [24]

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Monthly Trust Financial Report – Month 7 (October 2022)
Presented to:	Board of Directors
On:	07 December 2022
Presented by:	Kelly Knowles [Acting Chief Finance Officer]
Prepared by:	Senior Finance Team
Contact details:	E: Kelly.Knowles@wwl.nhs.uk

Executive summary

Description	Performance Target	Performance	Explanation
Revenue financial plan	Achieve the financial plan for 2022/23.	Amber	Year to date, the Trust is reporting an actual deficit of £7.5m against the planned deficit of £4.2m, creating an adverse variance of £3.3m. The Executive Team is committed to delivering the full year plan based on a deficit of £8.4m which is reflected within the forecast. However, this is increasingly challenging as we enter the second half of the year and the winter period. An Executive away day on 11th October 2022 agreed further mitigations and actions required to reduce the expenditure run rate. This includes a series of grip and control measures which will be managed though Trust Management Committee.
Activity	Achieve the elective activity plan for 2022/23.	Red	The month 7 activity data highlights that the Trust has not achieved the elective activity plan that was submitted to NHSE. There is a risk of a clawback of the elective recovery funding (ERF) to the financial position. NHSE have advised not to make a provision for a penalty at present.
Cash & liquidity	Effective cash management ensuring financial obligations can be met as they become due.	Green	Cash is £30.7m at the end of month 7 which is £2.9m below the plan. This is in line with our cash forecasting based on the current deficit and timing of capital creditors and the pay award.
Capital expenditure (CDEL)	Achieve CDEL for 2022/23.	Amber	Expenditure against total CDEL is £0.8m below plan in month 7 and £1.5m below plan year to date. A revised plan has been developed to mitigate risks to ensure delivery of the plan. The profile of the capital plan means there is a significant increase in expenditure planned for the remainder of quarter 3 and quarter 4.
Cost Improvement Programme (CIP)	Deliver a 5% efficiency in 2022/23 as per the mandate from the GM ICS.	Red	The year to date variance is adverse by £4.0m to the CIP target and this is one of the key drivers behind the Trust financial position and variance to plan.

Agency expenditure	To remain within the agency ceiling set by NHSE.	Red	Agency expenditure was £1.2m in month 7 and £8.2m year to date. WWL is currently £3.4m above the ceiling year to date. Agency expenditure is £3.1m (62%) higher year to date than for the same time last financial year.
COVID-19 expenditure	To reduce COVID-19 expenditure by 57% in line with the reduction in system funding.	Amber	COVID-19 expenditure was £0.4m in month which is £0.1m less than last month. The Trust has yet to see a significant reduction in COVID-19 expenditure to match the reduction in funding, which is a risk to the delivery of a key component of the Corporate CIP. During the October RAPID meetings, a full review of the COVID-19 forecast by division was undertaken for Surgery and E&F, with the remaining divisions to follow in November.
Business conduct	Comply with the Better Payments Practices Code (BPPC) of paying 95% of invoices within 30 days.	Amber	BPPC year to date is 91.8% by volume and 93.5% by value. Performance has improved from previous months due to the work by SBS, financial services and procurement teams. This work is ongoing, and a training plan is under development to address the root causes.
Financial Risk	Report the financial risks through the Board Assurance Framework.	Amber	There are multiple risks to delivery of the plan associated with operational pressures, CIP, workforce shortages, COVID-19 expenditure, and the elective recovery. These are reflected within the year to date variance to plan.

Link to strategy

This report provides information on the financial performance of the Trust, linking to the effectiveness element of the Trust strategy. The financial position of the Trust has a significant bearing on the overall Trust strategy.

Risks associated with this report and proposed mitigations

There remains significant risk in delivering the £8.4 million deficit given the year to date position. The Trust has a year to date deficit of £7.5m and is currently maintaining the forecast to deliver the full year deficit of £8.4m. However, this will require the bold actions identified by Divisions to be implemented with some pace.

The Executive Team have a strong commitment to achieve the plan and have identified a range of measures to support financial recovery. This includes renewed focus through the RAPID meetings, grip and control measures, mitigating actions and specific actions associated with the HfMA financial sustainability assessment. These are expected to take effect from month 8.

It is also worth noting that WWL agreed to a £2.0m system stretch for the final plan submission, to ensure GM submitted a balanced plan. This was based on additional income which has not materialised, and this is a contributing to the year to date deficit.

The cash balance has reduced by £23.4m since 31st March 2022 (from £54.1m to £30.7m at the end of October 2022). As it stands, the Trust has sufficient cash to service this planned deficit and the planned capital programme. However, that assumes that the full value of the efficiency programme is cash releasing and at present the expenditure run rate is not reducing.

There are underlying cost pressures, particularly within the clinical divisions of Medicine and Surgery, which continue to be complex and challenging to address. There continues to be a significant number of no right to reside patients within the Trust, which become increasing challenging over the winter period.

Financial implications

This report has no direct financial implications (it is reporting on the financial position).

Legal implications

There are no direct legal implications in this report.

People implications

There are no direct people implications in this report.

Wider implications

There are no wider implications in this report.

Recommendation(s)

The Finance and Performance Committee are asked to note the contents of this report.

Financial Performance

Key Messages

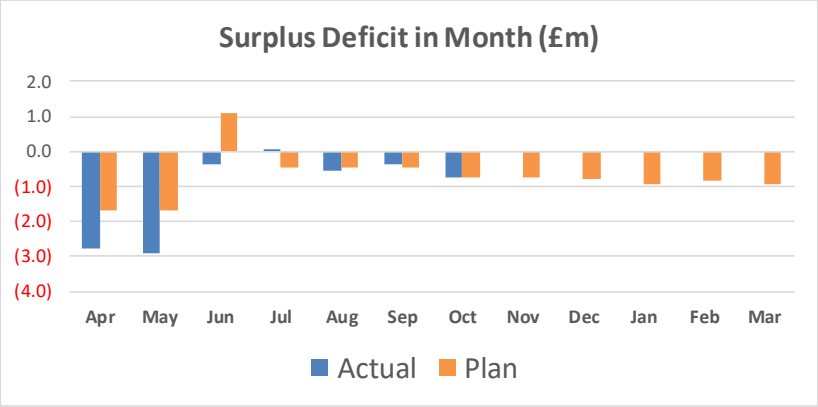
- The Trust has reported an actual deficit of £0.8m in month which is on plan.
- Year to date, the Trust has reported an actual deficit of £7.5m, which is £3.3m adverse to the planned deficit of £4.2m.
- The Trust is forecasting to deliver the full year planned deficit of £8.4m.

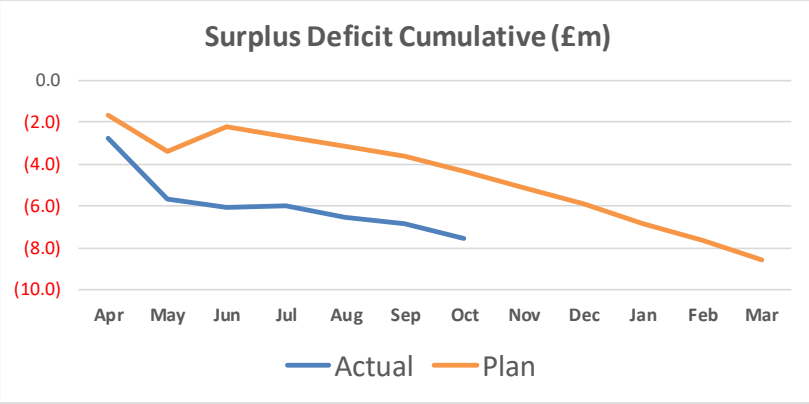
In month 7 (October 2022), the Trust has reported an actual deficit of £0.8m which is in line with plan. The year-to-date position is an actual deficit of £7.5m, which is £3.3m adverse to the planned deficit of £4.2m.

The Trust position includes pay award arrears of £6.4m (paid in September). The Trust is due to receive additional funding from the Greater Manchester Integrated Care System (GM ICS) to offset the impact of the pay award above the 2% assumed within the baseline. A further adjustment to contract income will be made from month 8 to reflect the reduction in employers' national insurance.

The GM ICS reported a year to date deficit of £93.4m at the end of quarter 2, which was an adverse variance of £74.6m to the planned deficit of £18.8m (see appendix 1). The Trust is collaborating with partners across the GM ICS to deliver a break even position across the system for the financial year.

The actual income reported in month was £40.5m which is £2.5m favourable to plan. Appendix 2 provides a breakdown of the income by source.





Key Financial Indicators

Key Financial Indicators	In Month (£000)			Year to Date (£000)			Full Year (£000)
	Actual	Plan	Var	Actual	Plan	Var	Plan
Financial Performance							
Income	40,506	38,052	2,454	278,664	266,578	12,086	457,108
Expenditure	(39,916)	(37,022)	(2,894)	(273,836)	(258,510)	(15,326)	(444,449)
Financing / Technical	(1,314)	(1,773)	459	(12,351)	(12,409)	58	(21,273)
Surplus / Deficit	(723)	(742)	19	(7,586)	(4,341)	(3,245)	(8,615)
Adjusted Financial Performance *	(753)	(726)	(27)	(7,488)	(4,228)	(3,260)	(8,426)
Other							
CIP	1,608	1,992	(384)	9,991	13,942	(3,951)	23,900
COVID-19 Expenditure	371	707	336	3,370	4,988	1,618	8,524
Agency Spend	1,230	311	(919)	8,212	2,177	(6,036)	3,731
Cash Balance	30,717	33,642	(2,925)	30,717	33,642	(2,925)	38,123
Capital Spend - CDEL	392	150	(242)	3,617	3,687	70	11,107
Capital Spend - PDC	75	400	325	459	1,900	1,441	11,843

* Surplus / Deficit less donated capital & grants & other technical adjustments

CIP

- £1.6m transacted in month 7 and £10.0m YTD.
- Split in month: Divisional £0.6m; Corporate CIP £1.0m (see appendix 3).

COVID Expenditure

- £0.4m expenditure in month (£0.1m less than month 6)
- £0.3m less than plan in month.
- Plan has been adjusted in month 7 for agreed divisional forecasts (Surgery and E&F).
- Plan to be adjusted once agreed for Medicine, Specialist Servces and Community (see appendix 4).

Agency

- Expenditure of £1.2m in month 7 and £8.2m YTD.
- Expenditure remains higher than last year (see appendix 5).

Cash

- £30.7m cash balance.
- £2.9m below plan due to timing issue of the pay award to staff and funding from GM ICS.
- Increase of £1.6m from month 6 (see appendix 6).

Capital

- £0.5m spend in month, £0.8m behind plan.
- £4.1m spend YTD, £1.5m behind plan.
- £1.4m of the variance is due to delay in PDC approval nationally, remaining £0.1m relates to delay in commencement of schemes (see appendix 7).

Divisional Performance

Medicine

- (£0.8m) adverse to plan in month
- Nursing including 1:1 (£0.3m)
- Medical staffing (£0.2m)
- Unachieved CIP (£0.2m)
- A&E escalation (£0.1m)

Surgery

- (£0.2m) adverse to plan in month
- Theatres bank and agency (£0.1m)
- Unachieved CIP (£0.1m)

Specialist Services

- On plan in month
- Orthopaedic hub £0.2m
- Private patient income on plan
- Drugs (£0.1m)
- Unachieved CIP (£0.1m)

Community

- (£0.1m) adverse to plan in month
- Nursing including temporary spend on CAU, Jean Hayes and district nursing (£0.2m)
- Other smaller variances £0.1m
- CIP on plan

Estates & Facilities

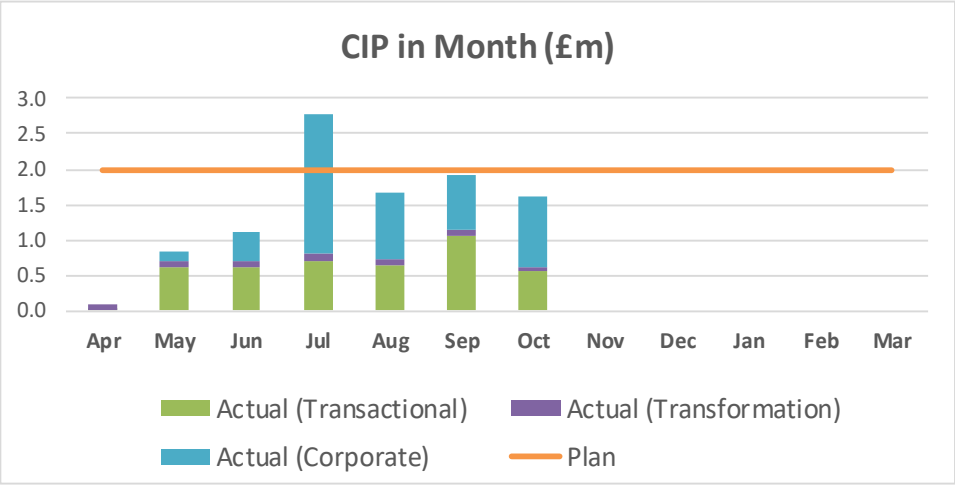
- £0.1m favourable to plan in month
- Community £0.2m
- Energy expenditure (£0.1m)
- CIP on plan

Corporate Divisions

- £0.4m favourable on aggregate
- Strategy and Planning £0.2m favourable due to Occupational Health income
- GTEC £0.2m favourable due to vacancies
- Other smaller variances £0.1m
- Unachieved CIP (£0.1m)

Contribution by Division can be seen in appendix 8, and the divisional RAPID metrics in appendix 8. All clinical Divisions (Medicine, Surgery, Specialist Services and Community) will be escalated to a RAPID meeting based on challenging financial and CIP position, with a focus on recurrent CIP delivery. Each Division will need to contribute to the financial recovery. The RAPID metrics are detailed in appendix 9.

Cost Improvement Programme



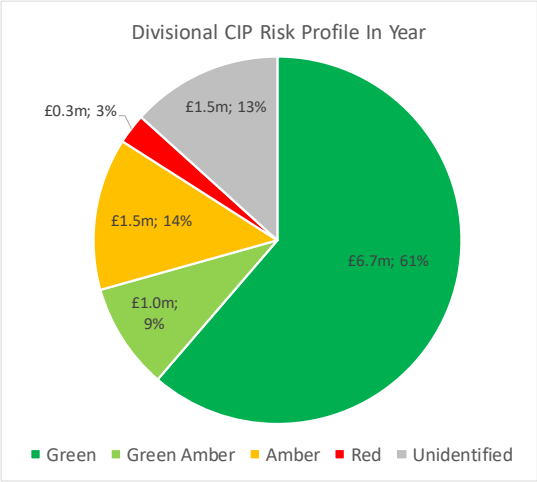
In month 7, £1.6m CIP was transacted which is £0.4m away from the £2.0m plan. This is split £0.6m divisional CIP and £1.0m Corporate CIP. There is a reduction in divisional CIP compared to previous months. Year to date £10.0m has been transacted which is £4.0m adverse to £14.0m plan.

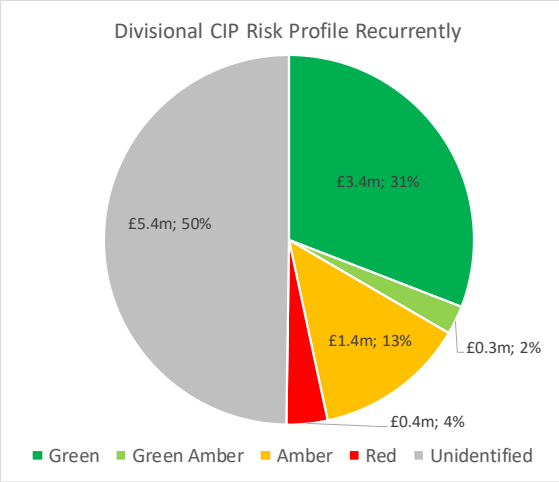
The divisional CIP transacted year to date can be split £4.2m for transactional and £0.5m transformational schemes. The transformational CIP relates predominantly to the clinical services collaboration scheme and private patient income for Trauma and Orthopaedics. A focus for Q3 will be to drive forward the Workforce Efficiency programme and ensure there is financial delivery. Further information on the divisional CIP delivery and forecasts can be found in appendix 2.

£5.3m of Corporate CIP has been transacted to date. As at month 7, the Trust is forecasted to deliver c.9.0m of corporate CIP non-recurrently in year, with the year-to-date position now reflecting this proportionately. This would leave a shortfall of £4.0m against the full year target of £13.0m.

The remainder of the corporate CIP was due to come from a reduction in COVID-19 expenditure, benefits realisation reviews and slippage on investments. A programme of benefits realisation is underway for the Finance and Performance Committee with the Bryn ward investment to be reviewed at the November meeting.

The forecast recurrent delivery is £5.5m which is a reduction of £0.8m from month 6. The recurrent forecast has deteriorated month on month since month 3, with schemes not progressing as originally planned. There is a greater risk profile associated with the recurrent delivery with 50% currently unidentified. This will be a key focus of the next RAPID meetings for the remainder of the financial year for all divisions.





Forward Look

The finance and strategy and planning teams have considered an outline approach to planning for 2023/24 which seeks to develop a 'baseline position' by the end of December 2022. Doing so will provide greater opportunity to focus on refining and improving our plans in quarter 4 of 2022/23, including making any necessary adjustments when the national planning requirements become known. It also seeks to align the development of both the NHSE operational planning submission and our own internal business plans which will encompass, but have a wider scope, than the NHSE planning submission.

The finance team are working with the Wigan locality team within GM ICB, Wigan Council and Greater Manchester Mental Health (GMMH) to develop a quarterly locality finance report. This will support local decision making and will have a particular focus on providing financial information to support the priorities of the Healthier Wigan Partnership (HWP).

As part of the drive for continual improvement, the finance team introduced a faster closedown of the month end position in month 6 (September 2022). Budget statements were issued on working day 3, bringing this forward by approximately 5 days. This will support clinical and operational colleagues to respond faster and make decisions in a timelier manner.

There are several upcoming opportunities to bid for national capital. The Trust will be expressing an interest for national endoscopy funding for 2023/24 and 2024/25 which would increase capacity and support the unit to achieve Joint Advisory Group (JAG) accreditation.

NHSE have introduced a protocol for changes to the year-end revenue forecast where the revised forecast shows a deterioration and an adverse variance to the full year plan. This will be applied for both providers and at a system level. Where this does occur, a recovery plan will be required, and additional conditions may be applied. This includes additional financial and other reporting requirements, a workforce review and system approval for any revenue investments above £50k.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	The themes identified by the Independent Investigation into East Kent Maternity Services.
Presented to:	Trust Board
On:	7 December 2022
Presented by:	Rabina Tindale Chief Nurse
Prepared by:	Cathy Stanford Divisional Director of Midwifery and Neonates
Contact details:	T: 01942 773107 E: Cathy.stanford@wwl.nhs.uk

Executive summary

The report by Dr Bill Kirkup into maternity services at East Kent Hospitals University NHS Foundation Trust (East Kent) published on 19 October 2022 revealed that substandard care, a dangerous culture and a failure by the Trust's management to act on warnings contributed to the deaths of at least 45 babies spanning an 11-year period.

The report includes a letter to the Secretary of State for Health and Social Care asking for action and highlighting what can no longer be denied: it states that; *"we can no longer treat these scandals as one-offs and we need a body that is able to identify poorly performing maternity units before they turn into another scandal".*

The report identifies four areas for action, which are described as:

The NHS could be much better:

- at identifying poorly performing units.
- at giving care with compassion and kindness.
- at teamworking with a common purpose.
- at responding to challenge with honesty.

HSIB in their review of the report conclude that:

Maternity and neonatal services nationwide must embark on a process of addressing the need for stronger, multi-disciplinary team-working, for open and honest disclosure and learning over concealment and deflection, and for compassionate care to form the bedrock of clinical practice. A suite of purposeful and timely outcome measures must be used by clinicians, regulators and the public in order to ensure that the findings of the Kirkup

Report, along with the plethora of sources which in recent years have clearly evidenced significant problems in maternity services, are implemented in a meaningful way. In this way, the vision of the Kirkup Report can be delivered through locally led and managed transformation, with support at national and regional levels, in order to ensure a higher quality of maternal and neonatal care for mothers and babies.

This paper sets out the key findings and recommendations made within the report and how WWL Maternity Services will respond to these findings and what plans are in place, however it should be noted that the 4 main recommendations within the report are not aimed specifically at Trust level as they are targeted at National Bodies, Royal Colleges and Training and Higher Education Institutions, and they will not be subject to easy analysis or a quick solution. Nevertheless, there is much we as a Maternity Service and Trust can do to ensure that Patient safety is paramount, and that the culture within our organisation is reflective of an open and honest service which learns from its mistakes and poor outcomes and is not defensive and remains inclusive to the families for whom we provide care to.

Link to strategy

Risks associated with this report and proposed mitigations
Failure to meet regulatory Requirements

Financial implications

Legal implications
Litigation following poor outcomes

People implications

Wider implications
Trust Reputation

Recommendation(s)
The Board are asked to review the report and consider how effective assurance mechanisms are at ‘reading the signals.’ within our own organisation and agree any actions they may need to take as a result of the East Kent Report.

Report

Reading the signals: Maternity and neonatal services in East Kent – the Report of the Investigation.

The themes identified by the Independent Investigation into East Kent Maternity Services.

The investigation examined East Kent Hospitals University NHS Foundation Trust's maternity services in two hospitals, The Queen Mother Hospital in Margate. and the William Harvey Hospital in Ashford, between 2009 and 2020

The report details that, over that period, the Trust provided clinical care that was:

- "suboptimal" and led to significant harm
- during this period, there were multiple missed opportunities that should have led to problems being acknowledged and tackled effectively
- Had care been given to the nationally recognised standards, the outcome could have been different in nearly half of the 202 cases assessed by the Investigation's panel.
- The outcome could have been different in 45 of the 65 baby deaths – more than two-thirds of cases.

The report acknowledges that it includes "minimum estimates" of the frequency of harm, with the panel having only worked with families who volunteered to be involved in the report

The themes identified are:

- **Failures in teamwork:** The report refers to "grossly flawed teamworking among and between midwifery and medical staff." and patients being conscious of unprofessional conduct or poor working relationships compromising their care.
- **Failures in professionalism:** the report refers to staff being disrespectful to women and disparaging about the capabilities of colleagues in front of women and families.
- **Failures of compassion:** Encountering a lack of kindness and compassion
- **Failure to listen** Not being listened to or consulted with directly affecting patient safety, as vital information was ignored.
- **Failures around investigations** stated in the report that there seems to have been a collective unwillingness to engage with families and a reluctance to invite them to contribute to investigations; some families were not even made aware that an investigation was taking place.
- **Failures when responding to investigations:** Feeling excluded during and immediately after a serious event. Parents reported feeling marginalised or disparaged after a serious event and being forced to live with an incomplete or inaccurate narrative.

In October 2022, all Trusts received a letter from NHS England advising Trust Boards to remain focused on delivering personalised and safe maternity and neonatal care, to ensure that the

experience of women, babies and families who use Maternity and Neonatal services are listened to, understood and responded to with respect, compassion and kindness.

Additionally, it requested that every board member examine the culture within their own organisation and how they listen and respond to staff and take steps to assure themselves and the communities that they serve that the leadership and culture across the organisation positively supports the care and experience we provide.

It is expected that every Trust and ICB review the findings of the report at its next public board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals.'

Recommendation 1

- The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use

Recommendation 2

- Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning
- Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance

Recommendation 3

- Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how teamworking in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset
- Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development

Recommendation 4

- The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies
- Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards

- NHS England (NHSE) reconsider its approach to poorly performing trusts, with particular reference to leadership

Reporting and escalation

Currently WWL Maternity and Neonatal Services have robust reporting mechanisms in place to provide assurance and oversight to the Board and Sub committees in regard to Perinatal Safety. The service adheres to the recommendations within the Maternity Incentive Scheme Safety Actions and Ockenden Immediate and Essential actions for reporting and escalation. The Monthly and Quarterly Perinatal Quality surveillance dashboard and quarterly report is to provide oversight and assurance to the Board that Maternity and Neonatal services are providing a safe and effective service to mothers and babies within our care. Any lessons learned from serious incidents are acted upon and that the relevant changes are made and sustained, the quarterly report also provides updates on progression towards The Maternity Incentive Scheme compliance and Ockenden recommendations. Several Dashboards for Maternity and Neonates are in use and updated monthly which outline activity and outcomes bench marked against local, regional and national metrics.

The Maternity Service at WWL have in place Obstetric, Midwifery and Neonatal Safety Champions and hold BI-Monthly safety Champions meetings attended by the Chief Nurse or Deputy and the Medical Director. Also, in attendance is the named Non-executive Director for Maternity and the Chair of the Maternity Voice Partnership(MVP).

Safety walkabouts are undertaken Bi-monthly by the NED who specifically asks staff do they have any safety concerns. Staff within maternity also have the normal channels to raise any concerns either through the safety champions, line managers or the freedom to speak up guardians. There have been no concerns raised during any of the walkabouts or through any other channel except for concerns raised in regard to staffing levels, which have in the last 2 years have not been up to full establishment with periods of extreme pressure due to vacancies and sickness.

Investigation and feedback.

Incident reporting and investigation within the service follows the normal Trust process, however there are additional regulations in place within Maternity and Neonatal services for the investigation and escalation of serious incidents.

Babies who fall under the Umbrella of “Each baby Counts ” criteria require referring to the Healthcare Safety Investigation Branch (HSIB) for independent review and investigation, and upon completion a further referral will be made to NHS Resolution’s Early Notification (EN) scheme which aims to provide a more rapid, caring response to families whose baby may have suffered severe harm. On completion of the HSIB safety investigation, where a case has progressed following referral for a potential severe brain injury, a copy of the final report is shared with NHS Resolution for them to commence their in-house specialist review.

All Maternal Deaths, Stillbirths and Neonatal Deaths are reported to MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries). Reports are published annually. The Perinatal Surveillance reports are customised for Trusts and contain additional information alongside the overarching national report.

WWL are fully compliant with The Perinatal Mortality Review Tool (PMRT) which was introduced to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales. The tool supports:

- Systematic, multidisciplinary, high-quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care.
- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process.
- A structured process of review, learning, reporting and actions to improve future care.

This approach is adopted for all maternity and neonatal investigations with parental involvement being sought from the onset of the investigation process

Multi-disciplinary Team working and Culture.

Multi-professional working plays a vital role in the provision of high-quality care for mothers and babies. This is recognised to be a key component in the delivery of safe maternity care. The importance of respectful team working which builds a supportive workplace culture is central to care provision for mothers and babies within the service.

Maternity has a defined programme of training additional to the Trust mandatory training which encompasses all aspects of obstetric emergencies with multi-professional skills and scenario-based drills. Additionally, there is a bespoke package for CTG interpretation and recognition of the abnormal CTG which can lead to fetal compromise.

The Saving Babies Lives Care Bundle V2 (SBL V2) also has training elements that each midwife a And obstetrician has to complete annually for recognition of fetal growth, smoking cessation and reduced fetal movements all of which are risk factors to stillbirth and fetal compromise.

WWL has been committed to improving patient safety, transparency, development of effective teams and improvement of services through quality improvement methodology. As such has implemented Human Factors Awareness Training and After Action Review Methodology across the organisation. The Maternity service has 4 staff who have completed the train the trainer course for Human Factors and they regularly undertake these sessions Trust wide. Additionally, a bespoke Human factors course is also offered to the maternity, Neonatal and Obstetric teams which has evaluated extremely well. Human Factors training focuses on behaviours, values, leadership, and

teamwork within the workplace. The sessions facilitate, communication and help to understand organisational culture and the importance of speaking up especially about safety concerns. Several staff have also attended the Courage Compassion Care and Connection Midwifery Leadership Development Programme and the aim is to facilitate as many staff as possible through the programme as places are available.

Midwives and Neonatal staff are also currently receiving Trauma informed Care sessions facilitated by the Safeguarding team which have provided valuable insight into how past experiences impact on patients care.

Maternity has for many years offered a Birth Afterthoughts service which facilitates a more in depth debrief for women following birth. This is now being offered in a more structured way with a clinic template that women are booked onto and the service is being rebranded as a Birth Choices, birth reflections service and is in the final stages of its development and implementation.

The Maternity Voices Partnership (MVP) is active within the Borough and supports the service by providing feedback and collaborative working to understand what service users want and need from

As a Maternity and Neonatal service, we are constantly reviewing and evaluating care and outcomes for mothers and babies, implementing improvement measure such as the Maternity and Neonatal Safety Improvement Programme (MatNeoSip) to improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high-quality healthcare experience for all women, babies and families across maternity and neonatal care settings in England.

This also contributes to the national ambition, set out in Better Births to reduce the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 50% by 2025.

WWL actively collaborate within the Greater Manchester and Eastern Cheshire Local Maternity and Neonatal System (LMNS) as members of the specific steering and service improvement groups. Evidence of compliance with National recommendations and initiatives is submitted and learning from incidents and adverse events is shared through the Regional Safety Improvement Groups (SIG) and Clinical Effectiveness Groups(CEG).

Maternity and Neonatal services actively support frontline staff to create the conditions for continuous improvement, inclusivity and to promote a positive safety culture where mutual respect for all disciplines is promoted and expected and where learning is shared both with staff and patients.

The service will continue to provide care in line with National recommendations and guidelines. Actions for improvements will be implemented and monitored and the service will engage with any

further recommendations as a result of the report whilst continuing to implement all off the Ockenden Immediate and Essential Actions (IEA's).

Appendix 1 Power Point presentation from Regional Maternity Team for further information

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	IPC Board Assurance Framework update. Version 1.11
Presented to:	WWL Board of Directors
On:	December 2022
Presented by:	[Rabina Tindale, Chief Nurse, Director IPC]
Prepared by:	[Julie O'Malley, Deputy Director of IPC], [Cheryl Osborne, Lead Nurse IPC]
Contact details:	T: 01942 773115 julie.omalley@wwl.nhs.uk

Executive summary

In line with guidance the IPC BAF is updated on a regular basis and required for presentation at Trust Board.

This report provides an update by exception of the IPC BAF new version 1.11 last updated November 2022. See appendix 1 for the full BAF update.

Gaps in Assurance and Mitigating Actions

.

- **Lack of an Infection Control Doctor:** Limited Microbiology provision continues within the Trust. This is noted within the Organisational Risk register and reviewed by the Risk Management Group.
- **The demand on the IPC workforce** has increased due to vacancies, sickness, the emergence of seasonal respiratory viruses. Support has been requested to secure funding for investment in the IPC Service. Risk assessments have been submitted for review.

The WWL Way

- **The IPC Audit Programme** continues to be modified in response to the COVID-19 virus and other seasonal respiratory viruses. The identification of other positive respiratory cases (Flu) within the Trust continues to impact on bed capacity and the response required by the IPC Team to deliver a full IPC audit programme.
  CDT cases are currently 46 against a threshold of 53 for the year. This is a significant increase compared to this time last year.
- **Within the Trust there is limited side room capacity** to consistently enable isolation as required for patients with confirmed or suspected infections, not limited to COVID-19. All identified COVID-19 positive in-patients are transferred to designated COVID-19 positive areas or isolation rooms. The IPC Team attend daily bed meetings and support bed managers with decision making, including during IPC On-call provision. A Datix is completed if unable to isolate a patient who should be – this includes those who have infections, those who are suspected to have an infection and patients who require protective isolation.
- **Limited capacity to segregate patients within ED without adaption of the environment.** Rapid PCR and Point of care/ LFD testing are available within ED. Point of care testing for other seasonal respiratory viruses is not in place. In December there is a plan to introduce 4 virus point of care testing kits that will enable decision making re safer patient placement.
- **Currently, the Trust are only cleaning prioritised areas within the non-clinical areas**. The 2nd wave of recruitment to undertake the cleaning and monitoring of non-clinical areas in 2022/23 has not been implemented due to the current financial position.
- **Mandatory IPC e-learning modules:** Trust compliance rates for November 2022 were 93% for Level 1 IPC, 84% for Level 2 IPC. This is an increase on October figures of level 2 training, level 1 remains static. Staff who are non-compliant, receive an email which is escalated to their managers to action the completion of the training.
- **Hand hygiene compliance** has increased across the organisation, increasing from 76% in audits undertaken in September to 83% in October.
- **Changes to the Emergency care delivery model:** include reverting back to pre-pandemic patient pathways. The previous requirement for separate resuscitation areas is no longer operational. The increased demands on the emergency floor and operational flow pressures have required areas within the existing footprint to be utilised in a different way and areas escalated to create capacity to meet patient safety. This has impacted on IPC mitigation measures in terms of our ability to segregate respiratory and non-respiratory viruses. Whilst Covid positive cases have not increased, we have seen in the month of November an increase in seasonal respiratory viruses such as Flu. Whilst we acknowledge that non segregation is a risk, patient safety and the timely treatment of life-threatening conditions out weighs the risk of transmission of infection.

Link to strategy

IPC is integral to WWL strategy with an increased focus from regional and national teams. Underpinning the delivery of the strategy to enable safe care and outcomes for patients, performing consistently to deliver efficient and effective care and improve the lives of our Wigan community, working together in Partnership across the Wigan Borough and Greater Manchester with our partner colleagues across health and social care.

Risks associated with this report and proposed mitigations
IPC risks are managed via the IPC Committee and the Corporate Risk Meeting.
Some IPC actions required may have adverse reactions in other areas of patient care e.g., insufficient isolation capacity and environmental cleanliness.

Financial implications
Some actions will require significant financial resource to implement fully e.g., Investment in IPC workforce, new cleaning standards and isolation capacity.

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., to address the current challenges associated with COVID-19 and other seasonal respiratory viruses on a background of a depleted team, the increasing IPC workload that continues to create additional ongoing pressure on the IPC team.

Wider implications:
IPC is fundamental to the way all staff work and requires a Trust-wide approach to comply with the requirements the Health and Social Care Act and CQC Regulatory action.

Recommendation(s)
The Board of Directors are requested to 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 infection.

Appendix 1: Infection Prevention and Control (IPC) Board Assurance Framework (BAF). Last updated November 2022:

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**
A respiratory plan incorporating respiratory seasonal viruses that includes: ▪ Point of care testing (POCT) methods for infectious patients known or suspected to have a respiratory infection to support patient triage/placement according to local needs, prevalence, and care services	POCT testing for COVID-19 is available in the emergency dept using the IDNOW machine. Patients displaying respiratory symptoms are tested to aid clinical diagnosis and patient management. POCT testing for seasonal respiratory viruses, is available for Paediatric pathways. Testing arrangements are in line with NHSE/ UKHSA Guidance published on 31.8.2022. Pause in asymptomatic patient and staff testing in line with current NHSE/ UKHSA guidance published on 31.8.2022.	POCT testing for other seasonal respiratory viruses is not currently in place in the emergency dept.	Patients displaying symptoms of respiratory viruses are isolated where possible Testing protocols for Flu and other seasonal respiratory viruses is carried out via the existing laboratory protocols. There is a plan in place to introduce 4 virus testing from December 2022.
▪ Segregation of patients depending on the infectious agent taking into account those most vulnerable to infection e.g., clinically immunocompromised	Patients known to be clinically immunocompromised are prioritised for side room allocation. Dedicated COVID-19 ward areas continue to be operational.	Limited options for segregation within the ED Department if the two resuscitation areas are consolidated into one area.	Options appraisal and support with approval for segregation/ ventilation within the ED Department.

	The Trust continues to experience an increased demand on bed capacity and isolation capacity.		
▪ A surge/ escalation plan to manage increasing patient/ staff infections	Winter Planning Meetings are operational within the Trust, surge/escalation plans for increasing patient/staff infections are discussed at this meeting.	Lack of isolation rooms across the Trust.	Risk assessment in place. Regular review of side room occupancy performed by IPCT as required.
▪ A multidisciplinary team approach is adopted with hospital leadership, operational teams**,** estates & facilities, IPC teams and clinical and non- clinical staff to assess and plan for creation of adequate isolation rooms/cohort units as part of the plan	Planning options are being considered by multi-disciplinary team for the patients receiving care in the resuscitation area of the ED department, with a focus on segregation of respiratory and non-respiratory patients and ventilation because of plans to consolidate two resuscitation areas into one area. External Ventilation specialist review and plans for resus area requirements undertaken, with further input requested. Peer review of Resus area requirements undertaken. Support requested from NHSE IPC Lead	High volume of patients requiring admission. The inability to create cohort areas in periods of high prevalence or new emerging infections. Unknown COVID-19 status of staff and patients (asymptomatic) may lead to increase in COVID-19 transmission if IPC Measures not optimal.	Patient placement/ isolation priority managed in collaboration with Operations Team, IPC Team, and Estates/ Facilities. Cohort areas are identified when required for patients positive with the same pathogen.
Organisational /employers risk assessments in the context of managing infectious agents are: ▪ Based on the measures as prioritised in the hierarchy of controls ▪ Applied in order and include elimination. substitution, engineering, administration and PPE/RPE	Measures consistent with the hierarchy of control are consistently reviewed in line with current UKHSA Guidance**.**	None	N/A

▪ Communicated to staff ▪ Further reassessed where there is a change or new risk identified e.g., changes to local prevalence	PPE/ RPE requirements in line with Trust Policies and SOPs and the National IPC Manual. The use of FFP3 masks by staff continues in COVID-19 positive areas. The NHS: National IPC Manual updated: September 2022 Reporting to the Trust Board, ETM and Chief Nurse. Input to and collaboration with operational flow and bed capacity with joint working between IPC, Bed Management and Operations Teams continues. Global/ IPC communications shared with all staff Wearing of face masks continues in all clinical/ patient facing areas, including corridors Mask fit Testing programme continues, with access available to staff to attend. Updates are provided to staff via Global communications. Changes in local prevalence of infection rates are closely monitored. Updates on National Guidance sought daily.		
▪ The completion of risk assessments has been approved through local governance procedures, for example Integrated Care Systems	Trust Risk Assessment tools approved through Trust Governance process	None	N/A

	Risk assessments completed by Ward Leaders/ Managers and Recruitment Team with support available from OH Team. Process for repeat/ update of risk assessments in line with UKHSA Guidance. DIPC presents to the Board through the performance report or specific agenda items. IPC Committee and Quality and Safety committee review quarterly IPC reports.		
▪ Risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with the infectious agents	Risk assessments in relation to infectious agents are carried out in conjunction with specialists in IPCT, Health & Safety, Microbiology, and specialists in Ventilation and water safety, in line with National Guidance.	None	N/A
▪ Ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons	This is adopted whenever possible and practicable in conjunction with IPC, Bed Management and Operations Teams. An IPC Team member attends the daily bed meetings to support appropriate patient placement.	Limited Isolation capacity. High volume of patients requiring admission. The inability to create cohort areas in periods of high prevalence or new emerging infections	Transfers of infectious patients between care areas are carried out based on clinical need and the requirement for Specialist care.
▪ Resources are in place to monitor and measure adherence to the NIPCM. This must include all care areas and all staff (permanent, flexible, agency and external contractors)	Ward and Service area visits, Walk Abouts and ASPIRE accreditation visits completed by the Senior Leadership Team, including DIPC and DDIPC, Senior Nurses and Governance to provide challenge and learning opportunities to	None	N/A

	support staff, compliance, and patient safety. The visits extend to include multiple areas of care, leadership, management, learning, staff wellbeing and development. IPC Team provide supportive visits to clinical/ practice areas in both hospital and community settings. Audits of practice include all staff members, including external contractors and staff who may be working from an agency or Bank. Feedback is given to individuals as required.		
▪ The application of IPC practices within the NIPCM is monitored e.g., 10 elements of SICPs	Trust IPC Mandatory training covers all elements of SICPs. IPC audits monitor compliance. Audit of the 10 elements of SICP's forms part of the IPC audits carried out as per schedule. Audits and action plans are provided to the clinical area with a requirement to complete a return for assurance. 1. Patient assessment for infection risk – patients are assessed on admission for signs and symptoms of infection. Patients known to be colonised with specific organisms i.e., MRSA, VRE, CPE have alerts visible on the HIS banner.	None	N/A

	2. Hand hygiene – Monthly audits in place in all clinical areas. 3. Respiratory and cough hygiene – signage available throughout Trust premises 4. Personal protective equipment (PPE) – Regular audits of practice carried out by IPCT. 5. Safe management of equipment 6. Safe management of environment 7. Safe management of blood and body fluids 8. Safe management of linen 9. Safe disposal of waste (including sharps) 10. Occupational safety & Exposure		
▪ The IPC Board Assurance Framework (BAF) is reviewed, and evidence of assessments are made available and discussed at Trust board level	The IPC BAF has been reviewed consistently to date. Reviewed with opportunity for discussion at Executive/ Board Meetings. Report presented by DIPC.	None	N/A
▪ The Trust Board has oversight of incidents/outbreaks and associated action plans	StEIS Concise Investigation Reports inclusive of Action Plans are reviewed at several Executive level and clinical meetings, Safety Committee, including external scrutiny. Quarterly Quality and Safety reports are submitted with opportunity for review at Executive meetings. Outbreak updates, email cascades include Trust Board members/ Senior Leadership Team.	None	N/A

	IPC activity reports through IPC Committee up to Quality and Safety and monthly Performance reporting to the Trust Board. Action plans and IPC Committee documentation are available for review and included in reports.		
▪ The Trust is not reliant on a single respirator mask type and ensures that a range of predominantly UK made FFP3 masks are available to users as required	Mask fit Testing programme continues, with access available to staff to attend. There are currently 5 makes and model of mask used by the Trust. 1. Drager 1730+ 2. Kolmi (Small & Medium) 3. GVS31000 4. 3M1863+ / 3M9330+ 5. Handanny	The make and model of mask used by individual staff is reliant on the mask fit test result, and whilst there are various FFP3 masks available not all are compatible for wearing by all staff. The Department of Health and Social Care (DHSC) PPE Portal continues to supply the Trust with FFP3 masks however, this is anticipated to cease in March 2023. All models of masks have been procured through the National NHS Buyers; however, the location of manufacture, whilst believed to be the UK in most cases, is	The Health and Safety Team are discussing any potential consequences of the DHSC PPE Portal withdrawal with Procurement and a plan is being drafted to ensure supplies of the masks staff are tested to remain available. Full Support, a former supplier of FFP3 masks to the Trust, with great mask fit test results pre-pandemic, also being approached to re-establish supply chain. A response from the National NHS Buyers is outstanding regarding the manufacturing

		to be confirmed by the buyers	location of each mask.

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 that: ▪ The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level	The Trust has implemented the NSHC this is evidenced by the appropriate auditing of the clinical areas.	None	N/A
▪ The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/room	All clinical areas have been assessed for the level of risk, and frequency of cleaning in line with the revised changes to the standards of Health care cleanliness. The Operations team, in collaboration with IPCT designate and communicate the functionality of in-patient areas and isolation rooms.	None	N/A
▪ Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment	Cleaning standards and frequencies are monitored by trained auditors in all clinical areas using an approved electronic system. Frequency of audit is dependent on risk. FR1 – Weekly FR2 – Monthly FR3/FR4 – Monthly and reported through IPC Group.	Non-clinical areas are not currently monitored in all areas. Priority is given to clinical areas.	Where an area consistently fails an audit on 3 occasions an efficacy training mechanism is put in place. Compliance issues relating to Nurse cleaning and Estates issues are escalated to the appropriate teams.

			The second wave of recruitment to undertake the cleaning and monitoring of non-clinical areas in 2022/23 has not been implemented due to the current financial pressures.
Enhanced/increased frequency of cleaning should be incorporated into environmental decontamination protocols for patients with suspected/known infections as per the NIPCM (Section 2.3) or local policy and staff are appropriately trained	Enhanced domestic and nursing cleaning is initiated on request of the IPCT for patients with known or suspected infections.	None	N/A
Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products	The Trust follows manufactures guidance and contact time for all cleaning and disinfectant cleaning solutions.	None	N/A
For patients with a suspected/known infectious agent the frequency of cleaning should be increased particularly in: ➢ Patient isolation rooms ➢ Cohort areas ➢ Donning & doffing areas – if applicable ➢ 'Frequently touched' surfaces e.g., door/toilet handles, chair handles, patient call bells, over bed tables and bed/ trolley rails ➢ Where there may be higher environmental contamination rates, including: ➢ Toilets/commodes particularly if patients have diarrhoea and/or vomiting	The Trust has an enhanced cleaning process in place for all wards and clinical areas incorporating Frequently Touched Surfaces (FTS) and toilets in addition to the standard daily clean. Enhanced cleans are instigated on request of the IPCT where there is an increased incidence of infection and during outbreaks. Nurse cleaning is also increased in isolation rooms and during outbreaks. This is reiterated in care pathways and checklists i.e., MRSA, c. difficile.	None	N/A
The responsibility of staff groups for cleaning/decontamination are clearly defined and all staff are aware of these as outlined in the National Standards of Healthcare Cleanliness	Domestic staff have defined responsibilities and duties which is	None	N/A

	outlined as part of their training package. Nurse/housekeeper cleaning schedules are in place in each clinical area. Ward/Dept. Leaders are responsible for monitoring the standards of cleanliness in their areas.		
A terminal clean of inpatient rooms is carried out: ➢ When the patient is no longer considered Infectious ➢ When vacated following discharge or transfer (This includes removal and disposal/or laundering of all curtains and bed screens) ➢ Following an AGP if clinical area/room is vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room)	The Domestic Response Team are responsible for the Terminal Infected Cleaning regime for all areas vacated by patients with known infections. Disposable curtains, where applicable are replaced as part of this process. HPV Decontamination Cleaning (Bioquell) process is also undertaken when applicable. Steam cleaning is also used as a methodical technique in decontamination and sanitisation. Responsibilities for the decontamination of equipment between use are clearly defined and communicated via Trust training packages. Cleanliness is monitored and audited by dedicated staff and IPCT. Staff are aware of specific downtime required following AGP.	None	N/A

▪ **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	All patient equipment is cleaned between use by clinical staff and follow Trust processes and SOP.	None	N/A
▪ Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment	The Trust has designated auditors who monitor the standard of cleanliness of the clinical environment in line with the NSHC. IPCT also audit cleanliness as part of the scheduled audit process.	None	N/A
▪ Ventilation systems should comply with HBN 03:01 and meet national recommendations for minimum are changes https://www.england.nhs.uk/publication/specialised-ventilationforhealthcare-buildings/ ▪ ▪ Ventilation assessment is carried out in conjunction with organisational estates teams and or specialist advice from the ventilation group and/ or the organisations, authorised engineer and plans are in place to improve/ mitigate inadequate ventilation systems wherever possible ▪ Where possible air is diluted by natural ventilation by opening windows and doors where appropriate	The latest version of HTM 03-01 is dated 2021 – WWL's ventilation systems designed and installed in late 2021 and into 2022 will generally be compliant with HTM 03-01 (2021) - any derogations will be clearly recorded. The earlier version of HTM 03-01 was dated 2007 - WWL's ventilation systems designed and installed post 2007 will generally be compliant with HTM 03-01 (2007) - any derogations should be clearly recorded. HTM 03-01 replaced HTM 2025 that guidance was first published in 1994 (reprinted in 1998) - WWL's ventilation systems designed and installed post 1994 will generally be compliant with HTM 2025.	There are some areas that have no mechanical ventilation and little or no natural ventilation – these are generally not patient areas and are small, such as storage or transit areas etc. RAEI Planned Investigation Unit (PIU) has neither mechanical ventilation or opening windows technical options have been investigated but can only be implemented	Many patient areas are not directly mechanically ventilated (especially RAEI Phase 2, RAEI Maternity and Outpatient Depts across many sites) and therefore accurate air changes cannot be dynamically measured. These areas were designed to be ventilated by natural ventilation (opening windows) – the NHS had subsequently introduced a 100mm maximum opening (falls from windows mitigation) – this

	Many clinical areas across WWL predate the current HTM and preceding HTM guidance documents and have not been upgraded since the original design / installation. "Critical" areas such as Theatres, Treatment Rooms, Cardiac Catheter Laboratories, ICU Isolation Rooms, PPVL Isolation Room etc are inspected and verified annually. That verification process checks that the ventilation system is operating correctly and determines the number of air changes. Those results are reported through the ventilation Working Group and to the Infection Prevention & Control Group. HTM 03-01 / HTM 2025 is generally used as the gauge for compliance purposes. Endoscopy at RAEI & Leigh have been included within a GM programme where "HEPA / UV-A air scrubbers" have been deployed and used to reduce "Fallow Time" between patients.	pending major maintenance funding (with associated major disruption to the unit). E&F Estates in conjunction with Microbiology and IP&C undertook an assessment of ventilation across WWL's acute sites during 2021. The ventilation Working Group and IP&C Committee were updated with the findings and actions.	obviously reduced the effectiveness of natural ventilation. Most in-patient areas have had their window openings increased to 200mm (with window bar safety mitigation in place) – most windows across RAEI now have 200mm opening windows.

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 processes are in place to ensure that: ▪ Arrangements for antimicrobial stewardship (AMS) are maintained and a formal lead for AMS is nominated	The Trust employs a nominated AMS Lead in pharmacy.	There is currently no Microbiologist/ Infection Control	Risk assessment is in place.

		Doctor in post to support AMS.	
▪ NICE Guideline NG15 https://www.nice.org.uk/guidance/ng15 is implemented - Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use	Trust Antimicrobial Prescribing Guidelines, and use of Microguide within the Organisation	None	N/A
▪ The use of antimicrobials is managed and monitored: ➢ To optimise patient outcomes ➢ To minimise inappropriate prescribing ➢ To ensure the principles of Start Smart, Then Focus https://www.gov.uk/government/publications/antimicrobialstewardship-start-smart-then-focus are followed	Daily checks of Therapeutic Drug Monitoring antibiotics, Thrice-weekly ICU antimicrobial reviews, quarterly work on AMS ward rounds Bi-annual Trust point prevalence audits, annual division-specific audits, quarterly AMS activity summaries, enrolment in relevant NICE CQUINs	Limited resources currently to provide regular scheduled teaching sessions and opportunities	Risk assessment in place due to the lack of an Infection control Doctor/Microbiology support.
▪ Contractual reporting requirements are adhered to, and boards continue to maintain oversight of key performance indicators for prescribing including: ➢ Total antimicrobial prescribing. ➢ Broad-spectrum prescribing. ➢ Intravenous route prescribing. ➢ adherence to AMS clinical and organisational audit standards set by NICE: https://www.nice.org.uk/guidance/ng15/resources	Use of Microguide within the Organisation, use of an on-call Microbiologist service, education provisions to healthcare staff, quarterly work on AMS ward rounds	None	N/A
▪ Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency and external contractors).	Limited resources currently to provide regular scheduled teaching sessions and opportunities	There is currently no Microbiologist/ Infection Control Doctor in post to support the IPC Nursing Service and lead on specific IPC Doctor role, i.e., IPC	Two IPC Risk Assessments currently subject to the review process: *Lack of Microbiology support to IPC Nursing Service* and *IPC Service unable to*

		Group (formerly Committee, Policy, Decontamination, Ventilation, antimicrobial stewardship role.	*deliver service due to lack of specialist staff*. Both awaiting review at Risk Management Group.

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 that: ▪ IPC advice/resources/information is available to support visitors, carers, escorts, and patients with good practices e.g., hand hygiene, respiratory etiquette, appropriate PPE use ▪ Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff, and visitors	In-patient/Departmental Visiting Policy updated September 2022 – maximum of two visitors at any one time. Trust external Intranet provides advice for visitors. Recorded message on Trust telephone system provides current advice for visitors, including not to visit if feeling unwell or displaying any respiratory symptoms. Facemasks & hand gel available at all entrances Waste disposal for facemasks available at all entrances.	None	N/A
▪ National principles on inpatient visiting and maternity/neonatal services will remain in place as an absolute minimum standard. National guidance on visiting patients in a care setting is implemented.	In-patient/Departmental Visiting Policy updated September 2022 – maximum of two visitors at any one time.	None	N/A

▪ Patients being accompanied in urgent and emergency care (UEC), outpatients or primary care services, should not be alone during their episode of care or treatment unless this is their choice	In-patient/Departmental Visiting Policy updated September 2022.	None	N/A
▪ Restrictive visiting may be considered by the incident management team during outbreaks within inpatient areas This is an organisational decision following a risk assessment and should be communicated to patients and relatives	Restrictions on visiting may be Implemented following multidisciplinary discussion at outbreak meetings as indicated in *In-patient/Departmental Visiting Policy* updated September 2022. Visitors are advised accordingly. Risk assessment in place. The utilisation of the Visiting decision tree is currently in place allowing visiting in exceptional circumstances.	None	N/A
▪ There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, respiratory hygiene, and cough etiquette. The use of facemasks/face coverings should be determined following a local risk assessment.	Hospital policy for continued use of facemasks in all clinical areas. Hand gel and masks available at all entrances. Masks available at all hospital entrances	Low compliance with mask wearing since the lifting of COVID restrictions nationally.	Options paper required for presentation to ETM to explore the reduction of the use of facemasks.
▪ If visitors are attending a care area to visit an infectious patient, they should be made aware of any infection risks and offered appropriate PPE	Mask wearing continues. Ward staff are advised by IPCT if visitors require additional PPE.	None	N/A
▪ Visitors, carers, escorts who are feeling unwell and/or who have symptoms of an infectious illness should not visit. Where the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting	Entry to wards is via swipe which restricts unauthorised access. Visible signage at entry points. Individual consideration and risk assessment by care area staff/ clinician Additional PPE provided when required	None	N/A

▪ Visitors, carers, escorts should not be present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian	Process in place with presence only following individual risk assessment on a specific patient basis: carer, child, guardian.	None	N/A
▪ Implementation of the supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted where required 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 Guidance will be reviewed where required if COVID-19 cases start to rise or a new strain emerges.	None	N/A

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 that: ▪ All patients are risk assessed, if possible, for signs and symptoms of infection prior to treatment or as soon as possible after admission, to ensure appropriate placement and actions are taken to mitigate identified infection risks (to staff and other patients)	Patients attending the emergency department are triaged on arrival for signs and symptoms of infection. Screening questions are in operation during triage for patients who may be at high risk of CPE. Patients displaying respiratory symptoms are assessed and point of care testing is in place for COVID-19. Testing for other respiratory viruses is performed where required. Patients with respiratory symptoms are encouraged to wear a Fluid resistant surgical mask where tolerated.	Limited capacity to segregate within ED. IPC, Estates, Operations and ED Teams are collaborating to identify options to enable segregation/ Respiratory/ Non-Respiratory Pathways. Lack of isolation facilities at RAEI.	Options to be presented and discussed at ETM for approval.

	Patients who are known to be previously colonised with an alert organism such as MRSA/CPE/c.diff have an alert on the HIS banner.		
▪ Signage is displayed prior to and on entry to all health and care settings instructing patients with symptoms of infection to inform receiving reception staff, immediately on their arrival (see NIPCM)	Posters requesting patients to inform staff of any respiratory symptoms are in place at entrances to key areas such as A&E and urgent treatment areas, out-patient departments. Patients are subject to screening questions and triaged in A&E.	None	N/A
▪ The infection status of the patient is communicated prior to transfer to the receiving organisation, department or transferring services ensuring correct management /placement	The hospital Information system displays alerts on the banner for patients known to be colonised with alert organisms such as MRSA, CPE, VRE, CDT. External website has clear information and advice. Signage is available at all entry points Suspected/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.	None	N/A

	Patients are swabbed for COVID-19, 48 hours before discharge to nursing or care home.		
▪ Triaging of patients for infectious illnesses is undertaken by clinical staff based on the patients' symptoms/clinical assessment and previous contact with infectious individuals, the patient is placed /isolated or cohorted accordingly whilst awaiting test results. This should be carried out as soon as possible following admission and a facemask worn by the patient where appropriate and tolerated.	Emergency patients are triaged for infectious illnesses, history of any known travel or contact with infectious individuals forms part of the initial assessment of the patient. Care home outbreaks are communicated daily by Local public health teams and communicate to the Operations team and Emergency floor staff. FRSM are offered to patients where required.	Limited capacity to segregate within ED. IPC, Estates, Operations and ED Teams are collaborating to identify options to enable segregation/ Respiratory/ Non-Respiratory Pathways.	Options to be presented and discussed at ETM for approval.
▪ Patients in multiple occupancy rooms with suspected or confirmed respiratory infections are provided with a surgical facemask (Type II or Type IIR) if this can be tolerated	FRSM are offered to patients when required following risk assessment. Advice provided by IPCT as required.	None	N/A

▪ Patients with a suspected respiratory infection are assessed in a separate area, ideally a single room, and away from other patients pending their test result and a facemask worn by the patient where appropriate and tolerated (unless in a single room/isolation suite) ▪ Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting test results and a facemask worn by the patient where appropriate and tolerated only required if single room accommodation is not available	Patients are assessed at triage and segregated appropriate to pathway and designated ward area. Patients are asked to wear a mask unless clinically impossible or medically exempt. Identified high risk/ symptomatic patients are prioritised for side rooms. Included in SOP with mitigation. Datix reporting for lack of isolation capacity. An IPC Lead nurse attends daily bed meetings and are available on call to support patient placement decisions.	Lack of isolation capacity in the Trust with competing priorities for isolation.	**See section 7**
▪ Patients at risk of severe outcomes of infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room protective isolation	High risk patients are prioritised for side rooms. Included in SOP with mitigation if no capacity. Datix reporting for lack of isolation capacity. An IPC Lead nurse attends daily bed meetings and are available on call to support patient placement decisions	As above	**See section 7**
▪ If a patient presents with signs of infection where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes	Clinical assessment required to inform decision making. Virtual consultation option to be considered.		

▪ The use of facemasks/face covering should be determined following a local risk assessment	FRSM are required by all staff, to be worn Universally within all clinical areas in Trust settings in line with current UKHSA guidance. RPE/ FFP3 masks are required in high-risk areas/ whilst undertaking AGPs and if indicated during respiratory outbreaks/ bay closures. FRSMs are available in all clinical areas and at all entrances. Visitors are requested to wear masks as they enter the hospital. Outpatients and visitors are requested to always wear, unless exempt. IPC SOPs includes information on mask wearing.	Compliance with mask wearing has reduced amongst staff and visitors since COVID-19 measures have been removed for the General public.	Options paper to be submitted to ETM for mask wearing during low prevalence of infections.
▪ Patients that attend for routine appointments who display symptoms of infection are managed appropriately, sensitively, and according to local policy	Patients attending routine appointments are advised not to attend if they are displaying signs and symptoms of infection. Patients found to have symptoms following triage are advised accordingly.	None	N/A
▪ Staff and patients are encouraged to take up appropriate vaccinations to prevent developing infection	Invitations for seasonal vaccinations (Flu, COVID-19) have been sent to all staff as part of the annual vaccination programme.	Staff compliance with Vaccination programme	
Two or more infection cases linked in time, place and person trigger an incident/outbreak investigation and are reported via reporting structures	Outbreaks are identified and monitored by the IPCT. Outbreaks	None	N/A

	are reported via the NHS Outbreak APP. Daily outbreak meetings are instigated, IPCT co-ordinate bay/ward closures and actions to manage the outbreak.		

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 that: ▪ IPC education is provided in line with national guidance/recommendations for all staff commensurate with their duties ▪ Training in IPC measures is provided to all staff, including: the correct use of PPE	IPC education is mandatory for all staff via the Trust e-learning portal. Content of the training package is in line with NIPCM which includes the appropriate use of PPE for standard and transmission-based precautions and appropriate use of respiratory protection as required. IPC Level 1: Compliance reporting: August 2022: 91%, September 2022:91% IPC Level 2: Compliance reporting: August 2022: 80%, September 2022: 82% IPC Team target support to ward areas during outbreaks and periods of increased incidence of COVID-19.	Staff access to training. Face to face sessions limited due to the COVID-19 pandemic.	Face to face sessions to resume where possible. Practical sessions to resume including during clinical induction/Cavendish sessions to focus on key areas of IPC and SICP's.
▪ All staff providing patient care and working within the clinical environment are trained in hand hygiene technique as per the NIPCM and the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it (NIPCM)	Hand hygiene technique posters are displayed at all clinical hand wash basins. IPCT provide support for staff with hand hygiene training and the use of the light box to highlight areas frequently missed.	Limited capacity of the IPC Team in response to COVID-19, additional IPC priorities against a background of staffing vacancies, annual leave, and	Communication and reminders to staff for training completion. Discussion with Finance/ Budget Lead to progress recruitment to Band

	Sessions on hand hygiene technique provided to Link workers. Donning and doffing of PPE is included in Mandatory e-learning Practical assessments have been provided throughout the COVID-19 pandemic. Refresher sessions are provided in key areas if emerging infections are identified.	sickness within the Team.	5/6 and Band 3 roles (within budget limits) to enable succession planning for the IPC Team. Review of IPC Structure and work programme.
▪ Adherence to NIPCM, on the use of PPE is regularly monitored with actions in place to mitigate any identified risk ▪ Gloves and aprons are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's ▪ Hand hygiene is performed: ➢ Before touching a patient ➢ Before clean or aseptic procedures ➢ After body fluid exposure risk ➢ After touching a patient; and ➢ After touching a patient's immediate surroundings	Compliance with correct technique reviewed, observed, and audited by the IPC Team during ward visits. Spot audits are undertaken by IPC Team and ward leaders. Responsive audits are undertaken during episodes of Outbreaks, Bay closures and episodes of C. *difficile* infection. PPE audit results are reported to IPCG, reviewed with action plans as indicated. Audit results are included within quarterly report to Quality and Safety Committee WHO 5 moments for hand hygiene posters are provided for all clinical areas. Auditing is carried out using this as a guide	PPE compliance is below expected standard in some ward areas. Hand Hygiene compliance is below expected standard in some areas.	A refocus on IPC Compliance with "Back to Basics" approach will be adopted to support improved compliance and ownership. Steering Group for the Gloves Off Campaign commenced meeting preparing for delivery of the campaign. Baseline data gathering in progress in preparation for improvement initiative.
▪ 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	Hand dryers are not in use in clinical areas.	None	N/A

is located close to the sink but beyond the risk of splash contamination (NIPCM)	Disposable hand towel dispensers in use in all areas.		
▪ Staff understand the requirements for uniform laundering where this is not provided for onsite	The laundering of staff uniforms is covered in the Mandatory e-learning package and the Trust Uniform policy.	None	N/A

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: ▪ That clear advice is provided; and the compliance of facemask wearing for patients with respiratory viruses is monitored (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs	Advice and guidance is provided to in-patients with respiratory viruses within the Trust with mask wearing, providing they can be tolerated and not detrimental to their (physical or mental) care needs.	None	N/A
▪ Patients who are known or suspected to be positive with an infectious agent where their treatment cannot be deferred, care is provided following the NIPCM	For patients with a known or suspected infection whose treatment cannot be deferred, advice is provided for by the IPCT and Microbiologist and an appropriate plan is put in place to minimise the risk of transmission.	None	N/A
▪ Patients are appropriately placed i.e., infectious patients are ideally placed in a single isolation room. If a single/isolation room is not available, cohort patients with confirmed respiratory infection with other patients confirmed to have the same infectious agent	Patients with infections are prioritised for side rooms. Patients with confirmed COVID-19 are cohorted in dedicated wards/bays as appropriate. IPCT and Operations team, work in collaboration to prioritise isolation rooms.	Lack of side room capacity to consistently isolate patients as required.	There is a risk assessment in place due to the lack of side room capacity. IPC attend bed meetings daily to support patient placement decisions. A DATIX is completed by staff when

	Patient flow pathways were developed by the Microbiologist and shared within Divisions/ Clinical colleagues. Patients continue to be appropriately placed if confirmed COVID-19 positive, transferred to COVID-19 ward. Collaboration between IPC Team, Operations Team, Bed Managers, and ward staff to inform patient placement. Patients tracked through the Bed management team, the number of transfers and outbreak occurrences to minimise risk. This is monitored and supported by IPC Designated side room capacity is utilised as available for incidence of infections, informed by risk assessment. This applies to clinical need, irrespective of infection as capacity allows and in collaboration with IPC and Bed management Teams.		patients are unable to be isolated. And mitigating measures put in place to maintain safety.

▪ Standard infection control precautions (SIPC's) are applied for all, patients, at all times in all care settings ▪ Transmission Based Precautions (TBP) may be required when caring for patients with known / suspected infection or colonization	Standard IPC measures as per UKHSA/NHSE guidelines are in place in all care settings, training is provided via the Mandatory e-learning package. Training is provided for appropriate use of PPE for patients with known infections. Posters are in place outside isolation rooms/cohort bays, displaying the level of PPE required.	Compliance with SICP's is below standard in some areas.	**See section 6**

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: ▪ Laboratory testing for infectious illnesses is undertaken by competent and trained individuals ▪ Patient testing for infectious agents is undertaken promptly and in line with national guidance	The Laboratories used are UKAS accredited. Testing is performed in line with national guidance. It is provided by Northern Care Alliance; monitoring of compliance is through contractual discussions (PAWS). Trust guidance is in line with national guidance on testing for suspected COVID-19 cases and for other infections.	None	N/A
▪ Staff testing protocols are in place for the required health checks, immunisations, and clearance	Staff are assessed by Occupational Health appointment to the Trust for immunisation status/health checks.	None	N/A

▪ There is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available	Testing is provided through central laboratories at Northern Care alliance. Turnaround times are monitored by this service.	None	N/A
▪ Inpatients who go on to develop symptoms of infection after admission are tested/retested at the point symptoms arise	Patients displaying signs and symptoms of infection are assessed by clinical teams and investigated as appropriate. Microbiology support is available 24 hours a day if required. Hospital acquired infections are subject to an internal review process where any deficiencies in care are highlighted, action plans developed and any learning is shared where required.	None	N/A
COVID-19 Specific ▪ Patients discharged to a care home are tested for SARS-CoV-2, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge. Coronavirus (COVID-19) testing for adult social care services - GOV.UK (www.gov.uk) ▪ For testing protocols please refer to: COVID-19: testing during periods of low prevalence - GOV.UK (www.gov.uk) C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	National guidance is followed for testing patients prior to discharge to care homes. Patients and staff are only tested for COVID-19 if symptomatic in line with National guidance 31.08.2022.	Increased length of stay for patients who are asymptomatic but identified as COVID positive prior to discharge.	

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure that: ▪ Resources are in place to implement, measure and monitor adherence to good IPC and AMS practice. This must include all care areas and all staff (permanent, flexible, agency and external contractors) ▪ Staff are supported in adhering to all IPC and AMS policies	Regular audits of practice are undertaken by ward teams and IPC. This includes assessment of all external visitors to the Trust. Individual feedback and support is provided where required. IPCT provide regular ward visits to monitor and support staff in adhering to IPC practice Dedicated ward pharmacists monitor the use of Antimicrobials and advise accordingly.	Compliance with SICP's is below standard in some areas.	**See section 6**
▪ Policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak	Trust policies and SOPs are available via the intranet. Surveillance by IPC Team identifies positive results, increased incidence, and identification of outbreaks in line with the recognised definition. Outbreaks are managed by the IPC Team in collaboration with Microbiology, ward staff teams, Operations, bed managers. Robust documentation of outbreaks is completed and informs reporting of outbreaks as incidents and completion of StEIS investigation. These are reviewed through Trust review and CCG systems/ National reporting systems.	None	N/A

▪ All clinical waste and infectious linen/ laundry used in the care of known or suspected infectious patients is handled, stored, and managed in accordance with current national guidance as per NIPCM	The procedure for handling infected clinical waste and linen is clearly defined in the Trust Standard Precautions and waste management SOP's. This is also reiterated in the Trust Mandatory IPC training. Advice is sought where necessary from waste management and IPCT for higher risk waste and management.	None	N/A
▪ PPE stock is appropriately stored and accessible to staff when required as per NIPCM	PPE is distributed to the wards daily. The main PPE store is on the RAEI site and is accessible 24/7. Opening times are highlighted in Trust communications. PPE stores also at Leigh and Wrightington. In Community settings, 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
Systems and processes are in place to ensure that: ▪ Staff seek advice when required from their occupational health department/ IPCT/ GP or employer as per their local policy ▪ Bank, flexible, agency, and locum staff follow the same deployment advice as permanent staff	Service level agreements (SLA) in place with external organisations and the Trust to provide an Occupational Health (OH) service and advice for staff. Occupational Health Policies as per organisation. Dedicated OH/IPC email/ inbox for staff to contact OH/IPC Services.	None	N/A

	A system of access and response available to all staff, operated by the OH staff team Pre-employment/ Recruitment on-boarding available for the lifetime of employment within the Trust.		
▪ Staff understand and are adequately trained in safe systems of working commensurate with their duties	Staff are required to undertake Trust Mandatory training and familiarise themselves with policies and SOP's relevant to their area of work.	None	N/A
▪ A fit testing programme is in place for those who may need to wear respiratory protection.	Fit testing programme is established and operational.	None	N/A
▪ Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: ➢ Lead on the implementation of systems to monitor for illness and absence ➢ **F**acilitate access of staff to treatment where necessary and implement a vaccination programme for the healthcare workforce as per public health advice ➢ Lead on the implementation of systems to monitor staff illness, absence, and vaccination ➢ Encourage staff vaccine uptake	Staff sickness/ COVID-19 absence monitoring within the Trust, Ward Leaders, Human Resources (HR). Data reported through Trust systems/ E-roster. Data systems: Diagnostic codes, statistics, and analysis support reporting (HR and Business intelligence). Staff sickness/ absence data and impact reported via Trust Senior Teams. Outbreak reporting/ IPC Teams. Access to antiviral treatment where required via general medical services/ routes (in-patients and Community). Signposting by OH Team. Staff self-refer to OH Service and access is available to support. Managers/ Ward Leaders refer staff to OH Services. Pre-employment/ Recruitment on-boarding	None	N/A

	available for the lifetime of employment within the Trust. Trust local Induction provides information of access routes to OH Services and services available, available to all staff inclusive of nursing, medical, ancillary, estates/ facilities, bank, agency, and locum staff. Staff Handbooks available to all staff; Matrons and Ward Leaders handbooks. Dedicated Trust Vaccination Team provides vaccination for all Trust staff including: COVID-19 and Influenza. Vaccination available to all staff across the Trust, Including, Agency and Bank. Opportunistic vaccination by OH Team. Vaccination uptake rates monitored within the Trust: Human Resources (HR) and reported via IPCC/ Board and IPC BAF, quarterly Q+S reporting and regional reporting. OH Doctor provides dedicated input to vaccination across the Trust. Mutual support by OH Team to support COVID-19/Flu vaccination across the Borough Regular internal/ global communications are emailed to all staff (minimum weekly, with increased frequency if indicated). Additional: Blogs, radio, Chief Exec Briefs and Blogs, Posters and constant reinforcement encouraging vaccination.		

▪ Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in NIPCM	Trust SOP'S and Policies. Audit and monitoring of IPC Measures in line with national guidance. Ward leaders support compliance with IPC Measures, SOP's, and Policies. Support available from IPC and OH Teams. National information provided at vaccination.	None	N/A
▪ A risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza or severe illness from COVID-19. ➢ A discussion is had with employees who are in the at -risk groups, including those who are pregnant and specific ethnic minority groups ➢ That advice is available to all health and social care staff, including specific advice to those at risk from complications ➢ Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff ➢ A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff	Risk assessments completed by Ward Leaders/ Managers and Recruitment Team with support available from OH Team. Process for repeat/ update of risk assessments in line with UKHSA Guidance. Risk assessments are completed for all staff including Bank, Agency and Locum staff across the Trust and all organisations within the Borough. Input to process from OH, IPC, HR Teams, and Ward Managers/ Leaders. Records of the outcomes from the self-declaration forms are logged and maintained within HR	**None**	**N/A**
▪ Testing policies are in place locally as advised by occupational health/public health	Testing policies are in place when required for specific infectious organisms. National guidance followed.	None	N/A
▪ NHS staff should follow current guidance for testing protocols: C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	Flowsheet in place in line with National guidance for staff who develop symptoms of covid.	None	N/A

Staff required to wear fit tested FFP3 respirators undergo training that is compliant with HSE guidance, and a record of this training is maintained by the staff member and held centrally/ ESR records	Face fit testing is available across all acute sites and in the community and is co-ordinated by the Health and Safety (H+S) Team. An RPE SOP has been developed and shared with all Testers. For staff who cannot wear a close fitting FFP3 mask e.g., due to facial hair. A limited number of air powered hoods are available and issued to Wards and Departments with instructions for use.	None	N/A
▪ Staff who carry out fit test training are trained and competent to do so	All mask fit testers have been trained in line with National legislation. External contractor provides accredited Fit to Fit tester training to the Trust Face fit testers who then fit test WWLFT employees. Database of Face Fit Testers maintained by H+S Team. Refresher training required every 2 years.	None	N/A
▪ Fit testing is repeated each time a different FFP3 model is used	Staff are instructed to be face fit tested for the mask they are using/have access to.	None	N/A
▪ All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	Face fit testing sessions continue with a plan in progress to achieve fit test to three models in high-risk areas and two models in all other areas for staff	None	N/A

▪ Those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators or an alternative is offered such as a powered hood ▪ That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions	Process in place: Individuals have two attempts on six models. If all failed, the individual is trained in the use of a powered hood. For staff who cannot wear a close fitting FFP3 mask e.g., due to facial hair. A limited number of air powered hoods are available and issued to Wards and Departments with instructions for use. A decontamination process in line with manufacturer's instructions is in place for all powered hoods.	None	N/A
▪ 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 ▪ 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	Included within the Respiratory Protective Equipment Policy - Training Guidance SOP. Line Managers are advised of all staff members/ individuals who fail a fit test to six models. A discussion is completed on available options including powered hoods. If an individual was unable to be provided with alternative respirators and hoods, opportunity for discussion provided with Occupational Health and HR Teams/ colleagues with regards to redeployment. The Trust has a designated Redeployment team who oversee staff skill mix, knowledge, and experience.	None	N/A
▪ 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	Trust Respiratory Protective Equipment Policy in place. A centrally held mask fit database is maintained by the Health and Safety Team and is available	None	N/A

▪ Staff who have symptoms of infection or test positive for an infectious agent should have adequate information and support to aid their recovery and return to work.	Flow charts based on national guidance for COVID-19 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. **Flowcharts:** Ending Isolation early for COVID-19 Positive staff and Ending Isolation early for COVID-19 Contacts are available via the intranet and IPC Team. 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-19 and other infections.	**October 2022:** Routine asymptomatic testing for COVID-19 has been paused in line with National Guidance 31.08. 2022.. Staff are required to only undertake a LFT if symptomatic.	Staff are advised to continue to access LFT via the Gov.uk website

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Cover report - Guardian of Safe Working quarterly report
Presented to:	Board of Directors
On:	7th December 2022
Presented by:	Chief People Officer
Prepared by:	Deputy Chief People Officer
Contact details:	T: [07795 021694] E: [james.baker@wwl.nhs.uk]

Executive summary

This guardian of safe working hours quarterly report was received within the consent part of the agenda at the People Committee on 18th October.

No issues were picked up by the Committee for discussion. The report details how in the reporting period, there were 10 medical exceptions and 14 surgical exceptions, often related to unscheduled care.

No points of particular escalation are noted for the Board's attention. Details surrounding the exceptions are detailed in the report.

Recommendation(s)

The Board is asked to note the content of the report and the recommendation that its findings be presented to the LNC, junior doctors forum and People Committee.

Title of report:	Guardian of Safe working Hours Quarterly Report QTR 1 2022 -2023
Presented to:	People Committee
On:	18 October 2022
Item purpose:	Information
Presented by:	Dr Shams Khan Guardian of Safe Working Hours
Prepared by:	Shams Khan, Leanne Preston 20 Sept 2022
Contact details:	T: [ ] E: leanne.preston@wwl.nhs.uk shams.khan@wwl.nhs.uk

Executive summary

There are 10 medical exceptions and 14 surgical exceptions. An exception report occurs when a junior doctor works over their contracted hours or misses a timetabled educational event. Education is dealt with separately by the Director of Medical Education and this report concentrates only on hours worked above contract.

The very nature of unscheduled care means that exception reports are a certainty. Unwell patients are difficult to diagnose, can fall between specialities, require time urgent management and time consuming communication. In the report I break down a medical and surgical exception to show how multiple tasks place added stress to the reporting doctor and to demonstrate how system error likelihood can increase in this circumstance. This is worth consideration when thinking about the issues of sickness, vacancies and difficulties in rota management.

There are a total of 14 Surgical Execptions, 10 medical (3 cardiology, 2 geriatric 5 general medicine)

There are 2 exceptions describing the need to hold double bleeps because of sickness

Vacancies contribute significantly to the exceptions and the stresses on day to day junior doctor working. Less than full time doctors mean that there are also partial rota gaps which can be complex for a rota co-ordinator to fill. Medicine has 4 vacancies and 3 less than full time and surgery has two vacancies.

Link to strategy and corporate objectives

Corporate strategy and objectives centre very heavily around the safety of patients in hospital and good medical practice of clinicians. The exceptions highlight the holes that appear when sickness occurs last minute and also how multiple jobs placed upon a single clinician can link to incidents. The exceptions fit with the experiences of junior doctors who highlight some of their issues in Junior Doctors Forum

Risks associated with this report and proposed mitigations

Mitigation to these risks come from interaction between junior doctor and educational supervisor. This allows feedback and debriefing to the junior but also involvement of the clinical supervisor in that speciality. The double bleep holding reported twice in these exceptions, whilst in itself not necessarily allowing for TOIL or payment should be addressed by Division of Medicine in their own governance processes

Financial implications

TOIL or Time of in Lieu will remove a doctor from the rota and impact on day to day working and payment to the doctor is a financial cost to the Trust

Legal implications

Exceptions do represent a breach of the working contract

People implications

The more detailed exceptions show the stress of multiple tasks on a junior doctor. The organisation has experienced junior doctors suffering burn out and having time off work through sickness because of this

Wider implications

Junior doctor burnout and clinical incidents are the most significant risks. I notice also the stress on rota co-ordinators trying to ensure adequate cover to clinical areas

Recommendation(s)

Present findings to LNC, JDF and People's Committee
The sharing of exceptions with medical and surgical leads for their own information and use
Stressing the importance of junior doctor and educational supervisor interaction for each exception produced

Report

Exception Reporting this quarter shows numbers consistent with acute speciality rotas and the unpredictable nature of acutely unwell patients. For Hours and Rest there were as follows:

Surgery 14
General Medicine 10 (Cardiology 3 Geriatrics 2 general medicine 5)
Paediatrics 3
O&G 2
T&O 1

The exceptions in medicine are on the whole due to patient complexity but also include the handling of multiple jobs (receiving calls from pharmacy, attending to ward round duties and covering multiple wards. One particular exception reads as follows:

"I was the only junior doctor in the afternoon covering the care of the elderly patients on Ince, the cardiology patients on Ince, and all the patients on CCU. One of the respiratory FY1s kindly did the care of the elderly ward round (usually this would be a cardiology junior however there were only 2 of us on in the morning so one of the FY1s did the CCU ward round and I did the cardiology ward round on Ince). I was handed over some jobs from the FY1s who saw the patients in the morning in CCU and care of the elderly as they had teaching in the afternoon. Throughout the afternoon more jobs were generated for the patients and some patients became fit for discharge and so required urgent discharge letters. As I was about to leave I as bleeped at 17:45 by the pharmacist who asked a query regarding the medications on one of the discharge letters for a care of the elderly patient. After this was resolved I was asked by the cardiology consultant to look into a patients CXR and previous letters with him to ascertain if the patient had a metallic aortic valve as his warfarin was being suspended because he was waiting for a pacemaker insertion. The patient did turn out to have a metallic valve and so I was asked to sort out his heparin infusion as per the local protocol. I handed over my remaining jobs to the on call FY1."

One can see how difficult it is for juniors to complete tasks. One can also see how human factors interact to increase the likelihood of systems error from the above exception report: there is one junior doctor covering Ince, CCU and elderly care. Another FY1 assists from goodwill – whilst this act is helpful to the doctor covering multiple wards, this additional work will increase the likelihood of a systems error that involves the assisting doctor (this doctor may not know the patients aswell as the regular doctor and may be less aware of other ward processes and also has work in addition to their own) The reporting doctor, whilst trying to leave, is then paged by a pharmacist and at around this time received other jobs from a cardiologist.

The above exception is a good illustration of the multiple jobs placed upon a junior doctor in the course of the day and this "juggling" of work is well recognised as a factor that increases the likelihood of clinical error and incidents and leads to increased stress upon junior doctors

In general surgery the exceptions follow a similar theme:

"1.30hrs extra due to need for retrospective documentation from day for both ward reviews and patient clerking. Covering GP, A&E and community referrals for general surgery, ENT and urology. Urology also covering Bolton admissions (Wigan hot week this week), therefore workload and

referrals very high. Due to long waiting time for patients arriving in A&E, reviewed few at once and then when computer available attempted to document. Also earlier, had to also do ENT ward rounds with Blackburn registrar, who does not have access to system. Therefore that delayed my referrals and also needed documenting as a ward roound note. Following handover, I also needed to update the surgery, ENT and urology lists - as well as arrange all the OP F/U, referrals and admin generated from those patients I discharged earlier/ plans from the post take WR e.g. MDT referrals which are paper based forms."

One junior doctor in a personal communication to me illustrates similar multitasking in surgery as was seen in the medical exception. In the case of the junior doctor in surgery it has to do with covering 3 surgical specialities – ENT, urology and general surgery with ward rounds, senior surgeons and clinical work all competing for the attention of the junior surgical doctor on call.

I note in surgery, theatre time contributes to some of the exceptions. This, of course, cannot be helped in surgery as it is part of the profession but I note how on occasions, staffing does appear thinly spread as alluded in this execption:

"Extra 4 hours worked on this day due to delays in theatre staff and not enough staff present for subsequent surgery - asked by consultant on call to assist registrar"

The above exception illustrates how short staffing levels affects surgery. It is not just ward work but also theatre work that is affected. One can see the difficulties placed upon a surgical consultant asking this doctor to assist in theatre. This is a challenge for the junior doctor in surgery who has competing interests of ward work, referrals to receive and also theatre to cover. Ideally, this would have been a good and positive experience for the doctor, assisting a registrar in theatre but thinly spread staffing makes this a stressful experience

Vacancies

Speciality	Rota	Tracks	Vacancies	LTFT	
General Medicine	FY1	18	0	0	0
General Medicine	SHO	27	3	1	1 x60%
General Medicine	ST3+	12	1	2	2 x 80% 1 x 70%
General Surgery	FY1	10	0	0	
General Surgery	SHO	10	1	0	
General Surgery	ST3+	12	1	0	
Paeds	SHO	13	3	1	1x 60%
Paeds	ST3+	8	0	2	2 x 80%
A&E	FY1	3	0		
A&E	SHO	18	1	1	1x60%,
A&E	Clinical Fellow	4	0	0	0
A&E	ST3+	16	0	4	1 x 60% 1 x 80% 2 x 50%

The above vacancy table shows that medicine have 2 vacant tracks. 3 trainees are also less than full time – this makes the gaps in the rota complex for a co-ordinator to fill and can often result in gaps discovered on that day. Surgery has 2 vacancies and this will also contribute.

Appendices

[Set out any supporting data as appendices, **maximum 20 pages**. Each appendix should be clearly numbered, i.e. Appendix 1, Appendix 2 etc. Do not embed documents into the report as they do not work with the meeting software and cannot be read]

Medicine Exception Reasons – Appendix 1

A few minutes before handover at the end of the night shift I was bleeped by CCU nursing staff as they were concerned about a patient who was being treated as a possible MI and had further episodes of chest pain. I therefore reviewed the patient and was late to handover. After handing over I documented for the patient and actioned the plan to ensure nothing had been missed for the patient. I would be grateful if I could receive this time as TOIL please, many thanks
Unable to take my break during the shift. Ward round started one hour late and therefore finished later than usual. A few urgent jobs generated along with urgent discharges. More jobs generated throughout the day as well. Also asked by the bereavement team to complete a COD form for a patient I saw the week before during my night shift as all the other doctors who had regular contact with the patient were not in and form had not been done for several days. Patient was complicated and not known to me, therefore took longer than usual to complete form. Furthermore, they also required coroner's referral. I would be grateful if I could receive the TOIL, many thanks.
I was the only junior doctor in the afternoon covering the care of the elderly patients on Ince, the cardiology patients on Ince, and all the patients on CCU. One of the respiratory FY1s kindly did the care of the elderly ward round (usually this would be a cardiology junior however there were only 2 of us on in the morning so one of the FY1s did the CCU ward round and I did the cardiology ward round on Ince). I was handed over some jobs from the FY1s who saw the patients in the morning in CCU and care of the elderly as they had teaching in the afternoon. Throughout the afternoon more jobs were generated for the patients and some patients became fit for discharge and so required urgent discharge letters. As I was about to leave I as bleeped at 17:45 by the pharmacist who asked a query regarding the medications on one of the discharge letters for a care of the elderly patient. After this was resolved I was asked by the cardiology consultant to look into a patients CXR and previous letters with him to ascertain if the patient had a metallic aortic valve as his warfarin was being suspended because he was waiting for a pacemaker insertion. The patient did turn out to have a metallic valve and so I was asked to sort out his heparin infusion as per the local protocol. I handed over my remaining jobs to the on call FY1.
Absence from grand round due to increased clinical demand on the ward
Could not attend grand round due to demand on the ward- several unwell patients
Board round started at 09:45 and WR started at around 10:15am. There was a lady on the cardiology ward with an ongoing upper GI bleed who required urgent discussions with the cardiology consultant, gastro team and haematology team as well as her daughter. I was the only cardiology junior doctor covering the cardiology patients on Ince and there was only one other cardiology doctor junior cross-covering the care of the elderly patients on Ince. Pt very difficult to bleed due to poor vascular access however managed to take bloods from her. I missed 1 hour of teaching as I was managing the unwell patient. I handed over the remaining jobs to the doctor looking after the care of the elderly patients. I would be grateful if I could have this time back as SDT/TOIL, many thanks.
Patient with upper GI bleed from the start of the day and required urgent attention over the course of the entire day. Ward round also started late due to one consultant being on to cover CCU, Ince ward and on call. In the afternoon, I was also the only doctor on the ward covering both cardiology and care of the elderly. Pt had her OGD in the afternoon and gastro created a long plan for her which I enacted. Pt continued to have coffee ground vomiting and melena in the afternoon so I needed to review the patient throughout the afternoon. Unable to take break throughout the day as pt became haemodynamically unstable throughout the day. Haematology also noted close to the end of the shift that pt will need to have beriplex so I went to the haem labs to order this with the charge nurse and handed the patient over the on call team to chase the repeat bloods

and make sure the beriplex was given. I would be grateful if I could have the 30 mins I did not have as a break as TOIL/SDT, many thanks.
Patient with upper GI bleed from the start of the day and required urgent attention over the course of the entire day. Ward round also started late due to one consultant being on to cover CCU, Ince ward and on call. In the afternoon, I was also the only doctor on the ward covering both cardiology and care of the elderly. Pt had her OGD in the afternoon and gastro created a long plan for her which I enacted. Pt continued to have coffee ground vomiting and melena in the afternoon so I needed to review the patient throughout the afternoon. Haematology also noted close to the end of the shift that pt will need to have beriplex so I went to the haem labs to order this with the charge nurse and handed the patient over the on call team to chase the repeat bloods and make sure the beriplex was given. I would be grateful if I could have the extra time worked as TOIL, with thanks.
I was the only doctor on CCU for the whole day. Jobs had been left over from the weekend ward rounds as well as jobs generated from the ward rounds that required completing. Several family discussions, including a long end of life discussion with relatives. A patient also briefly arrested during an angiogram procedure. At around 16:30, 2 more patients were ready to be discharged after having their angios and needed their discharge letters and medications sent. Another patient who also was meant to be discharged needed to be reviewed as he was starting to have chest pain again. There was also a patient with a haematoma post-angio who's haematoma was worsening and the nurse required help managing the patient. Remaining jobs handed over to the on call team. I would be grateful if I could have extra time worked as TOIL, with thanks.
I was rota'd to work the GP evening shift which is MAU cover from 5-9pm, following from a usual 9-5 shift on my normal ward. However, due to this being the Easter weekend, this shift fell on Good Friday. I received an email informing me that as this is a bank holiday, I would have to cover the MAU ward round starting at 8am. This cover is the same as the normal weekend cover provided by an SHO. I was informed I would be covering the same duties as my normal shift, however upon arrival of this shift I found that I was the sole junior for MAU so had to cover the ward round for 28 patients with the consultant, and complete all the jobs generated by myself. My normal day shift is performed by a team of juniors who divide the patients and the jobs so as to manage the workload. Given this shift is supposed to be covered by SHO's with experience and unfortunately this was my 7th day in a medical job and my first medical on call, I found this inappropriate with an unmanageable workload. The other doctors were very strained in their roles as the staffing was very minimal for the whole weekend so I had minimal support for this shift.
I was due to have teaching at half past 1 but there was no other Doctors available to handover the ward jobs too. I think my senior had to go review a patient in COPD clinic and I needed to hand over important jobs for a couple of unwell patients. As a result I was 15 minutes late for my teaching session and I had to sign the late register
Unable to attend mandatory FY1 Teaching due to ward staff levels.
Covered 2 bleeps during my oncall ward cover, including a crash bleep which I was not supposed to carry. Had minimal time for breaks and no SHO support. From 8:45am until 8:30pm.
Covered 2 bleeps on my on-call with no SHO support, including crash bleep which I was not supposed to carry and had minimal time for breaks.
I was the only doctor on CCU for the whole day, WR finished in the afternoon. Several jobs generated from WR. More jobs were generated as the afternoon went on, such as from the results of investigations, and family discussions/updates. I managed to complete most of the jobs and handed over the remaining jobs to the on call team at 5:30. I would be grateful if I could be financially compensated for this, many thanks.
I was due to have SDT in the afternoon however I was the only doctor on CCU for the whole day and WR finished in the afternoon. I therefore had to stay behind to complete the jobs, and as the afternoon went on more jobs were generated thus I was not able to take any of my SDT. I would be grateful if I could take this time as TOIL, many thanks.
Worked a medical night shift at Royal Albert Edward Infirmary, carrying ward cover SHO Bleep. Ward cover FY1 called in sick prior to the shift starting so I carried the FY1 bleep as well and covered their work. Unable to find cover for FY1. Half way through the night, one of the registrars went home sick. Therefore medical team consisted of 3 doctors instead of 5. Unsafe for patients and excessive work load.

Surgery Exception Reasons - Appendix 2

Weekend ward round shift 8-5pm. 48 patients on ward list today. Again only myself and 1 reg to undertake and document for the ward round, and myself as only junior to do the jobs. Ward round finished around 4.30. However following this, known unwell patient further deteriorated and bleeped by CCOT to urgently attend.

Reviewed and stabilised, inc taking bloods, and then had to discuss with gynae team as patient ? for theatre. Also had to discuss with family as matter of urgency as no previous family updates and patient very unwell. Following this, had to resume finishing off urgent jobs for ward round inc taking/ chasing bloods not yet done by wards without venepuncture skilled nurses and speciality referrals inc haematology and micro. Would not have been appropriate to handover to oncall team as complex and they do not know the patient/ situation.
8-5 weekend ward round shift. 56 patients on surgical list needing ward review between me and reg. This includes documentation and all the ward jobs to be only done by 2 people. For 56 patients. Around 11pm, unwell patient identified on ward. This needed me to escalate to med reg, involve cardiology consultant and eventually also review patient with ICU reg and consultant. On call surgical consultant also involved. These events delayed ward round significantly. Following sorting this patient, we resumed patient reviews. Last patient reviewed around 7.30pm. Following this, had to ensure urgents jobs were done. This include essential bloods where some wards did not have skilled nurses, therefore I needed to take this (and hand over to oncall team to chase). Other urgent jobs included speciality referrals (gastro, haematology, micro) and medical reg opinion for certain unwell but stable patients needing input that day. By the time I left, the night team had arrived, so I directly handed over to night team. This shift is impossible to finish within the hours, especially with this high inpatient number and only 2 staff covering. Furthermore, if we had any further unwell patients later, this would have also delayed events further. Also, this unwell patient would have been reviewed very late which is not safe. All day wards bleeping about why patient not reviewed. Again, last patient reviewed during ward round around 7.30pm. Within next hour only did urgent jobs and handed over, otherwise I would have stayed longer. Discharge doctor left at 15.30. Any ward discharges following this, I had to write the letter later which also added to extra overtime.
1.30hrs extra due to need for retrospective documentation from day for both ward reviews and patient clerking. Covering GP, A&E and community referrals for general surgery, ENT and urology. Urology also covering Bolton admissions (Wigan hot week this week), therefore workload and referrals very high. Due to long waiting time for patients arriving in A&E, reviewed few at once and then when computer available attempted to document. Also earlier, had to also do ENT ward rounds with Blackburn registrar, who does not have access to system. Therefore that delayed my referrals and also needed documenting as a ward roound note. Following handover, I also needed to update the surgery, ENT and urology lists - as well as arrange all the OP F/U, referrals and admin generated from those patients I discharged earlier/ plans from the post take WR e.g. MDT referrals which are paper based forms.
similar to previous entry (about staying late to update handover lists/arrange OP follow-ups)
stayed back at the end of shift to update ward round list, to ensure safe continuity of care for the ward teams the next day. In addition, to arrange any OP requests/emails for patients who had been discharged. Unable to do the above due to work pressure during working hours, especially with Wigan looking after urology patients during the whole week.
Extra 2.5hrs worked after on-call surgical shift due to complex surgery in theatre scrubbed. Only registrar and myself present
Normal 9-5 days - worked extra 4 hours until 9pm due to short staffing
Was in theatre assisting in difficult case
2hrs 15 minutes (also had no break)
3.5 hours (also had no break)
Covered clerking oncall until 5pm. However, due to job demands, have to stay late to complete necessary jobs. Consultant did PM post take rounds at near 5pm, therefore building up job lists. Have to update handover list to ensure safe continuity of care for the next oncall and ward teams.
Out of hours meeting
I was doing the on call SHO 08:00-17:00 shift as my ENT colleague is on call this week meaning she only takes the bleep from us at 17:00, at which point we go home. It's difficult to have to hand over when you're mid flow and stuck into referrals. I had a large number of referrals throughout the day and it's also the first time I've done this so naturally clerking and decision making took me longer than it would some of my colleagues. I also didn't get a lunch break so worked for the 11 hours solidly.
Extra 2.5hrs worked after on-call surgical shift due to complex surgery in theatre scrubbed. Only registrar and myself present
Extra 4 hours worked on this day due to delays in theatre staff and not enough staff present for subsequent surgery - asked by consultant on call to assist registrar

Title of report:	FTSU Report
Presented to:	Board of Directors
On:	07 December 2022
Prepared by:	Natalie Morgan, Guardian
Contact details:	Tel: 07732496588 // natalie.m@theguardianservice.co.uk

Executive summary

The FTSU report covering the period April -September 2022 was considered at People Committee in October. Assurance was received that the service was meeting all contractual key performance measures and that the number of colleagues raising concerns had increased significantly since the Trust procured the services of the Independent Guardian Service. This was expected and the Trust welcomes concerns being raised so that actions can be taken to aid resolution. Concerns raised by staff group and site are proportionate to the overall staff numbers in each group / site. It was pleasing to note that estates and facilities colleagues are now using the service, being a traditionally difficult to reach staff group. It should be noted that in many cases, colleagues felt comfortable to take forward their own actions with the support of the Guardian without requiring formal escalation to Trust management.

The annual report (covering the 12 months that the Trust has been working with The Guardian Service) will be taken to People Committee in December. This report includes thematic recommendations along with management responses and will be used to support thematic you said, we did communications.

<u>Standard KPIs:</u>

24/7/365 service availability

Through our policy of providing a lead and backup Guardian for each client along with our on-call rota operating nationally with the Guardian team we ensure 24/7/356 service availability for all clients. A dedicated backup Guardian is briefed by lead Guardian on the dynamics, protocols, escalation paths and status of their Trust on a monthly basis. This ensures that in the event of a lead Guardian's absence for whatever reason, the backup Guardian can step seamlessly into service provision, ensuring continuity.

Outcome: 24/7/365 service provision has been maintained

<u>Adherence to the RAG system timelines</u>

Of the 34 concerns raised, 8 concerns have required escalation to the Trust within the period. All were responded to within the agreed timeframe (Guardian escalated the concern as instructed by staff member and Trust responded within the agreed timelines in all cases). 1 case was escalated due to concern for patient safety. 2 cases have reached conclusion following escalation, 1 as a result of increased in support from the staff member's manager - this concern was escalated following a lack of communication during a period of sickness absence. The 2nd as a result of the staff member feeling satisfied with the next steps to manage their concern and the acknowledgement of learning points for within the associated department

being communicated to them. The remaining escalated concerns are at various stages of management with actions to be reported once cases have reached closure.
The remaining closed cases were dealt with directly by the staff member following consultation with the Guardian or the individual determined not to take the concern any further.

Outcome: Escalation RAG times have been met

Provision of monthly reports
GSL reports are produced monthly and are cumulative in nature. Reports run in line with the NHS financial year April to March. Reports are detailed and cover;

Cases – reported under a case number	Cases are colour coded against the RAG system and include open/closed status, outcomes and summary tables on current month and year to date
Thematic trends	Themes and trends are reported against agreed NGO definitions and are summarised by current month and year to date
Site visits by the Guardian	Reported by case related visits and promotional and communication visits. Each are reported by current month and year to date
Contacts	Reported by email, telephone and face-to-face by current month and year to date
Additional analysis	Data, where appropriate is displayed in graphical format

Monthly reports within this period have been shared with CEO, Chair, Director of Workforce and FTSU NED.

Outcome: All monthly reports have been submitted

It has been agreed that the bi-annual report will contain a management response detailing the thematic actions that have been taken in response to concerns that have been raised to the FTSUG.

Link to strategy
The FTSU process is aligned to psychological safety, which is an underpinning element of the Trust Strategy.

Risks associated with this report and proposed mitigations
Risks are less to the organisation where staff feel safe and supported when raising concerns and where feedback has been received that the organisation is listening and taking action as appropriate.

Financial implications
There are no financial implications arising directly from the content of this report, however it should be noted that FTSU cases which are not addressed appropriately can progress to employment tribunal claims where the protection of the Public Interest Disclosure Act 1998 applies, meaning that compensation is uncapped and potentially unlimited.

Legal implications
There is a requirement following the Francis report that every Trust has a FTSU service in place and this enables staff members to safely raise concerns, in the knowledge that they will be listened to and actions agreed and taken to resolve/ address the issue. Failing to handle FTSU cases appropriately can result in claims at Employment Tribunal under the Public Interest Disclosure Act (1998).

People implications
It is essential that there is continued engagement with new and existing staff members and managers, staff briefings and promotions and continued role out of the FTSU service is maintained and encouraged by senior leaders.

Wider implications
FTSU service will encourage an open culture where staff feel empowered to express opinion, debate issues and provide insights into the organisation which will improve staff relations and ultimately patient safety.

Recommendation(s)
The Board is asked to receive and note the report

Appendix 1

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SEP - 2022

Visits

	This Month	This Year
Promos	4	22
Comms	5	28
Briefing	1	7

Outcomes

	This Month	This Year
Written / Verbal Outcome	4	6
Chose not to pursue	2	8

Contact

	This Month	This Year
Email	19	118
Telephone	15	123
Face to face	1	21

Themes

	This Month	This Year
Patient Safety / Quality	1	1
Management Issue	0	10
System and Process	0	10
Bullying and Harrassment	0	8
Discrimination / Inequality	0	1
Behaviour / Relationship	0	4
Worker Safety	0	0
Other	0	0

Themes (Other)

	This Month	This Year
COVID	0	0
Fraud	0	0
Other	0	0

Cases

No of new cases this month	1
No of cases closed this month	6
Total no of cases year to date	34
No of cases open year to date	20
No of cases closed year to date	14

Open Cases

	This Month	This Year
Red cases	1	1
Amber cases	0	14
Green cases	0	19
No Risk cases	0	0
Total	1	34

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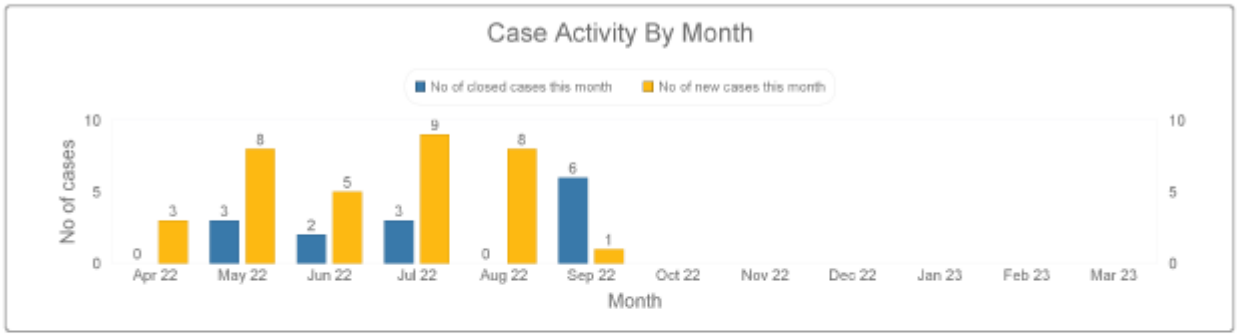
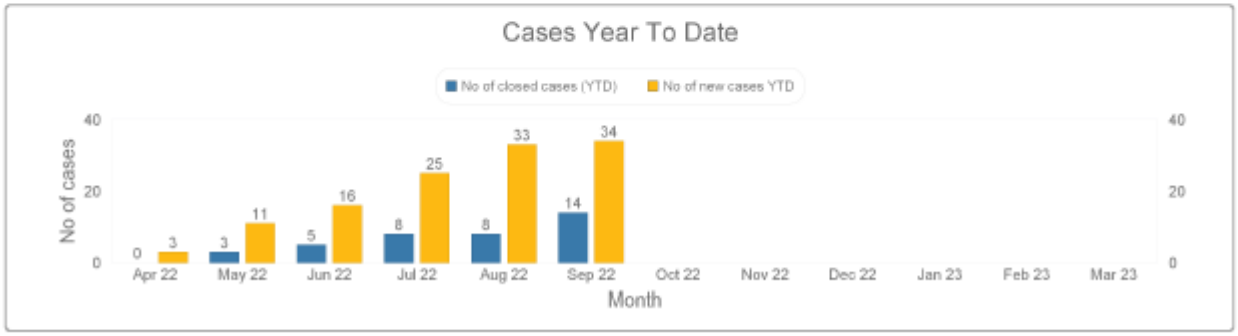
SEP - 2022





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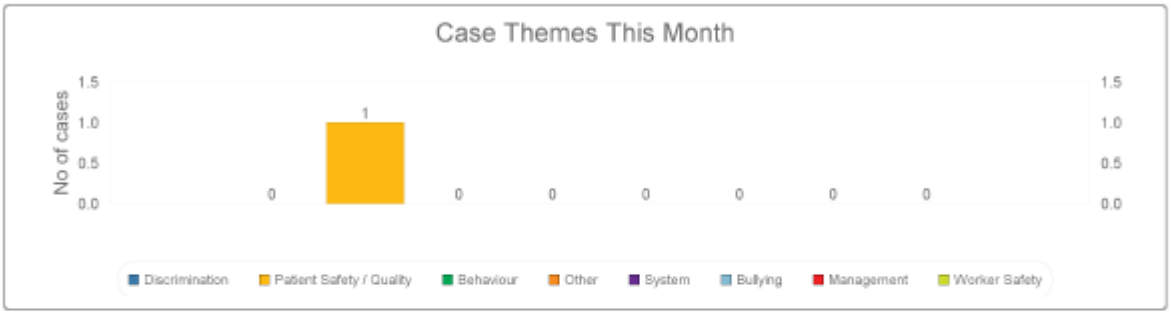
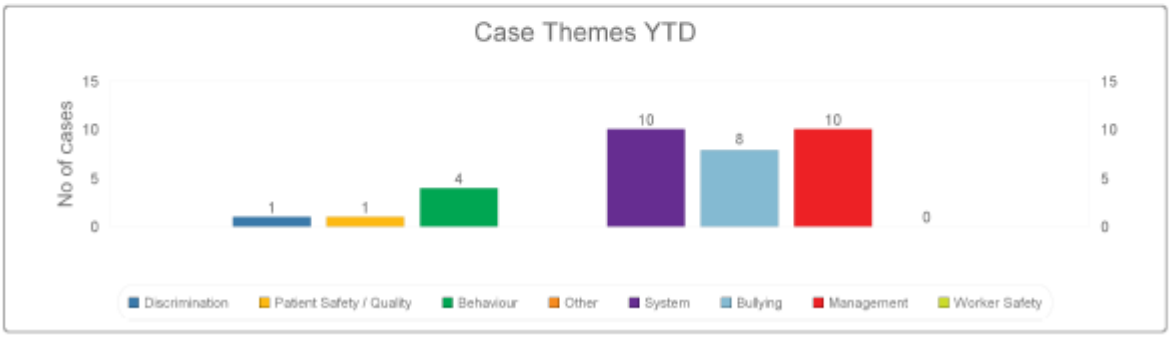
SEP - 2022





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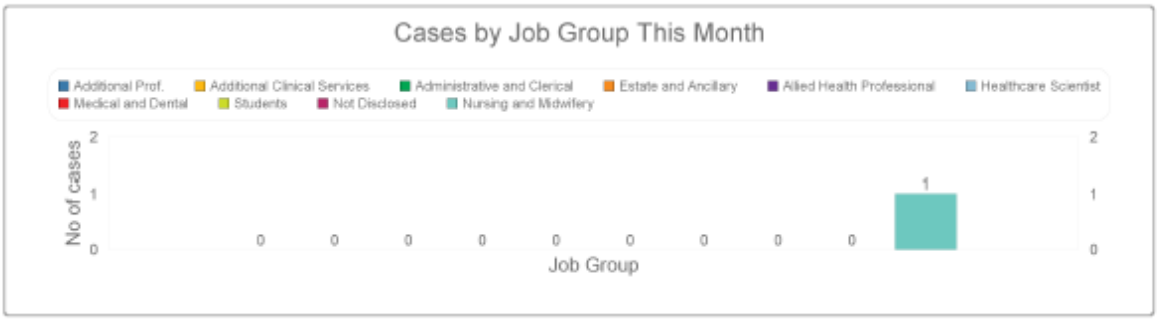
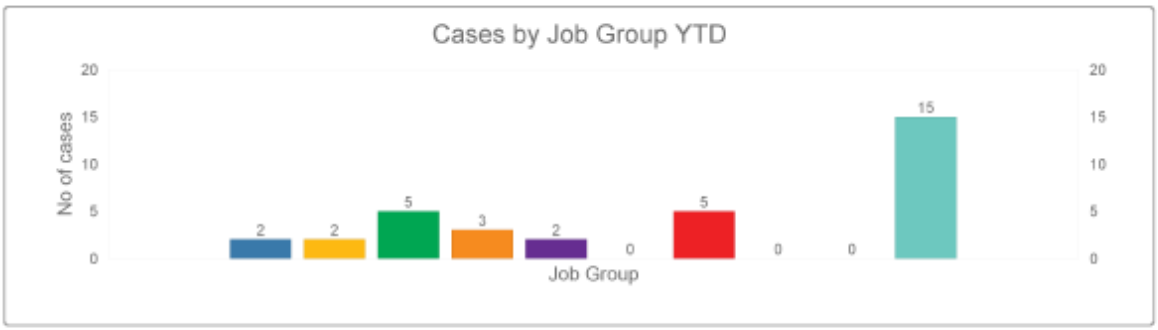
SEP - 2022





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SEP - 2022

Case status by Themes

Case Number	Start Month	Open	Closed	Patient Safety / Quality	Management Issue	System & Process	Bullying & Harrassment	Discrimination /Inequality	Behaviour / Relationship	Worker Safety	Other	Other Detail
WWL-22-01	Apr		✓		✓							
WWL-22-02	Apr		✓						✓			
WWL-22-03	Apr		✓		✓							
WWL-22-04	May		✓			✓						
WWL-22-05	May		✓				✓					
WWL-22-06	May	✓					✓					
WWL-22-07	May	✓					✓					
WWL-22-08	May		✓		✓							
WWL-22-09	May	✓							✓			
WWL-22-10	May		✓			✓						
WWL-22-11	May	✓				✓						
WWL-22-12	Jun		✓			✓						
WWL-22-13	Jun	✓			✓							
WWL-22-14	Jun		✓						✓			
WWL-22-15	Jun	✓				✓						
WWL-22-16	Jun		✓				✓					
WWL-22-17	Jul	✓							✓			
WWL-22-18	Jul		✓			✓						
WWL-22-19	Jul	✓						✓				
WWL-22-20	Jul	✓			✓							
WWL-22-21	Jul	✓				✓						
WWL-22-22	Jul	✓					✓					
WWL-22-23	Jul		✓		✓							
WWL-22-24	Jul		✓				✓					
WWL-22-25	Jul	✓					✓					
WWL-22-26	Aug	✓			✓							
WWL-22-27	Aug	✓					✓					
WWL-22-28	Aug	✓				✓						
WWL-22-29	Aug	✓				✓						
WWL-22-30	Aug	✓				✓						
WWL-22-31	Aug	✓			✓							
WWL-22-32	Aug	✓			✓							
WWL-22-33	Aug		✓		✓							
WWL-22-34	Sep	✓		✓								
Totals		20	14	1	10	10	8	1	4			

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SEP - 2022

Case Status by Outcome

Case Number	Start Month	Status	Outcome
WWL-22-01	Apr	Closed	1. Written / verbal outcome
WWL-22-02	Apr	Closed	1. Written / verbal outcome
WWL-22-03	Apr	Closed	2. Chose not to pursue
WWL-22-04	May	Closed	1. Written / verbal outcome
WWL-22-05	May	Closed	2. Chose not to pursue
WWL-22-06	May	Open	
WWL-22-07	May	Open	
WWL-22-08	May	Closed	2. Chose not to pursue
WWL-22-09	May	Open	
WWL-22-10	May	Closed	2. Chose not to pursue
WWL-22-11	May	Open	
WWL-22-12	Jun	Closed	2. Chose not to pursue
WWL-22-13	Jun	Open	
WWL-22-14	Jun	Closed	2. Chose not to pursue
WWL-22-15	Jun	Open	
WWL-22-16	Jun	Closed	2. Chose not to pursue
WWL-22-17	Jul	Open	
WWL-22-18	Jul	Closed	1. Written / verbal outcome
WWL-22-19	Jul	Open	
WWL-22-20	Jul	Open	

Case Status by Outcome

Case Number	Start Month	Status	Outcome
WWL-22-21	Jul	Open	
WWL-22-22	Jul	Open	
WWL-22-23	Jul	Closed	1. Written / verbal outcome
WWL-22-24	Jul	Closed	1. Written / verbal outcome
WWL-22-25	Jul	Open	
WWL-22-26	Aug	Open	
WWL-22-27	Aug	Open	
WWL-22-28	Aug	Open	
WWL-22-29	Aug	Open	
WWL-22-30	Aug	Open	
WWL-22-31	Aug	Open	
WWL-22-32	Aug	Open	
WWL-22-33	Aug	Closed	2. Chose not to pursue
WWL-22-34	Sep	Open	

Totals

Open Cases	20	Written / Verbal	6
Closed Cases	14	Chose not to pursue	8

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SEP - 2022

Why use the Guardian service? (Year To Date)

Reason	Number	Percentage
A Fear of damage of career	2	5.88%
B Fear of losing job	0	0.00%
C Fear of reprisal	7	20.59%
D Believe they will not be listened to	11	32.35%
E Believe the organisation will not take action	13	38.24%
F Have raised concern before but have not been listened to/nothing	1	2.94%
	34	100.00%

Confidentiality	Number	Percentage
1 Keep it confidential within Guardian Service remit	26	76.47%
2 Permission to escalate with names	5	14.71%
3 Permission to escalate anonymously	3	8.82%
	34	100.00%

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WRIGHTINGTON WIGAN & LEIGH

SEP - 2022

Cases by Directorate	This Month	Year to Date
Community Services		7
Corporate Services		6
Estates and Facilities		1
Medicine	1	17
Not Disclosed		
Specialist Services		3
Surgery		
Totals	1	34

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WRIGHTINGTON WIGAN & LEIGH

SEP - 2022

Cases by Location	This Month	Year to Date
Not Disclosed		1
Royal Albert Edward Infirmary		18
Wrightington Hospital		6
Leigh Infirmary	1	2
Thomas Linacre Centre		
Community Services		7
Totals	1	34

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WRIGHTINGTON WIGAN & LEIGH

SEP - 2022

Cases by Professional level	This Month	Year to Date
Senior Leader		5
Not Disclosed		1
Manager		13
Worker	1	15
Totals	1	34

The Guardian Service
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WRIGHTINGTON WIGAN & LEIGH

SEP - 2022

Case Escalations, Actions & Outcomes

Case Number	Case Date	Open	Closed	Escalated to	Escalation date	Org Response time	Action taken	Outcome after action taken
WWL-22-01	Apr		✓	Manager	08-Apr-2022	Same Day	Manager has communicated with staff member	Staff member felt more supported by manager following escalation
WWL-22-02	Apr		✓				Staff member spoke with HR & their manager to seek information, support & guidance around performance management of a direct report highlighting their concerns.	Expectation of support for the staff member was not met but an agreed way forward to manage the situation was implemented.
WWL-22-03	Apr		✓					Staff member chose not to pursue
WWL-22-04	May		✓					Staff member received the assurance they required.
WWL-22-05	May		✓					Staff member will take concern forward independently
WWL-22-06	May	✓		Director of Workforce	17-May-2022	Same Day		
WWL-22-07	May	✓						
WWL-22-08	May		✓					Staff member chose not to pursue
WWL-22-09	May	✓		CEO	24-Jun-2022	24 hours		
WWL-22-10	May		✓					Staff member to pursue
WWL-22-11	May	✓		CEO	08-Jun-2022	Same day		
WWL-22-12	Jun		✓					Staff member to take forward independently following GS support
WWL-22-13	Jun	✓						
WWL-22-14	Jun		✓				No further contact	Chose not to pursue
WWL-22-15	Jun	✓						
WWL-22-16	Jun		✓					Staff member choose not to pursue
WWL-22-17	Jul	✓						
WWL-22-18	Jul		✓				Staff member progressed	Staff member has escalated concern formally via trade union. Staff member reminded of support available through the Guardian Service
WWL-22-19	Jul	✓						
WWL-22-20	Jul	✓						
WWL-22-21	Jul	✓		Deputy HR Director	01-Aug-2022	24 Hours		
WWL-22-22	Jul	✓						

The Guardian Service
Here to listen

WRIGHTINGTON WIGAN & LEIGH

SEP - 2022

Case Escalations, Actions & Outcomes

Case Number	Case Date	Open	Closed	Escalated to	Escalation date	Org Response time	Action taken	Outcome after action taken
WWL-22-23	Jul		✓					FTSUG discussed a range of options for the staff member to consider and take forward Staff member was happy to explore options with management and would return for FTSUG support if felt necessary
WWL-22-24	Jul		✓	HR Advisor	28-Jul-2022	Same Day	HR Advisor discussed next steps & noted concerns. Learning points to be taken forward within the department.	Staff member satisfied with the outcome
WWL-22-25	Jul	✓		HR Business Partner	29-Jul-2022	24 Hours		
WWL-22-26	Aug	✓						
WWL-22-27	Aug	✓						
WWL-22-28	Aug	✓						
WWL-22-29	Aug	✓						
WWL-22-30	Aug	✓						
WWL-22-31	Aug	✓						
WWL-22-32	Aug	✓						
WWL-22-33	Aug		✓					Staff member chose not to pursue
WWL-22-34	Sep	✓		Ward Manager	30-Sep-2022	1 day		
	Totals	20	14					

Title of report:	Well-led action plan
Presented to:	Board of Directors
On:	7 December 2022
Presented by:	Director of Corporate Affairs
Prepared by:	Paul Howard, Director of Corporate Affairs
Contact details:	E: paul.howard@wwl.nhs.uk

Executive summary

In line with best practice, a development review of leadership and governance using the NHS well-led framework was undertaken by Deloitte during Q3 2021/22 and the outcomes were shared with the board in February 2022. The report contained 15 recommendations which are intended to support the organisation in its desire to go from good to great to outstanding.

The attached action plan for each of the recommendations has been approved by the board and the executive team has updated each of the open items with progress to date. Updates will continue to be provided to each board meeting until all recommendations have been fully implemented.

At today's meeting, the board is asked to approve the closure of the actions associated with recommendation 11.

Link to strategy

The well-led framework is based on established best practice and is a key component of our strategic vision to be a provider of excellent heath and care services for our patients and the local community.

Risks associated with this report and proposed mitigations

There are no specific risks to bring to the Board's attention.

Financial implications

There are no financial implications associated with this report.

Legal implications

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

People implications

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

Wider implications

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

Recommendation(s)

The Board of Directors is recommended to review the updates provided and approve the closure of recommendation 11.

Well-led review of leadership and governance
Action plan as at 29 November 2022

Open actions

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
1 High	The CEO should ensure that the pending executive team development programme explicitly captures good practice in providing focused executive presentations to board and committees and addresses the need to embed collective ways of working across the executive team.	Seven executive development sessions will be held between April 2022 and March 2023*. Each session will last around 3 hours and will focus on team and personal development. An additional executive development session on presenting to board and committee meetings will be delivered by 30 June 2022. Team members have agreed that attendance at all these sessions will be prioritised above all other items, including annual leave. *(*Deadline extended from 31 December 2022 to 31 March 2023 by the Board in August 2022.)*	Chief Executive	The executive programme has been commissioned and the first session took place on 8 April 2022. Sessions also took place on 6 September 2022, 17 October 2022 and 9 November 2022. The remaining sessions are scheduled to take place in December 2022, and in January and February 2023. The session on presenting to board and committee meetings took place on 9 June 2022.	

Completed | On track to deliver within agreed timescales | Minor slippage to timescales (actual or anticipated) but likely to deliver | Significant delay to delivery (actual or anticipated)

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
4 High	The CEO should consider including senior divisional leaders in some executive team development activities to help further build cohesion between the executive and divisional leadership levels, as well as exploring ways in which leaders can further demonstrate the values and behaviours expected within the organisation.	As part of the executive development programme referenced at recommendation 1 above, divisional leaders will be invited to participate in at least 2 sessions in H2 2022/23.* *(Original intention to provide 1 session in H1 2022/23 and a second session in H2 2022/23 was amended by the Board in August 2022 to reflect the narrative above).*	Chief Executive	The first joint session is scheduled to take place on 22 December 2022.	

Completed | On track to deliver within agreed timescales | Minor slippage to timescales (actual or anticipated) but likely to deliver | Significant delay to delivery (actual or anticipated)

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
5 High	The Trust should consider the development of a refreshed accountability and performance framework, in collaboration with divisional leaders, to formalise responsibilities and accountabilities for divisional and directorate leaders at different levels of the organisation.	By the end of Q3 2022/23,* we will have developed an 'Accountability Framework' incorporating the existing trust behaviours and we will have implemented this by the end of Q3 2022/23. *(Original intention to complete by end of Q2 2022/23 was amended by the Board in October 2022).*	Deputy Chief Executive	Divisional triumvirates attend a monthly performance and assurance meeting, focusing on areas of performance exception (including good practice) and ongoing improvement actions. Service, department and ward level performance is the responsibility of the triumvirate, through the service managers, matrons, and clinical leads and Divisional performance and Quality Executive groups. The meetings are board-to-board style, with the Executive team seeking assurance from the divisional triumvirate. The next review of the Performance Management Framework is due in April 2025, however, the framework may be updated to adapt to changes in the local, contractual, and regulatory position regarding performance management. A task and finish group has been established to consider the development of a Trust wide framework, due to complete in December 2022, intended to be included in the just	

Completed | On track to deliver within agreed timescales | Minor slippage to timescales (actual or anticipated) but likely to deliver | Significant delay to delivery (actual or anticipated)

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
				culture formal launch in January 2023.	
10 High	The Board should consider more detailed oversight of the digital agenda through the introduction of tailored board seminars in this area and by building this agenda item into the board and committee annual plans. This could involve assigning responsibility for the digital strategy to one of the existing committees, for example the Finance and Performance Committee, which is already responsible for the oversight of material business cases.	By the end of Q4 2021/22, we will have agreed where oversight of the digital agenda will take place. At least one board seminar session in H2 2021/22 as well as H1 and H2 2022/23 will include an aspect of the digital agenda.	Chair	The board has agreed that oversight of the digital agenda will take place via the Finance and Performance Committee and this has been incorporated into the revised terms of reference. The H2 2021/22 board seminar session was held on 23 Feb 2022 and focused on cybersecurity. The H1 2022/23 seminar session took place on 20 July 2022 and focused on the digital strategy in action. The H2 2022/23 has been provisionally scheduled to take place on 18 Jan 2023.	

Completed | On track to deliver within agreed timescales | Minor slippage to timescales (actual or anticipated) but likely to deliver | Significant delay to delivery (actual or anticipated)

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
11 High	In addition to the ongoing work to develop the Integrated Performance Report, the board and committees should make an effort to instil a culture where papers are more concise, focused and exception-based, with a view to facilitating presentations by executive directors, guiding debate and enhancing the quality of scrutiny. This process should also give due consideration to reporting around themes and trends in order to further refine debate and in the development of more bespoke, targeted action plans.	By the end of Q2 2022/23, we will have a new balanced scorecard which will facilitate more holistic discussion around performance and provide clear line of sight from board to ward. The narrative will aim to identify relevant trends and themes and metrics will include more SPC presentations rather than just threshold metrics where these enable a more appropriate discussion. By the end of Q2 2022/23, we will have delivered at least two report writing training sessions for report authors. During the year, executive directors will be invited to attend NED meetings to socialise complex issues before meetings as needed.	Director of Strategy and Planning	The balanced scorecard is now in use at board and committee meetings, and further refinement will take place as additional metrics are automated, although this is anticipated to take up to 2 years in line with the timescales associated with the migration of the data warehouse into the cloud. All directors have access to the interactive version in addition to the static report presented. Three report writing training sessions for authors have been delivered (on 26 May 2022, 7 Jun 2022 and 26 Jul 2022). Around 30 report authors have taken part in the training so far, as well as members of the executive team. Executive directors have attended NED meetings to socialise topics, such as the BAF and the Shadow Board programme.	

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№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
13 High	There is a need to revisit the role of the governor, both in relation to expectations regarding the participation of governors in trust forums, alongside how current activities could adapt and evolve in response to the emerging Integrated Care System. This should include the provision of bespoke training and development in order to further support governors with potential changes to their role in the coming months.	By the end of Q2 2022/23, we will have facilitated a workshop with governors to outline the trust's expectations around participation and to outline new ways of working. Bespoke training and development to support governors with potential changes to their role will take place during Q2 to Q4 2022/23.	Chair	A workshop was held with governors on 14 September 2022, and the focus is now on action planning; particularly in relation to external engagement. This will be supported by guidance from NHS England on the role of foundation trust councils of governors in system working and collaboration once published. At the Council of Governors meeting on 11 January 2023, we will consider an outline for integrated working with Wigan Borough, GM Integrated Care's Wigan Place Team and Healthwatch.	

Completed | On track to deliver within agreed timescales | Minor slippage to timescales (actual or anticipated) but likely to deliver | Significant delay to delivery (actual or anticipated)

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
14 High	The board should formulate a more detailed plan aimed at embedding a more structured approach to QI within the organisation. This should include clarity over how the approach will be implemented, how the impact will be tracked and shared as well as identifying opportunities for increased system working in this area. This should include consideration of how QI can be utilised within a system context.	By the end of Q4 2021/22, the Continuous Improvement (CI) Building Capability Plan will have been approved by the Continuous Improvement Group (CIG), setting out a systematic approach and plan to building CI capacity and capability over the next two years based on the 'dosing formula' and setting SMART goals to be achieved and monitored through the CIG. The Trust will continue to participate in and steer ongoing discussions with partners within the HWP in the shared objective of developing a shared approach to improvement, using the Trust's 5D Model for Improvement as the basis for this, and then ensuring this is used for transformation priorities within the 2022/23 Locality Plan.	Director of Strategy and Planning	Approval of the Continuous Improvement Building Capacity Plan is complete as at the end of Q4 2021/22. There was a further soft launch of the CI programme in Q3 2022/23 in order to target the continuous improvement capability to wider organisational challenges and work collaboratively with system partners. Work on the second part of the action plan is ongoing as part of the new place-based operating model currently being developed.	

Completed | On track to deliver within agreed timescales | Minor slippage to timescales (actual or anticipated) but likely to deliver | Significant delay to delivery (actual or anticipated)

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
15 High	At the time of fieldwork, a number of changes were underway to strengthen leadership development, including identifying and supporting future talent. This should take into account opportunities for a multidisciplinary approach (both within the trust and across system partners where appropriate) and should also consider the skills required both as a leader within the trust as well as those which will be needed as a result of greater levels of integrated system working.	By the end of April 2022, we will have relaunched the Leadership Development Framework within the organisation. The talent programme will be prioritised for development from April 2022, which will include identification of talent, assessment of potential, talent pathways and development programmes. The design element of the programme will be completed by the end of Q1 2022/23 and phased implementation for organisational tiers will commence from Q2 2022/23.	Chief People Officer	The Leadership Development Framework has been agreed and relaunch took place during March and April 2022. Work is underway to scope and develop the talent programme. Feedback has been obtained from key stakeholders and a survey has been distributed to leaders to gain insight on talent identification and talent management, coupled with the skills required for future leaders. The initial draft of the programme is being shared in August for consultation, input and feedback. The design element of the programme is in final stage of review and subject to ETM approval, pilot launch will commence Q4 2022/23.	

Completed | On track to deliver within agreed timescales | Minor slippage to timescales (actual or anticipated) but likely to deliver | Significant delay to delivery (actual or anticipated)

Actions which have previously been confirmed as closed by the board (for information)

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
2 High	The board should consider a board seminar session that takes stock of where WWL is with regard to enabling strategies and implementation of the corporate strategy. This should explicitly review the opportunity for accelerating the pace of strategy implementation, for enhancing board oversight of the process and in using a range of different communication methods to increase awareness within the organisation.	A board seminar will be scheduled during Q1 2022/23 to provide the board with dedicated time to review its enabling strategies and overall implementation of the corporate strategy. Any necessary actions to accelerate the pace of strategy implementation, enhance board oversight or increase awareness will be agreed and appropriate timescales and milestones developed.	Chair	The objectives that drive the strategy were challenged and updated at a Board away day on 23 February 2022 and at a workshop on 2 March 2022. They were approved in April 2022. A seminar which reviewed the strategy through the lens of place-based leadership took place on 4 May 2022. A Healthier Wigan Partnership session took place on 23 Mar 2022. Future work is planned in relation to reviewing the enabling strategies.	
3 High	The board should set aside time in a board seminar to review progress against the various initiatives aimed at positively influencing culture, to ensure it is appropriately apprised of activities and that suitable mechanisms are in place for it to monitor progress against plan over time.	By the end of Q1 2022/23, the board will have undertaken a dedicated session as part of a seminar or away day to review progress against the *Our Family, Our Future, Our Focus* programme and will have considered whether it is appropriately apprised of activities and whether it has appropriate mechanisms in place to monitor progress.	Chair	This session took place on 20 April 2022.	

Completed | On track to deliver within agreed timescales | Minor slippage to timescales (actual or anticipated) but likely to deliver | Significant delay to delivery (actual or anticipated)

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
6 Medium	The Chair should make provision in any future board development plans for a session focused on the impact of board committees and effective assurance reporting to the board. This session should also consider a consistent approach to engaging divisional leaders in board and committee meetings to enhance accountability.	By the end of Q1 2022/23, we will have undertaken a dedicated session on the impact of board committees and effective assurance reporting to the board, as well as agreeing a consistent approach to engaging divisional leaders in board and committee meetings.	Chair	Following discussions at the Board away day on 23 Feb 2022 and at Executive Team and NED team meetings during February and March 2022, assurance committee terms of reference have been updated so that core attendees are now explicitly identified. The new terms of reference address the issue of large numbers of attendees and the style (briefing vs. assurance) of the meeting. Divisional leaders and subject matter experts are invited on an agenda item basis, where they will play a key role in making the case and being accountable for the recommendations on behalf of their division or subject area. 'AAA' reports from committees have now been introduced for Board meetings. RAPID meetings have been introduced for divisions around financial position and CIP and attendees attend committees to	

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№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
				account for their position if necessary.	
7 High	The CEO should prioritise a range of activities aimed at developing senior leaders at the divisional and directorate levels, including clarifying individual and collective roles and accountabilities, raising the status of Divisional Assurance Meetings and providing greater focus to support leadership development and succession planning.	By the end of Q4 2021/22, we will have advertised a Shadow Board programme and sought expressions of interest. By the end of Q1 2022/23, the Shadow Board will have held at least one training module and one meeting. By the end of Q1 2022/23, we will have reviewed the status of Divisional Assurance Meetings and agreed how best this may be raised; with any actions being implemented by the end of Q2 2022/23.	Chief Executive	The Shadow Board programme was advertised during Q4 2021/22. 15 senior managers are participating in the programme. The first training module for the Shadow Board took place on 24 May 2022 and its first meeting took place on 7 June 2022. The review of Divisional Assurance Meetings has been completed.	

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№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
8 Medium	The Trust should consider further refinements to the presentation format of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) to ensure that it provides more focus that guides board and committee discussion. This could be accompanied by a board development session on best practice in the use of the BAF and CRR.	By the end of Q1 2022/23, we will introduce 'AAA' reports for committee chairs which, in conjunction with the BAF, will assist in focusing board and committee discussions. By the end of Q1 2022/23, we will have agreed a revised format for the BAF which will then be used throughout 2022/23. By the end of Q1 2022/23, we will have delivered a board development session on best practice in the use of the BAF and CRR.	Director of Corporate Affairs	AAA report template for committee reporting has been introduced. The revised BAF format has been agreed and the first report in the new format is being presented at today's meeting. This format will be used throughout 2022/23. The Board development session on best practice in the use of the BAF and CRR was scheduled for 20 April 2022 but did not happen due to agenda challenges. Given the sessions on the BAF and CRR that have recently been held with the executive team and at a NEDs meeting to review and agree the new BAF format which incorporated best practice use, the board is invited to agree that this element of the action has been completed.	

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№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
9 High	The Trust should revisit engagement and communications around changes to the quality governance structure to ensure that there is greater understanding of the rationale for change and the intended impact of this, and to ensure that all involved across the organisation are clear regarding the purpose, timing and sequencing of the changes.	By the end of Q2 2022/23, we will have approved an updated quality governance meeting structure and shared this within the organisation. We will have shared the structure at a meeting of Leaders' Forum and our intranet site.	Chief Nurse	The review of the quality governance meeting structure has commenced and a first draft was circulated for review and comment on 29 Mar 2022. It was shared with the Quality and Safety Committee on 10 Aug 2022 and is scheduled for Leaders' Forum in October 2022.	
12 Medium	The Chair should introduce a range of virtual forums aimed at providing additional organisational oversight for Non-Executive Directors (NEDs), whilst also raising NED visibility with staff. Initiatives could include NED divisional alignment, NED-led staff focus groups, 1:1 staff meetings and Chair webinars.	By the end of Q1 2022/23, NED walkabouts will have recommenced. By the end of Q2 2022/23, we will have introduced appropriate publicity materials on all main trust sites.	Chair	NED walkabouts have commenced and these will cover all parts of the Trust to ensure visibility amongst clinical and non-clinical teams. NEDs will be invited to undertake a walkabout at least once per quarter, accompanied by an Executive Director who they do not usually work with, to facilitate an additional networking opportunity. Non-Executive Directors will also be providing mentorship support to the Shadow Board programme which will help in increasing visibility with senior leaders. Publicity materials for all main sites are currently being printed and will be installed on receipt.	

Completed | On track to deliver within agreed timescales | Minor slippage to timescales (actual or anticipated) but likely to deliver | Significant delay to delivery (actual or anticipated)

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Emergency Preparedness, Resilience and Response (EPRR) Core Standards Report for 2022
Presented to:	Trust Board
On:	7th December 2022
Presented by:	Deputy Chief Executive (Accountable Emergency Officer)
Prepared by:	Head of Resilience
Contact details:	T: 07824 599379 E: helen.salvini@wwl.nhs.uk

Executive summary

The Emergency Preparedness, Resilience and Response (EPRR) readiness of NHS organisations is a legal requirement under the Civil Contingencies Act (2004) which identifies acute NHS Providers as type one responders with specific duties and also the NHS Act (2006) as amended by the Health and Social Care Act (2012). NHSI/E fulfil this requirement via an annual self-assessment against the EPRR core standards; this is undertaken by the Head of Resilience on behalf of the Accountable Emergency Officer. In addition to the core standards there is also an annual deep dive into a wider preparedness area which for 2022 is evacuation and shelter.

Overall the Trust is rated as "substantially compliant" with just 5 out of 64 core standards and 2 out of 13 deep dive competencies being only "partially compliant" and the remainder being "fully compliant". Action plans are in place to resolve these within the next 12 months which is the requirement in the standards (although the plan is deliver them all by 30th June).

Recommendation(s)

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

Report

Introduction

This paper outlines the purpose and outcome of the annual Emergency Preparedness, Resilience and Response (EPRR) core standards self assessment. The assessment was carried out by the Head of Resilience in conjunction with relevant subject matter experts. The overall outcome is "substantial compliance" which is the same as 2021 (and prior to covid-19).

Legislative and Statutory Context

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

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

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

The underpinning principles of EPRR in the NHS are as follows

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

Background to the Core Standards

NHS England has a statutory duty to seek formal assurance of EPRR readiness through the EPRR annual assurance process. This is a self-assessment which is peer reviewed locally by the Greater Manchester Local Health Resilience Partnership (LHRP).

The 2020 and 2021 assessments were reduced (the 2020 review focused on learning from the first waves of covid-19 and in 2021 some standards were removed because they were outdated due to not going through the standard tri-annual review) and therefore 2022 is the first time since 2019 that a full assessment has been completed. The Trust was substantially compliant in 2019 and remains so in

2022 (albeit not due to partial compliance in the same standards i.e. some have improved whilst others have deteriorated due to covid-19).

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

Summary of 2022 Results

Core Competencies

For 2022 there are 64 core standards and the Trust is fully compliant with 59 of them (92%). This results in an overall assessment of "substantial compliance" (classed at 89%-99%). This is consistent with previous years and is comparable with other Trusts across Greater Manchester and nationally.

There are 0 standards against which the Trust is non-compliant and5 standards against which the assessment is "partially compliant" and these are shown below.

Standard	Requirements	Trust Position
Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Whilst the Trust does have trained staff available 24/7 there is a gap in relation to mapping to the minimum occupational standards for emergency planning, resilience and recovery (EPRR). The training is currently being updated to reflect this and will be rolled out from January 2023.
Decontamination capacity availability 24/7	The organisation has adequate and appropriate decontamination capability to manage self-presenting patients (minimum four patients per hour) 24 hours a day 7 days a week.	Staff shortages at present mean that not all shifts are covered 24/7 but the plans have been updated and shared with all staff. A plan is in place to access external training in early 2023 to increase the number of staff with formal training.
Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAMGENE (radiation monitor) • Other equipment	These actions are completed but on an ad hoc basis by a number of staff and, in some cases, when notified by external partners (such as reminder to have the RAMGENE machine calibrated). This will be addressed from January 2023 along with wider improvements in CBRN readiness.

HAZMAT/CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	The training lead has recently changed and the handover is ongoing. The current post-holder is continuing to provide support until the required external training can be accessed (March 2023)
HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	There are staff who are trained to deliver this but they have moved into other roles and therefore have limited time. Training is being accessed externally to ensure that this is addressed.

Where standards are not fully compliant an action plan to address the gaps within 12 months is required. A copy of the action plan is included at Appendix 2 and this will be monitored through the EPRR group chaired by the Deputy Chief Executive (Accountable Emergency Officer)

Deep Dive

The deep dive in 2022 relates to evacuation and shelter. There are 13 measures of which 11 were deemed to be fully compliant and 2 partially compliant.

Standard	Requirements	Trust Position
Patient dispersal and tracking	The organisation has an interoperable patient tracking process in place to safely account for all patients as part of patient dispersal arrangements	Patient tracking for major incidents involving transfers to other NHS providers is in place but not for a whole organisation evacuation involving non-NHS organisations (such as the council, voluntary services or private providers). Clarification will be added to the plan by January 2023.
Partnership working	The organisation's arrangements include effective plans to support partner organisations during incidents requiring their evacuation.	Mutual aid arrangements are in place but not specifically in relation to evacuation and shelter. This will be addressed and agreed through the newly re-established Wigan Borough Resilience Forum by March 2023.

As with the core standards there is requirement to achieve full compliance within 12 months and actions are included within the plan at appendix 2 to achieve this.

Conclusion

The outcome of the self-assessment is “substantial compliance” which provides good assurance regarding the emergency planning, response and recovery arrangements of the Trust. The standards assessed as partially compliant are largely due to the legacy of covid or new requirements such as the minimum occupational standards. An action plan is in place to ensure the Trust will be fully compliant with the current standards by June 2023 and this will be managed and monitored by the EPRR group.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Appendix 2

EPRR Core Standards Action Plan

Monitoring Committee - EPRR Group

Version 1

No.	Issue Identified/ Recommendation	Actions to be taken (clear and specific identify resources where appropriate)	Lead Responsibility (Job Title)	Time Frame (date to be completed)	Risk to Completion (any risks that would prevent delivery of the action)	Progress towards Completion (include date the narrative relates to)	Date completed (RAG rate the column)	Evidence of completion
1	On-call staff should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards)	Training to be reviewed and updated to reflect the NOS	Head of Resilience	For roll out from January 2023	Resilience Team being pulled out of day to day job to support incident response			
2	The organisation does not have adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Major incident training reinstated from October 2022 and bi-monthly programme agreed. Decontamination training to be accessed at NCA to allow development of a WWL programme	Head of Resilience	June 30th 2023 to get sufficient trained staff and then it will be ongoing	Staff shortages and winter pressures may prevent staff from being released and still limit the number of trained staff on shift			
3	There is no preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination	PPM to be implemented as part of wider improvements in CBRNe readiness	ED Major Incident leads supported by Resilience Project Manager	31st January 2023	Staff shortages and winter pressures may prevent staff from being released.			

No.	Issue Identified/ Recommendation	Actions to be taken (clear and specific identify resources where appropriate)	Lead Responsibility (Job Title)	Time Frame (date to be completed)	Risk to Completion (any risks that would prevent delivery of the action)	Progress towards Completion (include date the narrative relates to)	Date completed (RAG rate the column)	Evidence of completion
	equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment							
4	The current HAZMAT/ CBRN Decontamination training lead is not appropriately trained to deliver HAZMAT/ CBRN training	External training to be accessed until ED major incident leads are appropriately experienced to deliver training at WWL	ED Major Incident Leads	30th June 2023	Staff shortages and winter pressures may prevent staff from being released for a 2 day off-site course.			
5	The organisation does not have a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	External training to be accessed until ED major incident leads are appropriately experienced to deliver training at WWL	ED Major Incident Leads	30th June 2023	Staff shortages and winter pressures may prevent staff from being released for a 2 day off-site course.			
6	The organisation does not have an interoperable patient tracking process in place to safely account for all	Patient tracking arrangements in the event of an "off WWL" evacuation to be added to the plan	Head of Resilience	31st January 2023				

No.	Issue Identified/ Recommendation	Actions to be taken (clear and specific identify resources where appropriate)	Lead Responsibility (Job Title)	Time Frame (date to be completed)	Risk to Completion (any risks that would prevent delivery of the action)	Progress towards Completion (include date the narrative relates to)	Date completed (RAG rate the column)	Evidence of completion
	patients as part of patient dispersal arrangements if this were completely external to WWL.							
7	The organisation's arrangements do not explicitly include effective plans to support partner organisations during incidents requiring their evacuation.	Utilise Borough Resilience Forum to formalise arrangements	Head of Resilience	March 31st 2023				

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
Domain 1 - Governance					
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations
Domain 2 - Duty to risk assess					
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
Domain 3 - Duty to maintain Plans					
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles.
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
Domain 4 - Command and control					
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.
Domain 5 - Training and exercising					
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	As part of mandatory training Exercise and Training attendance records reported to Board
Domain 6 - Response					
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Y	Guidance is available to appropriate staff either electronically or hard copies
Domain 7 - Warning and informing					
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media. • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response
Domain 8 - Cooperation					
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004
Domain 9 - Business Continuity					
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers
Domain 10 - CBRN					
55	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements
56	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies
57	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities
58	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	Rotas of appropriately trained staff availability 24 /7

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
59	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/epr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/epr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Completed equipment inventories; including completion date
60	CBRN	PRPS availability	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Y	Completed equipment inventories; including completion date
61	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	Record of equipment checks, including date completed and by whom.
62	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	Completed PPM, including date completed, and by whom
63	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	Organisational policy
64	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	Maintenance of CPD records
65	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training
66	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	Maintenance of CPD records
67	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique
68	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y	

Over arching changes:	Column previously titled "Standard" has been renamed as "Standard name" Column previously titled "Detail" has been renamed "Standard Detail" Column previously titled "Evidence" has been renamed "Supporting information" Organisation type previously "Clinical Commissioning Group" has been changed to "Integrated Care Board" Remove reference to "effective" arrangements/planning across all standards on the basis that all arrangements should be considered effective in nature. Domain 7 - Warning and Informing - has been reviewed and refreshed to reflect significant lessons in crisis communication identified during recent emergency and incident response. Domain 9 - Business Continuity - was reviewed in collaboration with project team undertaking the review of the Business Continuity toolkit and their associated stakeholder group. The review includes development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard Domain 10 - CBRN - to be reviewed as part of national CBRN work programme 2022-23. Core standards to be updated as part of interim review 2023.

Previous standard detail					New standard detail			
Ref	**Domain**	**Standard**	**Detail**	**2022 Changes**	**Ref**	**Domain**	**Standard name**	**Standard Detail**
Domain 1 - Governance								
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Standard amended to clarify that AEO should be a board level director "within their individual organisation" Removed reference to Non-Executive board member in light of national review of NED Champions. EPRR sits with the whole board and all NEDs should assure themselves that requirements are being met.	**1**	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Previously referred to as EPRR Policy statement, this has been amended to reflect the requirement that an organisation has an "EPRR Policy or statement of intent" Third bullet point under "The policy should" has been updated to include that arrangements are also "exercised" Standard now applicable to Clinical Support Unit and Primary Care Services Moved content requirements of policy to supporting information	**2**	**Governance**	**EPRR Policy**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Removed reference to "Clinical Commissioning Group Accountable Officer" as no longer applicable Removed requirement for EPRR reports to go to "Governing Body" as no longer applicable Added "The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements" Moved content requirements of reports to supporting information	**3**	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes.	Added a new first bullet point to include "Current guidance and good practice" Added: "The work programme should be regularly reported and shared with partners where appropriate"	**4**	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Removed "proportionate to is size" as this is not the only factor for consideration	**5**	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Standard detail wording amended to expand on what is implied by development of EPRR arrangements and specifically reference undertaking a "review and embed" learning into future arrangements	**6**	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.
Domain 2 - Duty to risk assess								
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Broadened standard detail to include consideration of all relevant risk registers including community and national risk registers Supporting information updated to address recommendation from the Health and care adaptation reports as part of the Greener NHS programme	**7**	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Added reference to "communicating and escalating EPRR risks internally and externally"	**8**	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally
Domain 3 - Duty to maintain plans								
9	**Duty to maintain plans**	**Collaborative planning**	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Standard description amended to encourage greater collaborative working on broader EPRR arrangements and wider stakeholder engagement.	**9**	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.
11	**Duty to maintain plans**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Previously separate standards relating to Critical Incident and Major Incident plans have been incorporated into a single standard which requires organisations to have effective plans in place to "define" and respond to "Critical and Major Incidents" as defined in the EPRR Framework	**10**	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.
12	**Duty to maintain plans**	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Removed this standard as incorporated into the Incident Response standard				
13	**Duty to maintain plans**	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Previously separate standards relating to Heatwave and Cold Weather Plans have been incorporated into a single standard which requires organisations to have effective arrangements "in place for adverse weather events." Supporting information updated to address recommendation from the Health and care adaptation reports as part of the Greener NHS programme	**11**	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.
14	**Duty to maintain plans**	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Removed standalone standard as it is incorporated in to the redefined Adverse Weather standard				
15	**Duty to maintain plans**	**Pandemic influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza.	Sub-section has been renamed "new and emerging pandemic" and reworded to reflect generic pandemic arrangements rather than disease specific (i.e. Influenza) planning, and differentiate separately form current arrangements in place to respond to the COVID-19 pandemic. The revised standard does however include reference to "reflecting recent lessons identified" recognising lessons likely to have been identified during the COVID-19 response and incorporated in to future planning. Revised standard has also been reordered to follow Infectious Diseases standard as these arrangements may be considered as a foundation for Pandemic response.	**13**	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic

16	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases such as Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3 and PPE trained individuals commensurate with the organisational risk.	Reference to specific diseases (i.e. VHF) and specific arrangements (i.e. IPC) removed to ensure broader planning considerations are taken in to account. Supporting information updated to include reference to DHSC FFP3 resilience in Acute setting guidance Revised standard has also been reordered to precede New and Emerging Pandemic standard as Infectious Disease arrangements may be considered as a foundation for pandemic response.	**12**	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.
17	**Duty to maintain plans**	**Mass-countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including arrangement for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. CCGs may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Standard has been revised and renamed so not to be specific to Mass Countermeasures but to reflect an incident requiring "countermeasures or a mass countermeasure deployment". All other wording specifically referencing Mass Countermeasures has been removed and moved to supporting information column until national guidance published. Standard is now applicable to Integrated Care Boards and Primary Care Services	**14**	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment
18	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Standard reworded to reference response to "incidents with mass casualties" rather than "responding to mass casualties". Specific references to freeing up of bed base in acute settings removed as these requirements are included in national guidance. Supporting information updated to reflect that arrangements should include safe patient identification system for unidentified patients in an mass casualty incident.	**15**	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.
19	**Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Standard removed and incorporated as a consideration as part of broader Mass Casualty planning.				
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Minor changes to standard name to reflect national guidance title i.e. "Evacuation and Shelter" rather than "Shelter and Evacuation" Removed reference to shelter and evacuation of whole buildings and sites etc. and working with other site users as this is incorporated in national guidance.	**16**	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Standard reworded to reflect different organisations types and any specific regulatory requirements	**17**	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	No change	**18**	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.
23	**Duty to maintain plans**	**Excess death planning**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Standard renamed No change to wording of standard	**19**	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.
Domain 4 - Command and control								
24	**Command and control**	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Standard reworded to move away from reference to EPRR specific on call, to more broader mechanisms for escalating and responding to incidents 24/7.	**20**	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanism and structures to enable 24/7 receipt and action of incident notifications, internal or external, and this should provide the facility to respond to or escalate notifications to an executive level.
25	**Command and control**	**Trained on-call staff**	On-call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Standard reworded to reflect that those staff supporting the 24/7 on call mechanism to respond to incidents (as described above) are appropriately trained in EPRR.	**21**	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions
Domain 5 - Training and exercising								
26	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Reference to training records removed from the standard description, as it is included as evidence.	**22**	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.
27	**Training and exercising**	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	Reference to "minimum standards in line with national guidance" included. Reference to specific exercise and testing requirements moved to supporting information and is included in national guidance. Addition to reiterate that exercise and testing should be undertaken "safely: no undue risk to exercise players or participants, or those patients in your care" "Lessons identified" removed from standard description but incorporated in to supporting information of post exercise	**23**	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements in line with guidance the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)
28	**Training and exercising**	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Standard renamed "Responder Training" and reworded to include all responders, and reflect shared responsibility to maintain personal development portfolios with the host organisation. National occupational standards updated to reflect new "Minimum Occupational Standards"	**24**	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role
				New standard	**25**	**Training and exercising**	**Staff Awareness and Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.
29	**Training and exercising**	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon	Moved to Domain 9 - Business Continuity	**54**	**Business Continuity**	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon
Domain 6 - Response								

30	Response	Incident Co-ordination Centre (ICC)	The organisation has a preidentified Incident Co-ordination Centre (ICC) and alternative fall-back location(s). Both locations should be annually tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Standard has been revised to accommodate smarter ways of working and coordinating incident response. This might include physical in addition to virtual arrangements but requires ICC arrangements to be resilient with dedicated BC arrangements. Requirement for equipment testing in line with EPRR Framework.	26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.
31	Response	Access to planning arrangements	Version controlled, hard copies of all response arrangements are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Standard has been revised to accommodate smarter ways of working and coordinating incident response. This might include easily access to digital response plans but requires dedicated business continuity arrangements in place.	27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.
32	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	No Change	28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).
33	Response	Loggist	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. Key response staff are aware of the need for keeping their own personal records and logs to the required standards.	Standard description amended in order that there is focus on the importance of maintaining personal records and decision logs and the utilisation of loggists to support this	29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Standard description revised	30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.
35	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	No change	31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Removed PHE branding from guidance title as this will likely change over time but recognise this has formally been published by PHE previously.	32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)
Domain 7 - Warning and informing									
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Domain 7 - Warning and informing has been reviewed and refreshed to reflect significant lessons in crisis communication identified during recent emergency and incident response. Supporting information has been added to support development of arrangements and future planning	33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.		34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.
39	Warning and informing	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Additional standard with specific requirement for organisations to have incident communication plans in place which can be enacted.	35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.
					36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media
Domain 8 - Cooperation									
40	Cooperation	LRHP attendance	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75% annually) Local Health Resilience Partnership (LHRP) meetings.	Standard name changed to "LHRP engagement". Further clarification of requirement for suitable representation of AEO included in line with EPRR framework. Minimum attendance requirement removed to ensure all efforts are made for organisations to send representation to all meetings.	37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with Delegated Authority to authorise plans and commit resources on behalf of their organisation, attends Local Health Resilience Partnership (LHRP) meetings.
41	Cooperation	LRF / BRF attendance	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Standard name changed to "LRF/BRF engagement"	38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Added in requirement to adhere to national NHS guidance around MACA etc	39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.
43	Cooperation	Arrangements for multi-region response	Arrangements outlining the process for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	Changed to reflect that there may be a requirement to plan for *and* respond to multi LHRP/LRF boundary incidents and the resource requirements for this Applicable to ICB	40	Cooperation	Arrangements for multi-area response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.
44	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and Public Health England will communicate and work together, including how information relating to national emergencies will be cascaded.	Changed PHE To UKHSA to reflect organisational change	41	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.
45	Cooperation	LHRP	Arrangements are in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.	Changed subheading to include Secretariat. Standard applicable ICB to reflect the new statutory responsibilities.	42	Cooperation	LHRP Secretariat	The organisation has arrangements are in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Added into supporting evidence additional legislative requirements	43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders and partners, during incidents.
Domain 9 - Business Continuity									
47	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.	No change to standard description. Development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard	44	Business Continuity	Business Continuity (BC) policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Standard description developed to provide further context regarding the requirement to define scope of the programme. Development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard.	45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.
49	Business Continuity	Business Impact Assessment	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	No change to standard description. Development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard	46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).

50	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	No change to standard description. Development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard	47	Business Continuity	Data Protection and Security Toolkit (DPST)	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be reviewed regularly (at a minimum annually), or following organisational change, or incidents and exercises.	Standard separated into two separate standards to reflect the requirement for a) Business Continuity Plans for the management of incidents and b) testing and exercising of BC Plans. This is extant for the requirement for testing and exercising of other non-BC EPRR and Incident response arrangements	48	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure
					49	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.
52	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	No change to standard description. Development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard	50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Standard description developed to better define audit cycle and internal and external requirement. Development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard	51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	No change to standard description. Development of supportive information reflecting updated national guidance to provide additional steer for compliance with standard Supporting information encompasses Monitoring, evaluating, lessons identified and audit cycle findings	52	Business Continuity	BCMS continuous improvement process	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	No change to standard description. Supporting information developed to include support from Procurement and commercial teams at tender stage.	53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.
Domain 10 - CBRN								
55	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	No substantive change to standard content. Domain 10 - CBRN due to be reviewed as part of national CRBRN work programme and core standards updated as part of interim review. Standards renumbered as necessary	55	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.
56	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.		56	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.
57	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.		57	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.
58	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.		58	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.
59	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/		59	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/
60	CBRN	PRPS availability	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.		60	CBRN	PRPS availability	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.
61	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks		61	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks
62	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment		62	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment
63	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.		63	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.
64	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training		64	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training
65	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.		65	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.
66	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.		66	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.
67	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.		67	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.
68	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.		68	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.

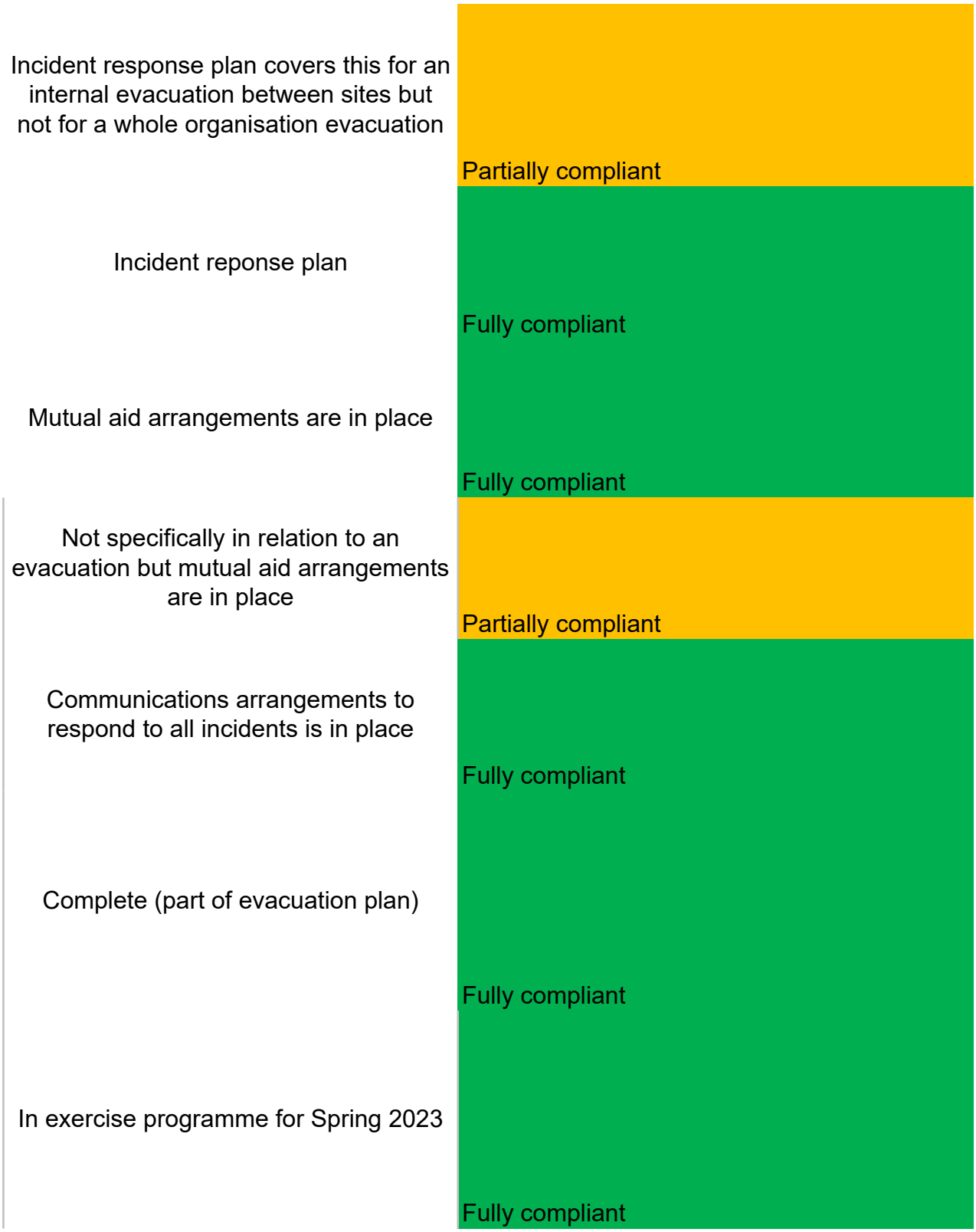
Ref	Domain	Standard
Deep Dive - Evacuation and Shelter		
Domain: Evacuation and Shelter		
DD1	Evacuation and Shelter	Up to date plans
DD2	Evacuation and Shelter	Activation
DD3	Evacuation and Shelter	Incremental planning
DD4	Evacuation and Shelter	Evacuation patient triage
DD5	Evacuation and Shelter	Patient movement
DD6	Evacuation and Shelter	Patient transportation

DD7	**Evacuation and Shelter**	**Patient dispersal and tracking**
DD8	**Evacuation and Shelter**	**Patient receiving**
DD9	**Evacuation and Shelter**	**Community Evacuation**
DD10	**Evacuation and Shelter**	**Partnership working**
DD11	**Evacuation and Shelter**	**Communications-Warning and informing**
DD12	**Evacuation and Shelter**	**Equality and Health Inequalities**
DD13	**Evacuation and Shelter**	**Exercising**

Deep Dive question	Further information	Acute Providers
The organisation has updated its evacuation and shelter arrangements since October 2021, to reflect the latest guidance.	https://www.england.nhs.uk/publication/shelter-and-evacuation-guidance-for-the-nhs-in-england/	Y
The organisation has defined evacuation activation arrangements, including the decision to evacuate and/or shelter by a nominated individual with the authority of the organisation's chief executive officer.		Y
The organisation's evacuation and shelter plan clearly defines the incremental stages of an evacuation, including in situ sheltering, horizontal, vertical , full building, full site and off-site evacuation.		Y
The organisation has a process in place to triage patients in the event of an incident requiring evacuation and/or shelter of patients.		Y
The organisation's arrangements, equipment and training includes the onsite movement of patients required to evacuate and/or shelter.		Y
The organisation's arrangements, equipment and training includes offsite transportation of patients required to be transferred to another hospital or site.		Y

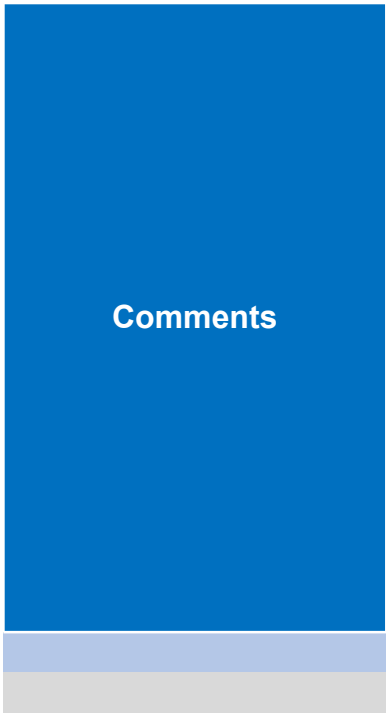
The organisation has an interoperable patient tracking process in place to safely account for all patients as part of patient dispersal arrangements.	Y
The organisation has arrangements in place to safely receive patients and staff from the evacuation of another organisations inpatient facility. This could with little advanced notice.	Y
The organisation has effective arrangements in place to support partners in a community evacuation, where the population of a large area may need to be displaced.	Y
The organisation's arrangements include effective plans to support partner organisations during incidents requiring their evacuation.	Y
The organisation's evacuation and shelter arrangements include resilient mechanisms to communicate with staff, patients, their families and the public, pre, peri and post evacuation.	Y
The organisation has undertaken an Equality and Health Inequalities Impact Assessment of plans to identify the potential impact evacuation and shelter arrangements may have on protected characteristic groups and groups who face health inequalities.	Y
The evacuation and shelter arrangements have been exercised in the last 3 year. Where this isn't the case this will be included as part of the organisations EPRR exercise programme for the coming year. Please specify.	Y

Organisational Evidence - Please provide details of arrangements in order to capture areas of good practice or further development. (Use comment column if required)	Self assessment RAG Red (not compliant) = Not evidenced in evacuation and shelter plans or EPRR arrangements. Amber (partially compliant) = Evidenced in evacuation and shelter plans or EPRR arrangements but requires further development or not tested/exercised. Green (fully compliant) = Evidenced in plans or EPRR arrangements and are tested/exercised as effective.
Evacuation SOP updated	Fully compliant
Evacuation SOP supported by decision making arrangements per the incident response plan	Fully compliant
Evacuatio SOP plus surge plan and incident response plan	Fully compliant
Incident response plan	Fully compliant
Normal arrangements would apply, supplemented by additional support triggered by the declaration of an incident	Fully compliant
Contracts in place and MOU with Council for mutual aid relating to transport (and reception centres)	Fully compliant


Incident response plan covers this for an internal evacuation between sites but not for a whole organisation evacuation
Partially compliant
Incident reponse plan
Fully compliant
Mutual aid arrangements are in place
Fully compliant
Not specifically in relation to an evacuation but mutual aid arrangements are in place
Partially compliant
Communications arrangements to respond to all incidents is in place
Fully compliant
Complete (part of evacuation plan)
Fully compliant
In exercise programme for Spring 2023
Fully compliant

Action to be taken	Lead	Timescale

Patient tracking arrangements in the event of an "off WWL" evacuation to be added to the plan	Head of Resilience	Jan-23
Utilise Borough Resilience Forum to formalise arrangements	Head of Resilience	Mar-23


Comments