Board of Directors - Public Meeting

Wed 06 April 2022, 13:15 - 16:15

Trust HQ Boardroom

Agenda

12. Declarations of Interest

Information *Mark Jones*

13. Minutes of Previous Meeting

Decision *Mark Jones*

13. Minutes - Public Board - Feb 2022 4.pdf (12 pages)

14. Chair's Opening remarks

Information *Mark Jones*

Verbal Item

15. Patient Story

Discussion *Rabina Tindale*

Verbal item

16. Chief Executive's report

Information *Silas Nicholls*

16. CEO Board Report April 2022_FINAL.pdf (4 pages)

17. Committee chairs' reports

Discussion *NEDs*

17.1. Quality and Safety

17.1. AAA Q&S - Feb 2022.pdf (2 pages)

17.2. People Committee

17.2. AAA _ People - 23 Mar 2022 LL AB.pdf (2 pages)

17.3. Finance and Performance

17.3. AAA F&P - 30 Mar 2022 IB.pdf (2 pages)

18. Board assurance framework for 2021/22 and 2022/23

Decision *Paul Howard*

18. Report - Board - BAF April 2022 (updated).pdf (33 pages)

19. Well-led action plan

Decision *Paul Howard*

19. Well-led action plan report.pdf (10 pages)

20. Corporate Objectives 2022/23

Decision *Richard Mundon*

20. 22-04-06 Trust Board 2022-23 Corporate Objectives submitted version.pdf (10 pages)

Break

Patients

21. Safe nurse staffing report

Discussion *Rabina Tindale*

21. Safe Staffing summary Report for period Jan - Feb 2022 for Board.pdf (4 pages)
21a. Safe Staffing Report for January 2022 Appendices one for Board.pdf (14 pages)
21b. Safe Staffing Report for February 2022 Appendices 2 April 2022 Board.pdf (13 pages)

22. Maternity Dashboard

Discussion *Rabina Tindale*

22. Maternity Dashboard report Feb 22.pdf (5 pages)
22a Maternity Dashbaord.pdf (5 pages)
22e. Provider report March Board.pdf (4 pages)
22.b Update to Trust Board on the ten maternity safety actions Year 4.pdf (7 pages)
22c. Assessment and assurance tool v 1.9 Feb 2022 update.pdf (32 pages)
22d. B0807-maternity-self-assessment-tool-v6 (3) fEB 2022 UPDATE.pdf (23 pages)
22f. B1318 - Letter to system - Ockenden One Year On_250122 (002).pdf (2 pages)
22g. Copy of Ockenden Kirkup Returns Templates.pdf (15 pages)

23. Infection Prevention and Control Board Assurance Framework

Discussion *Rabina Tindale*

23. IPC BAF. New. v1.8. 24.12.2021. 21.3.2021 (003) April 22 Board.pdf (55 pages)

People

24. Staff Survey Report

Discussion *Alison Balson/Mary Fleming*

24. NSS 2021 Results Board 04.2022.pdf (30 pages)

Performance

25. Integrated Performance Report

Discussion *Sanjay Arya/Mary Fleming/Rabina Tindale*

25. Board of Directors M11 2122 Scorecard.pdf (4 pages)

26. Consent Agenda

26.1. Revised Committee Terms of Reference

26.1 Committee ToR redrafting - Board report.pdf (3 pages)
26.1. ToR - F&P Committee 2022 IB AT NG.pdf (4 pages)
26.1. ToR - People Committee 2022 NG AB LL.pdf (4 pages)
26.1. ToR - Audit Committee IB IH NG.pdf (6 pages)
26.1. ToR - QSCommittee 2022 FT RT NG.pdf (5 pages)

26.2. Finance Report

26.2 Board Report 21-22 February month 11 Public.pdf (2 pages)

26.3. Board diversity policy

Board diversity policy.pdf (5 pages)

26.4. GTEC Governance arrangements

26.4. GTEC Governance.pdf (5 pages)

27. Date, time and venue of next meeting

Information *Mark Jones*

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST (WWL)

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

HELD IN PUBLIC ON 2 FEBRUARY, 1.15PM

BY VIDEOCONFERENCE

Present:	Mr M Jones	Chair (in the Chair)
	Mr S Nicholls	Chief Executive
	Prof S Arya	Medical Director
	Prof C Austin	Non-Executive Director
	Mrs A Balson	Director of Workforce
	Mr I Boyle	Chief Finance Officer
	Lady R Bradley	Non-Executive Director
	Ms M Fleming	Deputy Chief Executive
	Mr I Haythornthwaite	Non-Executive Director
	Mr P Howard	Director of Corporate Affairs
	Mrs L Lobley	Non-Executive Director
	Mrs A-M Miller	Director of Communications
	Mr R Mundon	Director of Strategy & Planning
	Ms R Tindale	Chief Nurse
	Mrs F Thorpe	Non-Executive Director
	Mrs A Tumilty	Non-Executive Director
In attendance:	Mr J Cavanagh	Appointed Governor
	Mrs N Guymer	Deputy Company Secretary (minutes)
	Mrs P Gregory	Public Governor
	Ms N Heath	Surgical Matron (to item 19/22 only)
	Mr A Haworth	Public Governor
	Ms R McGrory	Senior Communications & PR Officer

The Board reconvened following an adjournment

*** NUMBERING TO BE ADJUSTED ***

14/22 Declarations of interest

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

15/22 Minutes of the previous meeting

The minutes of the last meeting held on 24 November 2021 were **APPROVED** as a true and accurate record.

16/22 Ratification of use of emergency powers

The Director of Corporate Affairs explained that on 6 December 2021, the Chair and Chief Executive exercised the powers that the Board has retained to itself, in accordance

with Standing Orders, to approve a business case for a permanent CT scanner on the Wrightington Hospital site.

To do so, there is a requirement for them to consult with at least two Non-Executive Directors. Mrs A Tumilty as Chair of the Finance and Performance Committee and Mr I Haythornthwaite as Chair of the Audit Committee were duly consulted during a meeting in which all were convened.

The Chair and Chief Executive approved the business which means that the CT scanner will be leased over a 7-year period, with additional revenue costs of £1.5m over the life of the contract.

The matter could not be delayed in order to convene a meeting of the Board due to the fact that externally-dictated procurement timescales would prohibit this. He advised that the matter was immediately communicated to the Board and that the use of emergency powers is being reported to the Board today for ratification.

The Board **RATIFIED** the use of emergency powers, as described.

17/22 Chairs opening remarks

The Chair provided a summary of his activities undertaken since the last meeting. He commended the work done by the Trust throughout the most recent pandemic wave, including the opening of the Jean Hayes Reablement Unit (JHRU). He welcomed Mr A Haworth as the new Lead Governor and advised that 11 new governors have also recently been appointed.

18/22 Staff story

The Chief Nurse welcomed Matron, Ms N Heath, who explained how her participation in the newly established Matron and Service Lead meeting has supported her personal development, including the achievement of additional management qualifications and increased her confidence.

She described how the meeting is split in to two parts: the first half focussed on providing peer support and the second part, which is highly attended by nursing senior leaders, acting as a forum for colleagues to build relationships with those working at higher levels and in different divisions. Regular attendance and updates from the Chief Nurse have been well received, making colleagues feel valued and providing them with a platform to voice opinions and suggest organisational changes. She provided the example of a piece of work completed to improve patient experience on the night shift by reducing the amount of agency staff working. The process involved peer reviews of other trusts, ascertaining the views of staff working on night shifts around improvements to be made and looking at skill mix. Positives changes implemented included band 6 staff working at night, with band 7 staff given the opportunity to shadow duty matrons shifts at night to aid both their development and also nurse succession planning. The use of coloured property boxes to aid a reduction in loss of patients personal property was noted as another success which had come out of the meeting.

The Deputy Chief Executive noted the positive results for the nursing workforce and queried how similar needs of Advanced Healthcare Practitioners would be addressed. The Chief Nurse recalled that they were going to be invited to this forum initially but as they identified a different need from the forum, they have now been supported to set up their own separate group.

The Director of Workforce was keen that Ms N Heath's story is shared more widely, such as through the All Staff Teams Brief and noted the positive message for colleagues across the organisation.

ACTION: Director of Workforce

The Chief Executive noted how this story is testimony that the Trust's "Our Family, Our Future, Our Focus" initiative is having a positive and practical effect on staff engagement.

Mrs F Thorpe highlighted the clear link between this story and the improvements to quality and safety which have been made as a result.

The Board thanked Ms N Heath, and the Chief Nurse for the progress made with and through this forum.

19/22 Chief Executive's report

The Chief Executive expressed thanks to colleagues across the Trust who have worked tirelessly throughout the most recent pandemic wave and acknowledged the difficulties not only due to the additional demand for services but also due to staff shortages. He highlighted the Trust's pause in non urgent elective activity and was content that the correct decision was made here, albeit that this type of activity must be resumed as quickly as possible to prevent an unnecessary delay for patients waiting for this type of care. The Wrightington site is slowly returning to operate as a fully orthopaedic site and relinquish support provided for other care services. The JHRU was opened to assist demand and cardiology at the Wigan site, was taking patients from across the region and has been working collectively with the Greater Manchester system as a whole. He advised that military assistance has been provided by 15 navy staff following an invitation for Trusts to make a request for this. He noted the positive engagement that the executive team have had with the press, in efforts to keep the public informed and also internally, through the All Staff Team Brief. Staff wellbeing programmes have been well maintained and are having a positive impact on staff.

Mr I Haythornthwaite queried whether WWL are engaged in any initiatives that other NHS Trusts will be able to learn from. The Chief Executive advised that WWL's wellness work has been recognised both nationally and regionally. The work around virtual wards and hubs is also being recognised and WWL are happy to share the journey and learning around this, with other Trusts wishing to do the same thing.

The Board received and noted the update provided.

20/22 Committee Chairs' reports

The Chair begun by noting that the length of recent assurance meetings and associated agendas had been greatly reduced to allow contributing staff members additional time to focus on day to day activity and alleviating pandemic related pressures.

Mrs F Thorpe, Chair of the Quality and Safety Committee, noted that the Committee would not meet until the following week but affirmed that the agenda would have a strong focus on how patient safety has been maintained throughout the most recent pandemic wave.

Mrs A Tumilty, Chair of the Finance and Performance Committee, advised that a short meeting was held in January 2022 to obtain approval for a business case requesting funding to recruit 111 international nurses. The Committee supported the proposal and had therefore approved the business case. The Committee also received assurance around finances and current performance.

Mrs L Lobley, Chair of the People Committee recalled that the Committee met to consider the areas affected by the most recent pandemic wave. These included in particular, redeployment, including better inductions into new areas to better support staff and vaccination as a condition of deployment, with assurance around robust processes put in place by WWL to deal with this sensitive matter, despite that this may now be revoked. Notwithstanding that absence rates have increased overall throughout the pandemic period, the Committee were assured that levels have significantly reduced to around 8%. The wellbeing service was stepped up to provide support for staff and will be evaluated and reported on in due course. Recruitment and retention risks were noted, as were the mitigations in place with regard to these risks, including novel approaches to recruitment and removing barriers to recruitment, such as the requirement for a DBS check to be fully completed prior to the commencement of employment, since this often causes delays and its absence can be mitigated by completion of a risk assessment and supervision being provided for the new recruit. The Freedom to Speak Up report from the new guardian at the Guardian Service was noted to provide an increased level of assurance and the pause on the mandatory training link to pay progression was noted. She concluded by advising that an amber rating was agreed in relation to the board assurance framework for all 'People' objectives.

It was noted that the next Research Committee meeting would take place at the start of March 2022. In respect of the Trusts' University Teaching Hospital status, Prof Clare Austin advised that a group has been set up to monitor this but is yet to meet.

Mr M Jones asked Lady R Bradley to provide an update following her attendance of the most recent Safeguarding Group meeting. She noted that despite that safeguarding issues have increased over the course of the pandemic, the group are assured through the data provided that referrals are being made appropriately, and that associated processes are being properly followed.

The Board received and noted the updates provided.

21/22 Board assurance framework

The Chair introduced the item, noting the inevitable gaps in the evidence provided, resulting from pandemic pressures. He observed that the figures for the hospital standardised mortality ratio (HSMR) and summary hospital mortality-level indicator (SHMI) were last updated in June 2021 and requested that this is kept more up to date.

In respect of corporate objective CO5, he noted that the business case for human factors training which is mentioned has now been approved by the Board and that the document should therefore reflect this.

Mr I Haythornthwaite queried the amber rating for corporate objective CO5, since he had expected that the roll out of training would have been much further along by this point. The Chief Nurse advised that significant progress has been made here and that this is expected to change to green in the next few weeks.

Mrs A Tumilty was surprised by the scoring of corporate objective CO10, around waiting lists and elective recovery. The Chief Executive advised that the score is likely to be accurate, since although the quantum of patients to progress is identified, it is unclear as to how quickly staffing levels will return to normal and therefore how quickly service levels will reduce in line with national recommendations. It was noted that waiting lists are reviewed on a regular basis.

In respect of the £5m funding relating to corporate objective CO12 and delivery of the digital strategy, the Chief Finance Officer clarified that this has been allocated but not yet all received; the narrative will be amended to reflected the position once funding for the next financial year is received.

Mrs F Thorpe suggested that there may have been delays in updating the BAF. The Director of Corporate Affairs noted the ongoing work to reform risk management and emphasised the importance of ensuring that the Trust have a single version of the truth which is now recorded on the Datix system.

ACTION: Executive Directors

The Chair noted that the additional verbal updates given by the Executive Directors had provided the assurance required and evidenced that the additional data is available and that improvements are ongoing.

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

22/22 Safe nurse staffing report

The Chief Nurse presented the November and December 2021 reports, which had been circulated in advance of the meeting, noting that the nursing workforce is monitored closely to ensure safe staffing along with recruitment which will be an enabler in increasing safety.

Mrs F Thorpe queried the source of band 2 staff, noting the possible risk that if these staff are being taken from the wider system, this may destabilise the system in other areas, such as the care home sector.

The Chief Nurse advised that these roles usually attract people who are not already in similar roles, with people already working at that level more likely to apply for band 3 roles.

The Director of Workforce added that WWL are collaborating with NHSP, Wigan and Leigh College and recruitment company Indeed, to develop a pipeline for the future to ensure that the rest of the system does not destabilise.

Mrs C Austin noted that a scoping exercise is currently being undertaken to identify staff, mainly internationally recruited nurses, in the latter years of the Global Training and Education Centre's scheme who wish to continue to work for with WWL and asked whether this number of staff is known.

The Chief Nurse advise that a preliminary piece of work identified that 95% of staff would like to remain working for WWL, although the full piece was unable to be completed due to the pandemic surge. Currently, a scoping exercise is taking place to ascertain where it is possible move these staff to gain experience in alternative areas, which will allow their positions to be backfilled with new international recruits.

The Chief Executive highlighted that international recruitment is becoming more competitive and that WWL may need to consider how their offer can be made more attractive, for example, through providing childcare, investing in on site staff facilities and providing subsidised meals.

Mr I Haythornthwaite observed that the increase in spend on temporary staff appears to be a permanent feature of the report. He asked whether this is a symptom of the current pandemic climate or is expected to remain as a permanent issue moving forwards. He asked whether it is expected that initiatives outlined will aid reduction of this.

The Chief Executive noted that these initiatives will help but that the Trust may need to aim to go over and above the recruitment target to be able to achieve the desired levels.

The Chief Nurse added that ever changing COVID-19 variants and the resulting absences are adding to the requirement for this increase in the current climate.

The Board received and noted the report.

23/22 Safe medical staffing report

The Medical Director presented the report which had been circulated in advance of the meeting. He noted that this is the first time that such a report has been presented to the Board and that, since there is no national requirements for such a report to be provided, there are no set requirements in respect of what the report should entail. He invited feedback from the Board.

Mr L Lobley welcomed the report. She requested that, going forwards, other specialities suffering from a shortage of staff and where locum use is high are identified through the report. She noted that Trusts which are not in city centre

locations or located close to a university often find it difficult to recruit to their medical workforce. She noted that Edge Hill University will not deliver graduates for WWL for some time and suggested that other routes are considered in terms of graduate recruitment in the short term.

Mrs F Thorpe noted the 30% locum requirement and queried the process for reviewing the establishment based on additional demand. The Director of Workforce explained that the Associate Medical Director is running a workforce efficiencies programme in respect of temporary spend on medical staffing, which identifies six areas of focus to be address in reducing spend. This reports in to the Transformation Group.

Prof C Austin asked whether physician associates are included within medical staffing and whether they are used in A&E currently or whether this could be considered.

The Medical Director explained that WWL were pioneers in taking on physician associates as an alternative to the usual medical workforce, however, in recent years have experienced difficulty in recruiting them and have only managed to recruit two of these staff recently. However, highlighted the more significant problem with staffing as being with middle grade consultants and those within medical specialties, rather than A&E, which would be unable to be addressed by the recruitment of physician associates.

Mr I Haythornthwaite noted the difficulties in planning for staffing, particularly in relation to the funding element, where the requirement for locum staff is so high.

The Medical Director appreciated the issues with the increased use of locums and the increased associated expenditure. However, he noted that with the subsidence of the pandemic and the reduction in A&E attendance which is now starting to be seen, as well as the change in IPC guidance allowing the A&E footprint to reduce, A&E staff will be able to reduce, which will in turn reduce the need for locum staff within medicine.

The Director of Workforce noted that By August 2022, the e-rostering system for the medical workforce will have added rolled out and that this will provide a fuller picture of the medical staffing position at any given time, through data analysis.

The Board thanked the Medical Director for the report and the Chairman requested that the next report endeavours to set out the changes to the staffing requirement resulting from required changes to the pandemic approach.

The Board received and noted the report.

ACTION: Medical Director

24/22 Biannual nurse staffing rereview

The Chief Nurse presented the report which had been circulated in advance of the meeting, highlighting the difficulty in providing an accurate picture of the current position through this report, given the demands of the pandemic and the changes to ward requirements.

Lady R Bradley queried whether nurse staffing ratios, of registered versus non registered staff, should be reviewed in detail and at what point this should happen. She asked when WWL should be aiming for a 70-30 split, in line with CQ requirements.

The Chief Nurse highlighted the issues with recruitment on a national scale and that the profession will need to consider this as a whole, with the possibility that the ratio may be reduced nationally, particularly where more tasks may be allocated to qualified band 4 staff.

Mrs F Thorpe agreed, particularly in relation to the community divisional infrastructure, which she agreed does require more focus, despite that there is no national requirement to consider ratios here. She asked whether the report is a form business case, requesting funding to allow changes to be implemented, to address the concerns set out, moving forwards. She wondered whether reference costs would be lower if the Trust have more non registered staff compared to registered staff.

The Chief Nurse noted that the report outlines the areas in which she considers investment is required, although it is not a business case per se. She suggested that executive colleagues could be consulted in respect of the priority order of these investments, to determine where business cases should be worked up and funding sought.

In response to a comment from Mrs A Tumilty it was agreed that a financial strategy is required to be written in tandem, although appreciated that the current financial arrangements for all Trusts makes this difficult. As financial plans become finalised, required and available resource will be identified and necessary changes implemented as quickly as possible.

Silas Nicholls highlighted the need for forward thinking, since the Trust need more staff to allow existing staff to live their 'compassionate' organisational value. Ultimately, there are unlikely to be enough staff to recruit, even if funding becomes available and therefore a key piece of associated work will be to identify how best this risk can be managed.

The Board received and noted the report.

25/22 Maternity dashboard

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

Aliso Tumilty queried whether steps are being taken to introduce a midwife led unit which would result in a higher level of normal births overall along with other improvements to provide the best experience for women.

The Chief Nurse noted aspirations to ensure all metrics are green, she noted that some elements are not within the Trust's control but in respect o those that are, the team are working to plan how initiatives can improve these metrics. Whilst there are no plans to

introduce a midwife led unit, this is a Trust aspiration, although will be difficult to explore until staffing levels are in amore stable position.

Mrs L Lobley welcomed the 'maternity voice' feedback element which had been incorporated into the dashboard although was concerned in relation to the comments provided here, which generally suggested that additional staffing is required. She asked how these would be taken forwards.

The Chief Nurse advise that the Head of Midwifery reports these back to the team in their Clinical Cabinet and governance meetings. There is no current capacity for additional staff although again, this will be explored when staffing levels improve.

Prof C Austin asked what can be done to improve the position in relation to provision of steroids related to premature births.

The Chief Nurse she agreed to ask the team to carry out some deep dives into this area to identify areas for improvement. She advised that she will be undertaking a comparison with other trusts and would also pick this up at the Midwifery Regional Meeting in March 2022, which she would attend as the representative for GM chief Nurses.

The Board received and noted the report.

26/22 Infection control board assurance framework

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

Mrs F Thorpe queried the timeframe in respect of the business case put forward to address staffing and improve adherence to national cleaning standards. The Director of Finance advised that recruitment has begun and that the staff filling the roles identified within the business case will start work with WWL very soon.

A discussion ensued around the reduced compliance in respect of hand hygiene. It was noted that, in spite of the increased requirement for compliance, due to the pandemic, factors associated with the increase in demand and staffing pressures, had actually contributed to this dip in compliance.

The Board received the report and noted its content.

27/22 Learning from deaths report Q3 2021/22

The Medical Director presented the report which had been circulated in advance of the meeting, highlighting the drastic reduction in COVID-19 related mortality. He noted that the provider analysing Trust data to provide these figures has now been changed from Dr Foster to HED and that a 12 month trial period is been undertaken with the new provider.

Mrs L Lobley queried the reason for this and asked whether the past data can be linked to the data from the new provider.

The Director of Strategy advised that the new provider is perceived to be able to provide better quality of data and that SHMI and HSMR will continue to be measured in the same way, with no discontinuity of data.

In response to a query from Mrs F Thorpe, he advised that in order to determine what falls within the category of 'potentially avoidable deaths', cases are reviewed by a group of clinicians who consider whether, even if the patient had followed the correct course, the outcome would have been the same.

In a response to a query from Mr I Haythornthwaite, the Chief Executive advise that the report is reviewed by the Executive Team regularly and used to inform management level decisions.

The Board received the report and noted its content.

28/22 Performance score card

Mary Fleming provided a supplementary update to the score card provided. She highlighted that the most recent wave of the pandemic has seen a greater demand on the general and acute bed base than in previous waves. The closure of 98% of care homes across the borough has impacted both on discharge and on urgent care services, including ambulance turnaround times and A&E waiting times.

She summarised the key actions taken by the Trust to alleviate these pressures, including the launch and expansion of virtual wards, a focus on same day emergency care, the operationalising of JHRU as a step down facility and use of 'super surge beds' on the Wrightington site, which meant that the elective programme had to be paused.

She highlighted that before elective care was paused for the second time, the Trust had shown increased activity against pre pandemic levels, waiting list growth had slowed and the 104 week waiting time had fallen for the ninth consecutive month.

She noted the concerns identified with progression of recovery and that the Emergency Care Improvement Support Team were therefore invited in to work with the Trust on improving this. As a result, going forward, the Trust's approach will be to to share the risk taken on by A&E across the whole organisation, as well to reintroduce full internal professional standards, which had not been possible to adhere to fully during the pandemic period, and to ensure robust escalation processes . Individual issues to tackle will include a reduction in ambulance handover times to 60 and then 15 minutes, a reduction in the number of patients waiting in A&E and an increase in the number of medically optimised patients discharged in a timely manner.

The Chair suggested that, when the JHRU is able to be opened for its originally intended purpose, a date is identified for an official opening.

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

29/22 Finance report

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

Mrs L Lobley queried what the interim arrangements will be until the Integrated Care System comes into operation. The Chief Finance Officer noted that the technical financial guidance for the financial year is yet to be received and that this yet to be confirmed. He was comfortable that there would be no significant changes taking place during the first year.

The Board received the report and noted its content.

30/22 Consent agenda

(a) Freedom to Speak Up Guardian Report

The Director of Workforce highlighted that the Trust see the increase in reporting as a positive change and that this was anticipated flowing introduction of service provision by an external organisation. She suggested that the increase reflects an increased level of psychological safety amongst staff.

The Board received the report and noted its content.

31/22 Date time and venue of the next meeting

The next meeting of the Board of Directors will be held on 30 March 2022, 1.00 to 2.30pm, by videoconference.

Action log

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
2 Feb 2022	18/22	Staff story	Consider how story can be shared in All Staff Team Brief.	Director of Workforce	10 Mar 2022	**Action completed.**
2 Feb 2022	21/22	Board assurance framework	Executive lead for each CO to ensure that Datix is updated on a regular basis and before presentation to board	Executive Directors	Ongoing.	Included here for noting but will be removed after the next meeting, as this is an ongoing requirement.
2 Feb 2022	23/22	Safe medical staffing report	Further develop the report and bring back at an appropriate point in time.	Medical Director	Ongoing.	Verbal update to be provided.
2 Feb 2022	24/22	Biannual nurse staffing review	Work with executive team to take the findings of the review and consider how this will be taken forward and prioritised over the coming year(s)	Chief Nurse	Ongoing.	Verbal update to be provided.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	06 April 2022
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 no 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

The WWL Way

There are no wider implications associated with this report.

Recommendation(s)

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

Report

As we begin this new financial year, I want to say a big thank you and commend all colleagues at WWL for their commitment and support as to what can only be described as another challenging year responding to COVID-19 and the ongoing impact it is having on our services. I would also like to thank our patients and their loved ones for their support and patience whilst we have had to make adjustments to our services, along with partner organisations, to meet the increasing demands that COVID-19 has presented to us as a healthcare system.

I am pleased to report that we are now well on our way to restoring our elective services and, in implementing our Elective Recovery plan even further, we are taking the opportunity to think about how we can deliver services differently and how we can improve them for our patients in the long term. The world is a very different place than it was two years ago, pre-pandemic, and across all specialties, our teams continue to commit themselves to provide the best possible care to our patients and the communities we serve. This means a commitment to ending the 104-week-wait for a small proportion of patients and reducing the 52-week-wait overall.

Whilst there has been a strong focus on recovery and urgent and emergency care services, we have also continued to make investments and improvements across many of our sites. At Wrightington Hospital we have seen the arrival of a new CT scanner, which will be used to create additional capacity for outpatients, reduce patient waiting times and provide a lower risk facility for vulnerable patients. Elsewhere at Wrightington Hospital, Ward 7, which houses our Rheumatology Department, significant refurbishments have been made to provide a more suitable facility for patients and our staff. Plans are also in place to develop our orthopaedic theatres which will further assist in our recovery strategy.

At Leigh Infirmary, I am pleased to be able to say that the Jean Heyes Reablement Unit will soon be operating as it was originally intended, a step down reablement service, working alongside community colleagues as an Allied Health Professionals-led (AHP) facility. Staff there have done an amazing job of taking on the responsibility of opening the unit and must be recognised for their efforts.

At our Royal Albert Edward Infirmary site, the Community Assessment Unit (CAU) recently celebrated its one-year anniversary, a truly innovative service that WWL is incredibly proud of. Managed by our Community Division and uniquely led by AHPs, the unit also links into primary care and is the home of our flagship Greater Manchester Virtual Hub. This allows us to support patients in their own home with the very latest cutting-edge technology.

We continue to ensure that we have the right workforce in place to care for our patients and, following investment into this, we recently welcomed a new cohort of international nurses who joined us throughout February and March. In recognising and responding to the continued difficulties nationally of recruiting nurses, we have committed to recruiting an additional 180 nurses before the end of December this year.

Our commitment to research continued in recent months, with the positive news that our Patient Research Advisory group has contributed to a research publication in the British Medical Journal Open and WWL's Consultant Respiratory Physician & Divisional Medical Director for Medicine, Dr Abdul Ashish, has been appointed as Theme Lead for Exceptional Experience at the National Institute for Health Research (NIHR) Clinical Research Network Greater Manchester (CRN GM).

I am pleased to report that our Steps 4 Wellness team has continued to rise to the challenge in caring for the psychological resilience and safety of our staff in response to the COVID-19 pandemic. Following the implementation of the SOS Rooms, which have become a vital tool in our staff wellbeing kit, investment into the team means they can now expand their service, ensuring that those staff members continue to feel supported, and look at new ways in which our WWL Family can be cared for. One example of how we are listening to staff and what matters to them is

through further investment at our Royal Albert Edward Infirmary site, where an area is being developed to provide rest and changing facilities for staff which will be opened later this year.

More recently we have supported the people of Ukraine, both within our Trust and overseas with our Steps 4 Wellness and Chaplaincy Teams providing guidance and spiritual care. I am proud that our staff have stepped up to support this cause and have been able to collect equipment, clothing and medical supplies to be sent to Ukraine and we continue to give our support to those members of staff from the country.

Finally, I want to close this report by thanking and acknowledge the efforts of the Royal Navy personnel who served our patients and supported staff for six weeks at the beginning of the year. As the servicemen prepared to leave our Royal Albert Edward Infirmary site, we were visited by Commodore Phil Waterhouse, the Royal Navy's Senior Officer in the North-West, who presented the Trust with a plaque in recognition of the work between the Royal Navy and the NHS. This support assisted us to stabilise the pressures on staffing and allowed our clinicians to focus on the provision of clinical care as we prepared our sites for full restoration of activity, and we are extremely thankful for their assistance.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Quality and Safety Committee
Date of meeting:	9th February 2022
Chair:	Francine Thorpe

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

ALERT ***(matters that the Committee wishes to bring to the Board's attention)***

- The Trust has maintained a sustained focus on patient safety during the recent Omicron surge; however due to exceptional pressures there have been a small number of incidents reported linked to this situation. They are currently being investigated, once completed information will be received by the Committee on lessons learned and any actions being taken.
- Service user feedback has been negatively impacted over recent months due to the excessive demand on services, staff shortages and inability for families to visit. It is expected that this will improve and the Committee will continue to monitor through regular reports.
- Data presented indicated that the Trust will not meet the objective for 2021/22 in relation to a 25% reduction in sepsis related mortality. The sepsis improvement plan is regularly reviewed and monitored by the Committee and this objective will be rolled over into 2022/23

ASSURE ***(matters that the Committee wishes to bring to the Board's attention)***

- Data presented indicates that the Trust has already achieved the objective relating to a 25% reduction in mortality related to AKI and to bring SHMI in line with the expected range.
- The Trust is on track to meet its objective of achieving a 50% reduction in grade 3 and 4 hospital acquired pressure ulcers.
- The IPC report was received which provided assurance in relation to Trust compliance with national standards and ongoing management of COVID-19.
- Reports were received that gave a good level of assurance that robust processes have been put in place to monitor nursing and medical staffing levels during the recent Omicron surge. Daily senior oversight and re-distribution of staff where necessary has been maintained to ensure patient safety.
- Regular oversight and audit of internal processes within the A&E department have been maintained during the current period of excessive demand, which provided the Committee with assurance that maintaining patient safety within this pressured environment remains a high priority.
- Assurance was provided on the process for monitoring and prioritisation of P2 and cancer patients whose treatment has been delayed as a result of the pandemic. This report

provided clear evidence of clinical oversight at speciality level to minimise the risk of patient harm.

- A detailed report in relation to Safeguarding was received providing assurance in terms of how the Trust is meeting statutory responsibilities in relation to this area.

ADVISE *(items presented for the Board's information)*

- The Harm Free Care report indicated that there has been an increase in inpatient falls and community acquired pressure ulcers during Q3. This will be monitored closely through regular reports to the Committee with further information being escalated to Board if necessary.
- Information provided indicated that there has been a reduction in serious incidents reported during Q3, work is ongoing to identify whether these relate to the deteriorating patient which is one of the Trust objectives for 2021/22.
- The review of P2 and cancer patients awaiting treatment has identified some incidents in terms of endoscopy follow up. An investigation is underway, the outcome of which will be presented to Q&S once completed. This will provide details on the number of patients affected/level of harm and provide assurance on actions taken to mitigate any further risk.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- Trust Board is already aware of the risks relating to IPC in terms of lack of availability of side rooms and the challenges around the new national cleaning standards. This continues to be closely monitored and a plan is in place to achieve the required standards.
- No new risks were identified

NHS
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NHS Foundation Trust

Committee report

Report from:	People Committee
Date of meeting:	23 March 2022
Chair:	Lynne Lobley

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

ALERT ***(matters that the Committee wishes to bring to the Board's attention)***

- The National staff survey identified many areas where positive feedback had been received but concerns were raised in respect of the 29.5% response rate – one of the lowest in the country. WWL are a negative outlier in respect of metrics relating to personal development – at 4.93 vs the 5.23 sector average.
- The Guardian of Safe Working's report raised concerns and questions around whether the impact of COVID-19 related absences has impeded the Trust's ability to support safe staffing. It was proposed that Q&S Committee should consider this when reviewing safe staffing reports.
- Staff group differentials were noted during the discussion on the gender pay gap – there is still a 30% gender pay gap but this is disproportionally impacted by the medical and dental workforce. When this staff group is removed the pay gap reduces to just over 3%. There are significant gender pay gaps within two of the staff groups – medical and admin. The Trust will look at implementing positive action strategies to address this, but for the medical staff group, it was acknowledged this will take many years to impact.

ASSURE ***(matters in relation to which the Committee received assurance)***

- When the medical and dental staff group is removed from consideration, it was agreed that the gender pay gap does not raise significant concerns.
- The workforce plan was positively received, covering all staff groups and being aligned with finance and operational submissions.
- The fair experience for all report shows that the race disparity ratio for BAME colleagues entering formal disciplinary processes is currently only 0.02%, demonstrating that the just and learning culture programme, including the exec led disciplinary triage process is working. This triage panel process is to be replicated for medical staff.
- The Empactis system roll out has generated very positive feedback, the Committee heard this first-hand through the radiology service manager's staff story.
- The three programmes of work on workforce digitisation are well aligned and a clear project plan set out with delivery time frames. BAU infrastructure is still to be identified and subject to business case process.
- Concerns raised with the FTSU Guardian are all being acted up on within the agreed timeframes.

ADVISE ***(items presented for the Board's information)***
▪ Progress has been made in respect of recruitment and retention and there are many supporting initiatives ongoing – the team is undertaking a piece of work to create a clear visual to show performance in line with key trajectories. ▪ In respect of staff wellness, positive discussions have taken place with the GM resilience hub and fast track pathways are now established and working well with the Wigan IAPT service. A single point of access for all Trust well-being services (Steps 4 Wellness and Psychological Support) has been established. ▪ The BAF will be recommended as amber overall, with some individual risk scores being reduced. ▪ The national staff survey demonstrates that the focus set out under Our Family, Our Future, Our Focus remains valid and is starting to see signs of improvement. It was noted that culture change takes time, but we are now building on a sound base, following a number of years of declining results, which took WWL from being one of the highest performers in this area to being aligned with the sector average. A fifth priority programme of work under our FFF for personal development will be added, with scoping work commencing now. The personal development pillar will focus on delivering the Trust wide learning needs analysis (prioritisation options paper is being taken to ETM) and meaningful appraisal. ▪ Robust process are in place for management of workforce related audit and risk, managed through divisional DQEG.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
▪ NA

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	F&P Committee
Date of meeting:	30 March 2022
Chair:	Alison Tumilty

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

ALERT ***(matters that the Committee wishes to bring to the Board's attention)***

- International recruitment has seen a drop in figures and a number of nurses withdrawing – this is due to personal choice and also financial incentives offered by other trusts - mainly in the London region.
- Delivery of the elective recovery plan is challenged – whilst the Trust is improving its position against NHSI/E recommendations it is not forecast that the 110% activity target and the 104% value target will be met.
- There was a lack of rigour around cyber security measures during the pandemic period but plans are now in place for staff training, which will strengthen WWL's position.
- The Trust are awaiting feedback on submission of their plan from NHSE/I and until this is received the work on the budget, the assumptions and risks are noted (with specific regard to the deliverability of 5% cost reductions), but formal approval will take place once the national planning round completes. Extraordinary F&P and Board meetings will be held to approve the budget at the appropriate time.

ASSURE ***(matters in relation to which the Committee received assurance)***

- Cyber security is compliant with core standards.
- The Trust is meeting its financial plan for month 11 and forecasting to break even at year end.
- There has been £4m of funding allocated for investments within IM&T. The Trust will make investments into artificial intelligence, amongst other initiatives.
- The Trust was scored 2nd in GM in terms of digital maturity. WWL achieved stage 5 of 7 with good progress made to achieving stage 6.
- The Trust is on trajectory to achieve the forecasted position in terms of 104 week waits and do not expect any patients to remain on this list past 30 June 2022.
- The Trust has made good progress in respect of reducing the number of patients waiting over 12 hours in A&E.

ADVISE ***(items presented for the Board's information)***

- A briefing on GTEC was received and associated governance recommendations were approved.

- The BAF requires updating as the new financial year approaches, with new risks to be included around recovery and budget.
- The Trust are participating as one of 15 trusts in a national programme to try and reduce occupancy rates – the 'hospital only discharge programme'.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- The £4m of allocating funding for digital must be spent within 6 weeks' notice. The operational, IT, finance and procurement teams are working closely to ensure that this happens.
- There are material risks from the financial planning exercise that the Trust may not be able to deliver a break even plan for 2022/23.
- There are risks to the delivery of the 'hospital only discharge programme'
- There are risks to the delivery of the elective recovery programme
- Risks identified in respect of both of the above are:
    - Increased attendances in A&E
    - A lack of reduction in the 'no right to reside' numbers
    - Increased occupancy rates due to IPC guidance

Title of report:	Board Assurance Framework update
Presented to:	Board
On:	6 April 2022
Presented by:	Director of Corporate Affairs
Prepared by:	John Harrop, Head of Risk Paul Howard, Director of Corporate Affairs
Contact details:	E: paul.howard@wwl.nhs.uk

Executive summary

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

Link to strategy

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

Risks associated with this report and proposed mitigations

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

Financial implications

There are no financial implications associated with this report.

Legal implications

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

People implications

There are no legal 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 provides a robust foundation to support our understanding and management of the risks that may impact the delivery of Our Strategy 2030 and the annual corporate objectives. This report considers those risks that are most likely to materialise and those that are likely to have the greatest adverse impact on delivering the strategy.

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

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

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

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

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

2. Strategic Priorities

2.1 The trust's strategy is focused on the delivery of annual corporate objectives within 4 strategic priorities:

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

3. Risk Rating Matrix

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

RISK RATING MATRIX (CONSEQUENCE x LIKELIHOOD)

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

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

4. Board Assurance Framework Review

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

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

5. New Risks Recommended for Inclusion in the Board Assurance Framework

5.1 There are no new risks recommended for inclusion in the Board Assurance Framework in April 2022.

6. Risks Accepted and De-escalated from the Board Assurance Framework in April 2022

6.1 The current risk scores for the following risks have been reduced to their target risk scores. The Board are invited to consider accepting and de-escalating these risks from the Board Assurance Framework in April 2022.

- Risk 5.1 (3277) Human Factors Training - Releasing Ward Managers to undertake training
- Risk 6.1 (3278) Health and Wellbeing - Funding to deliver the stepped care model for physical and mental health
- Risk 7.1 (3281) Recruitment and retention – vacancies
- Risk 7.2 (3282) International recruitment
- Risk 12.1 (3293) Digital Strategy Funding

6.2 In addition, a number of corporate objectives have been marked as completed and risks relating to those objectives have been removed from the Board Assurance Framework.

7. Review Date

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

8. Recommendations

8.1 The Board of Directors are asked to:

- Review the risks and confirm that they are an accurate representation of the current significant risks to the delivery of the Trust's strategic objectives
- Approve the recommendation to reduce the risk scores, tolerate and de-escalate risks from the Board Assurance Framework as of April 2022.

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Board assurance framework

April 2022

The content of this report was last reviewed as follows:

Quality and Safety Committee:	09 Feb 2022
Finance and Performance Committee:	30 Mar 2022
People Committee:	23 Mar 2022
Audit Committee:	15 Feb 2022
Executive Team:	31 Mar 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 delivery of the agreed objectives by the Executive Team. It sets out the risks to achieving those objectives and provides a clear analysis of progress. It also provides a mechanism for delivering against our longer-term strategic objectives.

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

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

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

Understanding the Board Assurance Framework

RISK RATING MATRIX (CONSEQUENCE x LIKELIHOOD)

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

DIRECTOR LEADS

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

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

Our approach at a glance

Our Strategy 2030

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

FY2021/22:
A year of balance

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

Recovering from the impact of COVID-19

- Supporting our workforce
- Recovering the elective care programme

Progressing key elements of the strategy that make us unique

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

Ensuring we have a robust foundation to build on

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

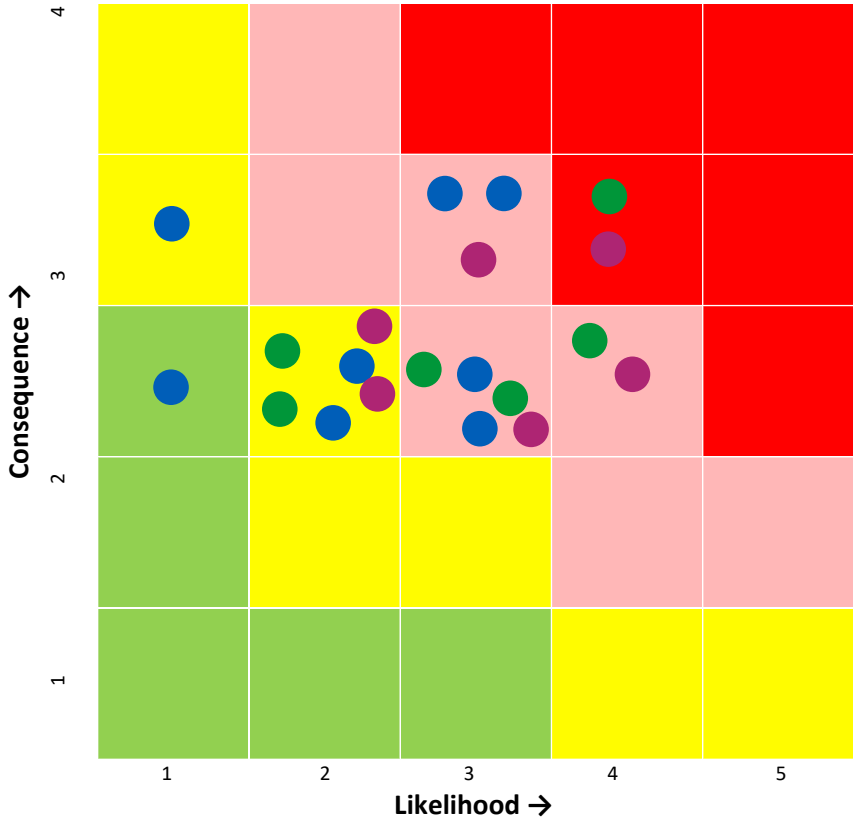
Risk management

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

Our risk appetite statement is as follows:

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

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



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

Patients

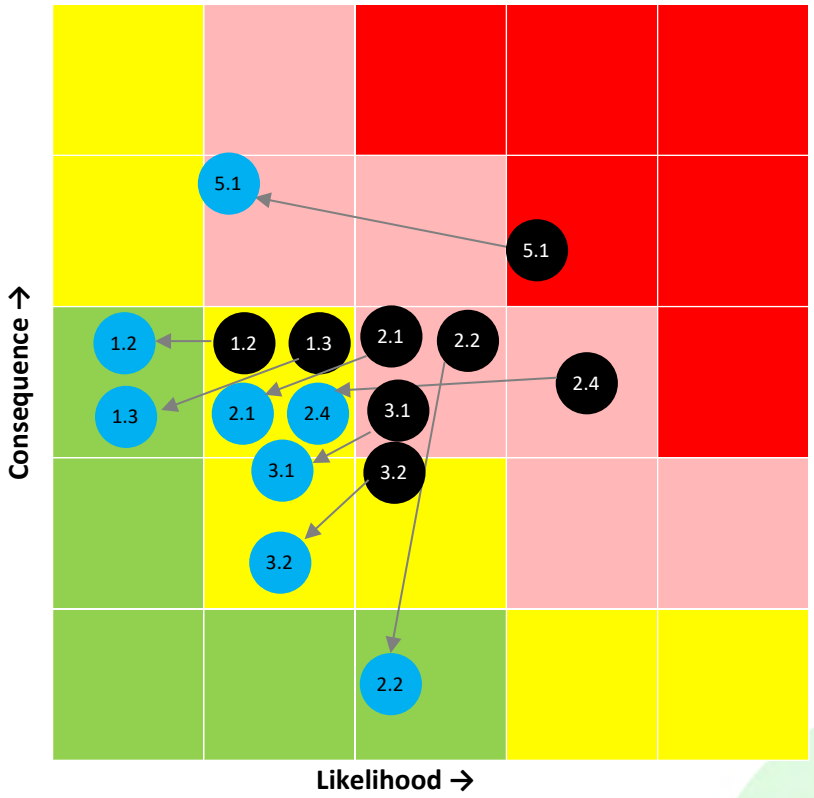
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

Monitoring: Quality and Safety Committee

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

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

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



CO1: To reduce SHMI to within the expected range			
Lead Director: MD	**Risk appetite:** Low (Quality/innovation and outcomes); Moderate (reputation)	**Assurance level:**	**ACHIEVED**
Detailed objective:	We will reduce preventable death, demonstrated by bringing the Summary Hospital-level Mortality Indicator within the expected range by 31 March 2022.		

CO2: Improve safety and quality of clinical services			
Lead Director: MD	**Risk appetite:** Low (Quality/innovation and outcomes); Moderate (reputation)	**Assurance level:**	
Detailed objective:	We will improve the safety and quality of our clinical services by achieving a 25% reduction in mortality related to sepsis and a 25% reduction in mortality related to acute kidney injury by 31 March 2022.		
Rationale for assurance level:	Whilst the improvements relating to AKI have been achieved, we have not achieved the desired level of reduction in relation to sepsis.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
2.1 (ID 3268) There is a lack of recognition, screening and treatment of the deteriorating patient across the foundation trust	L3 x C3 9 High	L3 x C3 9 High	L2 x C3 6 Moderate	This is a dedicated corporate objective for FY2021/22 Rapid Improvement Group Sepsis QI group Sepsis Improvement Plan Visibility of Sepsis Nurse in clinical areas Sepsis audits undertaken Themed SIRI panel on sepsis in Sept 2021 focused on improvement work and highlighted achievements to date	Mar 2022	Workload demands for Sepsis nurses	Deteriorating Patient Improvement Group continues to meet monthly - completed 24.03.22 Sepsis on HIS now live – completed 24.03.22

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
2.2 (ID 3269) Limited resources in relation to training and development for staff	L3 x C3 9 High	L3 x C3 9 High	L1 x C3 3 Low	Sepsis nurse attends all corporate sessions Sepsis nurse attends clinical audit Sepsis Bulletins Learning from incidents Monthly AIMS Blood cultures training every 2 weeks via in house trainers who have now undergone train the trainer education programme.	Mar 2022	Workload demands for and sepsis nurse Reduced AIMS faculty members to support the programme Reduced number of blood culture trainers	In addition to monthly AIMS sessions there is a plan in place for AIMS to be added to Clinical induction programmes once training returns to face to face. Two blood culture train the trainer role now in place with a further 2 to undergo this training. First wave of training set to be complete in February 2022 with remaining nurses to have this as part of their return to work schedules

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
2.3 (ID 3271) The sepsis service is currently single nurse led over a 5-day working week.	L4 x C3 12 High	L4 x C3 12 High	L2 x C3 6 Moderate	Separate clinical leads in place Support is provided by the Critical Care Outreach Team Information is cascaded through attendance at corporate and divisional meetings There is a policy and SOP in place.	Mar 2022	No cover is in place during annual leave, Bank Holidays or other absence. There is no contingency plan in place for patient safety nurses.	Sepsis nurse to work collaboratively to provide cross-cover and aligning workplans. Business case for Harm Free Care Services had initial review – further information requested and to be re-presented in April 2022. This team will include additional resources to support sSepsis Sepsis mortality improvement will continue and this objective will be carried forward to 2022/23 objectives

CO3: To improve safety and delivery of harm-free care			
Lead Director: CN	**Risk appetite:** Low (Quality/innovation and outcomes); Moderate (reputation)	**Assurance level:**	
Detailed objective:	We will improve the safety and delivery of Harm Free Care by achieving a 50% reduction in hospital-acquired category 3 and 4 pressure ulcers and a 20% reduction in serious incidents related to deteriorating patients 31 March 2022.		
Rationale for assurance level:	Measures implemented to date are working effectively. We have seen a 67% reduction in HAPU, and a 37.5% reduction in CAPU in total the reduction of SI reported pressure ulcers, both HAPU and CAPU are 66%.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
3.1 (ID 3322) 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	C 3 x L 4 12 High	C3 x L3 9 High	C3 x L2 6 Moderate	Training package 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 now approved	Mar 2022	Staff being able to be released to undergo training. Package not yet live 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	Pressure ulcer improvement plan updated to include the following: • Training package developed to be uploaded to Training Hub • Harm Free Care Group and Pressure Ulcer Improvement Group to be commenced. • Stop the Pressure Week underway 15th -19th November Datix improvements started to better capture pressure ulcer management.

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
3.2 (ID 3323) There is a risk that the Tissue Viability Team are not able to undertake key improvements such as supporting with validation of ulcers, investigations, training and education programmes due to capacity within the Team	C4 x L4 16 Significant	C3 X L3 9 High	C2 X L2 4 Moderate	Community and Acute TVN team amalgamated within the corporate Nursing structure.	Mar 2022	Lack of resilience within the team to support both community and acute services.	Harm Free Care Business Case drafted and submitted to BCOG – further information has been requested before considerations can be made Measures implemented to date are working effectively. We have seen a 67% reduction in HAPU, and a 37.5% reduction in CAPU in total the reduction of SI reported pressure ulcers, both HAPU and CAPU are 66%.

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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
The review which is currently being undertaken will identify the risks to achievement of this objective and this will be reported in future board assurance framework reports Update Feb 2022 – the Accreditation assessments are currently underway and to date wards assessed have achieved a Bronze rating.							

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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
5.1 (ID 3277) The fact that many ward managers are not able to act in a supernumerary capacity impacts on their ability to be released to undertake the training.	L4 x C4 16 Significant	L2 x C4 8 High	L2 x C4 8 High	Paper presented to ETM and supported in principle, business case now being drafted for submission to BCOG.	Mar 2022	No arrangements confirmed as yet	CN developing business case for review at BCOG Business case approved by Board – Nov 2021 71% of ward leaders have received training. Risk recommended for closure.

People

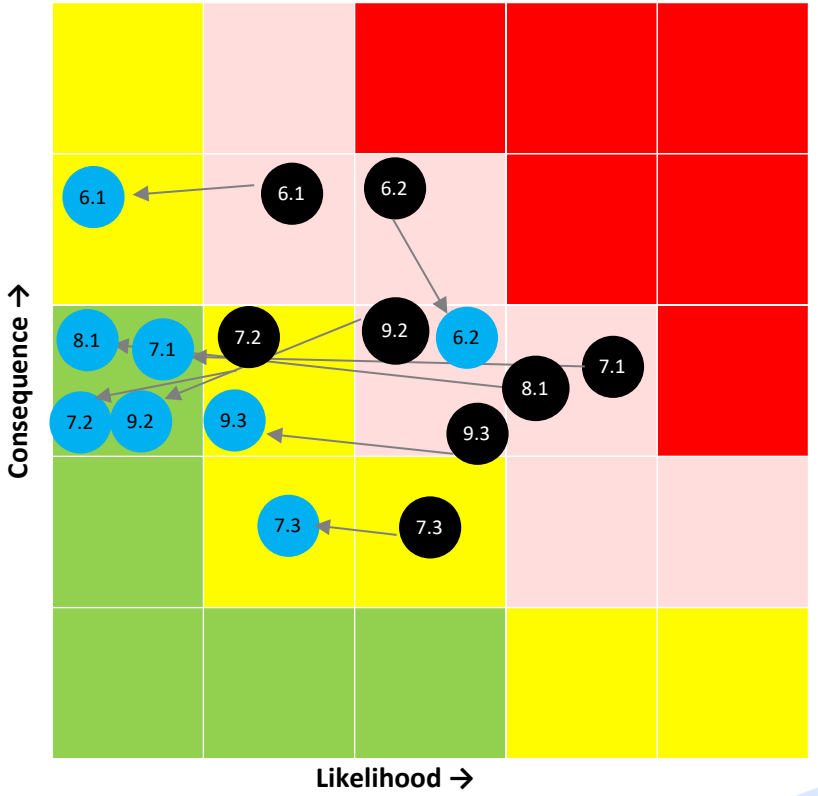
To create an inclusive and people-centred experience at work that enables our WWL family to flourish

Monitoring: People Committee

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

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

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



CO6: Health and wellbeing			
Lead Director: DW	**Risk appetite:** Moderate (reputation)	**Assurance level:**	
Detailed objective:	We will support the physical health and mental well-being of our WWL family by ensuring we have a comprehensive range of wellbeing activities and services that are accessible to our colleagues. By the 31st March 2022, we will have achieved: • Well-being score of 3.75 in Your Voice Survey • Positive evaluation of Steps 4 Wellness services		
Rationale for assurance level:	Recruitment taking place following approval of the S4W business case to ensure resilience in service delivery. Evaluation and outcome measures extremely positive for those accessing well-being services. Offers have been amended during pandemic wave escalation to align to expected needs of WWL colleagues. The Q4 Your Voice Survey has not been run due to operational pressures associated with the pandemic – this is the mechanism to measure the well-being score. Given the levels of absence associated with the Omicron wave, it is unlikely that the well-being score measure would have been achieved if it was measured in Q4.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
6.1 (ID 3278) There is a risk that the necessary funding to deliver the stepped care model for physical and mental may not be prioritised, meaning that the service cannot be provided.	L2 x C4 8 High	L1 x C4 4 Moderate	L1 x C4 4 Moderate	Business case drafted and subject to review prior to submission to BCOG Working with GM Resilience Hub where appropriate Transferred OHD MSK and counselling services into Steps 4 Wellness function for better resource efficiency Outline Business Case submitted to BCOG (August 2021) – categorisation awaited	Mar 2022	Key roles to provide full stepped care model (included in business case)	Steps 4 Wellness to prioritise and recruit to required structures, following business case decision – completed 28.02.22. Risk recommended for closure.

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
6.2 (ID 3279) There is a risk that, because of workload pressures, sufficient time is not available for staff to participate in preventative and restorative wellbeing activities within working hours, meaning that engagement levels will be lower and evidence suggests this will reduce the success of the programme.	L3 x C4 12 High	L3 x C4 12 High	L3 x C3 9 High	Targeted in-reach activities in high-risk areas. Current focus on returning redeployees and critical care. Feedback from wellbeing walkabouts Demand for services is outstripping capacity. Evaluation data provided to People Committee and recruitment activity is reducing the vacancy gap. Well-being measures included in Your Voice Survey, includes knowledge of and accessibility of services Re-prioritisation and amendment of offers during pandemic wave – well-being report to People Committee	Jun 2021 Jun 2021 Jul 2021 September 2021 September 2021 January 2022 March 2022	Commitment to roster time for people to be released as needed.	Divisional leadership teams Colleagues do currently appear to be supported to engage with activities - DNA rates are low and there has been positive engagement with the Theatres stress management team pilot Service offers have been amended during the Omicron Wave. Will be reviewed fortnightly to ensure that staff needs are being met. Significant focus on in-reach activities, taking well-being services to teams in their place of work. A strategic needs assessment will be completed when the Consultant Clinical Psychologist is in post. This will include liaison with divisions regarding finding the balance between operational service delivery and meeting employee well-being needs.

CO7: Recruitment and retention			
Lead Director: CN	**Risk appetite:** Moderate (reputation)	**Assurance level:**	
Detailed objective:	We will improve nursing, AHP and midwifery recruitment and retention so that by 31 March 2022 we will have: • achieved a reduction in the clinical vacancy rate to under 5%; • 95% of our people having a prioritised personal development plan that is supported by the trust; • talent mapping and succession plans for nursing, AHP and midwifery leadership roles; • a personal development score of 3.75 in Your Voice survey; and • a 5% reduction in leaders with less than 12 months' service		
Rationale for assurance level:	Vacancy rates decreased, but with the approval of business cases associated with the substantive establishment of the escalation areas, vacancy rates have increased as a result. Significant programmes of work with local partners to address HCA vacancies are in place and international recruitment business cases have been approved for registered nurses. Development and retention programmes in place to support the Trust in reducing Band 6 nursing vacancies. Personal development opportunities have been limited due to staffing pressures and the pandemic. Improvements are being made in turnover rates for those with less than 12 months service. Business case approved for additional 108 additional nurses Dec 2021. Recruitment in progress with GTEC.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
7.1 (ID 3281) We do not currently have a robust process which provides a single version of the truth about vacancies, which hinders effective decision making	L5 x C3 15 Significant	L1 x C3 3 Low	L1 x C3 3 Low	Currently using finance spreadsheets to understand vacancy position and for reporting purposes (not real time) PID agreed at ETM (shared at People Committee) to implement ESR manager self service and establishment control People committee report – workforce digitisation	Jun 2021 Aug & Sep 2021 Dec 2021 / Feb 2022	Full establishment control arrangements in ESR Process changes required for recruiting managers as we transition	ESR team recruited – commenced in January 2022. Teams to align with all workforce digital programmes to improve data quality – Empactis, E-roster, establishment control and self-service. Risk recommended for closure.

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
7.2 (ID 3282) International recruitment a) National pause of recruitment from India due to Covid travel restrictions Funding risk for any IR requirements in excess of 40 that have been budgeted for in 2021/22	L5 x C3 15 Significant	L1 x C3 3 Low	L2 x C3 6 Moderate	National pause has ended and recruitment pipelines are open again Recruitment & Retention report to People Committee	Mar 2022		Modelling 5 year profile requirements (Deputy CNO and Deputy HRD) – business case to be developed. Risk recommended for closure.
7.3 (ID 3283) LNA requirements may not meet the funding criteria set by HEE resulting in gap in funding	L3 x C2 6 Moderate	L3 x C2 6 Moderate	L2 x C2 4 Moderate	Full LNA analysis from Divisions being compiled – to be reviewed against available funding sources and provision methods. Update provided to Education Governance Group LNA reports at Education Governance Committee and People Committee reports LNA report to education governance – further discussion at NMALT before recommendations presented to ETM Education Governance - Review of Learning Needs Analysis completed and arrangements in place to maximise use of available HEE funds this year and next. Prioritisation options paper to be taken to ETM regarding LNA funding gap	May 2021 September 2021 February 2022 March 2022	Ability to roll forward HEE funding allocations (3 year funding, may not be equally distributed over the 3 years)	Full detailed review to be completed (CNO, DCNO, DW and education leads) November 2021 2021/22 HEE allocations have not been able to be used due to staffing and operational pressures restricting the ability to release staff. National staff survey raw data shows personal development as our outlying area – to be added as a 5th theme for priority action under Our family, Our future, Our focus LNAA recommendations to be taken to ETM in April, following scrutiny at education governance and NMALT LNA has prioritisation process has been completed in March by NMALT and Education Governance as final scrutiny stage

CO8: Culture			
Lead Director: DW	**Risk appetite:** Moderate (reputation)	**Assurance level:**	
Detailed objective:	We will make the WWL experience at work positive and fulfilling by creating an environment where our people feel safe to be themselves, to make suggestions and to call out concerns, knowing that we always look for learning and ways to improve. By 31 March 2022, we will have achieved: • Implementation of the civility and just culture programmes of work • Engagement and psychological safety score of 3.75 in Your Voice Survey • 30% of people leaders will have undertaken or have completed (with modular top up requirement) an accredited leadership development programme		
Rationale for assurance level:	The culture pilot programme roll out has been paused due to the operational pressures associated with the Omicron wave. The civility and just culture toolkit soft launched in January. Formal leadership programmes due to start in January have been paused until March / April due to operational pressures. Leadership support circles launched in January and engagement forums for clinical leaders have continued. Measures from the Your Voice Survey will not be available for Q4 as the decision was taken not to run the survey due to the operational pressures associated with the Omicron wave. FTSU contacts have increased significantly since the outsourced and independent service was launched. This is a positive marker of psychological safety improving		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
8.1 (ID 3284) There is a risk that participation in the programmes will not be prioritised as a result of other service pressures.	L2 x C3 6 Moderate	L3 x C3 9 High (Reduced from L4 x 3 = 12)	L1 x C3 3 Low	"Our family – Our future – Our focus" engagement reset programme under DCE leadership Board visibility of programme Launch events for Our FFF and associated programmes of work Prioritisation programme during Omicron Wave – ETM Commitment to restart of culture and engagement programmes – discussed linked to National Staff Survey	Jul 2021 September 2021 January 2022 March 2022	Metrics to be reported via Board	Workforce team There has been good engagement in the pilot teams so far. Escalation has been needed to ensure medical staff are engaged Activities to restart in April 2022. Support Circles for leaders / staff members are being run – these are about creating safe space for leaders / staff members to share. Leadership and culture programmes restarting March -April 2022

CO9: Fairness and compassion			
Lead Director: DW	**Risk appetite:** Moderate (reputation)	**Assurance level:**	
Detailed objective:	We will place fairness and compassion at the centre of our people policies, always respecting the needs and diversity of our colleagues. By 31 March 2022, we will have achieved: • reduced our gender pay gap by at least 5% and improved our Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) outcomes • Compassionate leadership score of 3.75 from Your Voice Survey • Re-designed key WWL Employment Policies (Disciplinary, Grievance, Dignity at Work, Attendance Management, Performance Management and Raising Concerns)		
Rationale for assurance level:	New civility and just culture framework in place. Key employment policies have been updated. YVS has not been run in January 2022 due to operational pressures – compassionate leadership score will not be measured. NSS raw data indicates that relationships with managers stable when compared with the previous year, but without significant improvement. Improvement made in the gender pay gap, primarily linked to medical workforce Clinical Excellence Awards being allocated to all eligible consultants. WRES and WDES will not be available to assess progress until full publication of National Staff Survey (February)		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
9.2 (ID 3287) There is a risk that the organisation does not have workforce EDI expertise nor any supporting infrastructure	L3 x C3 9 High	L3 x C3 9 High	L1 x C3 3 Low	Workforce EDI specialist recruited (fixed term contract) EDI strategy update and governance proposal – ETM & People Committee EDI strategy approved Expanded staff networks commencing in Q4. Training in place for network sponsors and EDI Champions. Three independently assessed schemes approved for implementation – Rainbow Badge, Disability Confident & Race Equality Scheme	July 2021 August & September 2021 November 2021	No ongoing funding commitment	EDI strategy to be approved at Board November 2021. Staff network remit to be expanded (FAME network) and additional networks launched in January 2022 for disability / long term conditions and LGBTQIA. This was supported at Trust Management Board in November. No substantive EDI workforce resource to support delivery against strategic aims set out in the strategy. Discussions across GM HRDs commenced March 2022, given scarcity of workforce EDI expertise regarding potential shared solutions
9.3 (ID 3288) There is a risk that we will not get buy-in or funding for a locality-wide workforce EDI strategy	L3 x C3 9 High	L3 x C3 9 High	L2 x C3 6 Moderate	Proposed EDI governance structures that include links to HWP EDI strategy – Trust Board	September 2021 November 2021	HWP commitment on shared agenda	Discussions around locality-wide approach required at HWP (Chief Executive and Deputy Chief Executive) Engagement is still needed with locality partners through Healthy Wigan Partnership. This will form part of the anchor institution work programme.

Performance

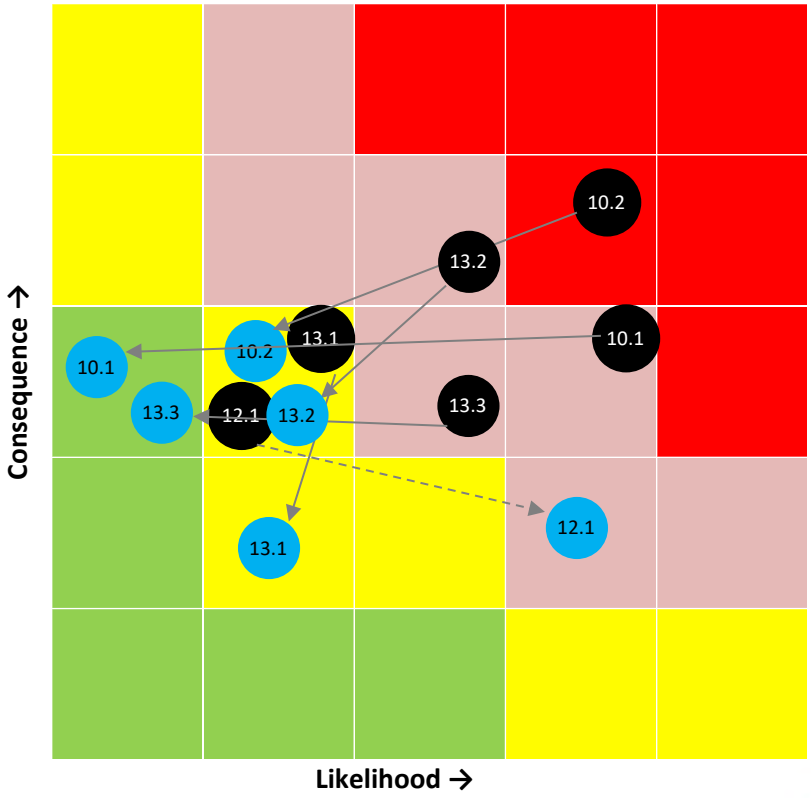
Our ambition is to consistently deliver efficient, effective and equitable patient care

Monitoring: Finance and Performance Committee

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

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

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



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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
10.1 (ID 3289) There is a risk that because the overall waiting list is growing due to increased numbers of referrals, the waiting list is growing more quickly than we are able to address the backlog which would lead to us not being able to reduce the backlog in a timely way across all three indicators	L5 x C3 15 Significant	L4 x C3 12 High	L1 x C3 3 Low	Regular reviews of risk stratification are undertaken according to clinical priority in accordance with Royal College recommendations. Additional clinical check has been introduced in Div. of Surgery where largest volume of long waits are. Patient lists managed by risk stratification National communications being issued around how patients will be contacted for review (Ext)	Mar 2022	Lack of capacity to undertake reviews of allocated risk stratification across all specialties. Patients to be given mechanism for getting in contact with GP or WWL if deteriorating.	Currently being reviewed by senior leadership teams. Harm reviews undertaken for patients waiting 104 weeks on elective pathways and 104 days on cancer pathways. Joint correspondence from WWL and CCG being sent to every patient to update them and provide contact information.

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
10.2 (ID 3290) There is a risk that the value of core (or core +) activity exceeds the funding available because we have to use additional bank/agency or independent sector provision, or we are unable to access ERF funding if we exceed our trajectory, meaning that all work cannot be undertaken.	L5 x C4 20 Significant	L4 x C4 16 Significant	L2 x C3 6 Moderate	Work is ongoing to value the plan that we have submitted and to triangulate that with the activity plan. GM Elective Recovery Reform Group in place with two programmes of work; (1) capacity and demand across GM and (2) reform. Deputy Chief Executive attends for WWL. (Ext.) Reviewing how we can address the issue by activating elective recovery fund at GM level. (Ext) Continue to access independent provider capacity.	Mar 2022	Nil at present; final submission is due in June. The next phase is then to describe the additional capacity available, the costs of doing so and what using that capacity will mean.	---

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

CO12: To create and implement Digital Strategy							
Lead Director: DCE	**Risk appetite:** Low (quality, innovation and outcomes)					**Assurance level:**	
Detailed objective:	We will have created and communicated our Digital Strategy to drive excellence in digital healthcare for patients by 1 October 2021 and by the end of March 2022 we will have modernised key elements of our IT infrastructure, demonstrated through: ▪ 100% of staff being provided with the latest versions of MS Office and MS Teams; ▪ the deployment of a new, modern telephony solution throughout WWL; ▪ implementation of the first clinical pathway in HIS; and ▪ increased critical system availability from a year-end 2020/21 position of 95% to a 2021/22 year-end position of 98% through conforming to NHS Digital's DSPT resulting in the reduction of unplanned outages						
Rationale for assurance level:	The capital allocation required to support IM&T infrastructure agreed.						
Principal risks	**Initial risk score**	**Current risk score**	**Target risk score**	**Key controls and assurance (Ext = external)**	**Evidence last seen**	**Gaps in controls/assurance**	**Actions planned (What? Who? When?)**
12.1 (ID 3293) No funding is available to deliver digital strategy as the capital application was rejected on the basis of CDEL being allocated to business critical or existing commitments.	L4 x C3 12 High	L2 x C3 6 Moderate	L4 x C2 8 High	Digital strategy stakeholder engagement sessions are underway. Further sessions are due to take place in coming weeks. Lobbying via GM (Ext) 6,000 MS Office deployments completed, expected to be completed by end of October 2021. Telephone business case approved and pre-contract activity commenced. Storage cases also approved. Sepsis pathway now live.	Mar 2022	Alternative funding for digital developments to be explored sought	Chief Information Officer to monitor availability. Risk recommended for closure.

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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
13.1 (ID 3294) There is a risk that because the clinical strategies are still under development the estates strategy may not address all elements of intended future delivery	L3 x C3 9 High	L2 x C3 6 Moderate	L2 x C2 4 Moderate	Capital prioritisation exercise undertaken which will inform the estate strategy and therefore link to the future development of clinical strategies.	Mar 2022	Group to discuss the development of the estates strategy alongside clinical strategy development	Director of Strategy and Planning and Director of Estates and Facilities to coordinate
13.2 (ID 3295) There is a risk that because of uncertainties around capital funding arrangements the strategy may assume that more investment can be made than is available	L3 x C4 12 High	L3 x C4 12 High	L2 x C3 6 Moderate	Lobbying via Greater Manchester (Ext)	Mar 2022	---	---
13.3 (ID 3296) There is a risk that the estates strategy will not fully address the net carbon zero requirements	L3 x C3 9 High	L3 x C3 9 High	L1 x C3 3 Low	Sustainability Officer in place who can provide expert input Net Zero Champion appointed	Mar 2022	Need to develop Green Strategy for WWL	Director of Estates and Facilities working with external company to undertake this work

Partnerships

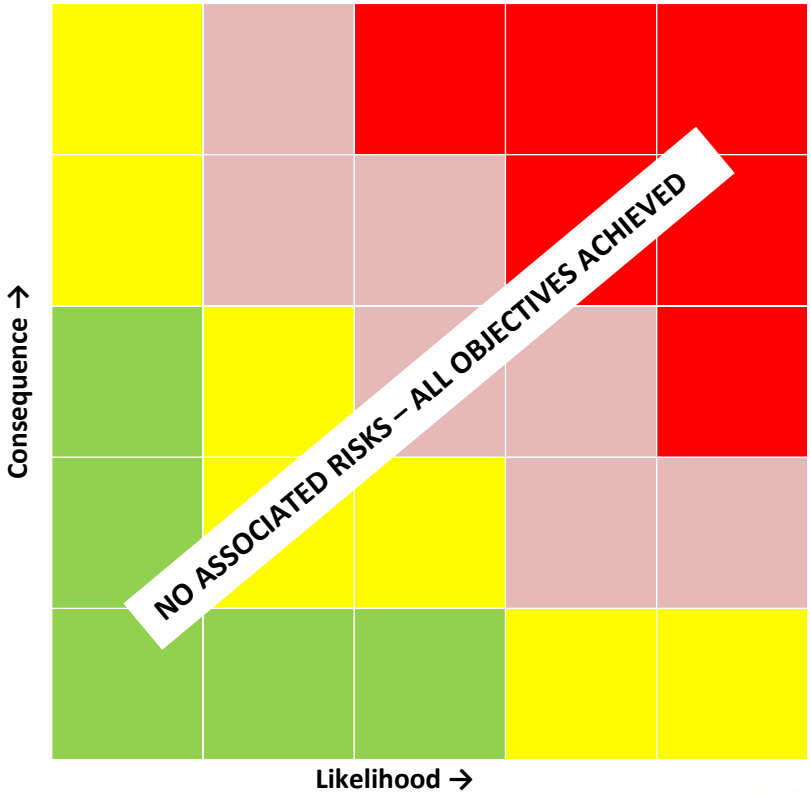
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

Monitoring: Board of Directors

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

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

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



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

CO15: University Teaching Hospital			
Lead Director: MD	**Risk appetite:** Significant (Quality, innovation and outcomes)	**Assurance level:**	ACHIEVED
Detailed objective:	By the end of Q1 2021/22, we will create and agree our development and delivery plan for achieving the criteria required to become a University Teaching Hospital organisation in a maximum of five years' time and we will deliver the 2021/22 elements of the plan by the end of March 2022.		

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

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Well-led action plan
Presented to:	Board of Directors
On:	6 April 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, the Board of Directors commissioned a development review of leadership and governance using the NHS well-led framework, and this was undertaken by Deloitte during Q3 2021/22. The report contains 15 recommendations which are intended to support the organisation in its desire to go from good to great to outstanding.

An action plan for each of the recommendations has been prepared for the Board's review and is attached to this report, alongside an update on progress as at the date of writing. Updates will be provided to each Board meeting until all recommendations have been fully implemented.

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 summary report.

People implications

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

The WWL Way

Wider implications

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

Recommendation(s)

The Board of Directors is recommended to approve the attached action plan and to note the updates provided.

Well-led review of leadership and governance
Action plan as at 6 April 2022

№ 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 and December 2022. 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.	Chief Executive	The executive development programme has been commissioned from an external supplier and the first session is scheduled to take place on 8 April 2022. Part of the first session involves a diagnostic to allow team members to identify areas of focus for the remainder of the programme.	
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 are being presented for approval at today's meeting. The seminar which will review the strategy through the lens of place-based leadership is provisionally scheduled to take place on 4 May 2022. Following the seminar, any further changes to the strategy objectives or activities will be signed off at the Board meeting on 6 June 2022.	

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
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 is provisionally scheduled to take place on 20 April 2022.	
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 1 session in H1 2022/23 and at least one further session in H2 2022/23.	Chief Executive	This has been shared with the programme facilitator and is being built into session plans. The first joint session is provisionally scheduled to take place during Q2 2022/23.	
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 Q2 2022/23, we will have considered whether it is necessary to refresh and develop an updated Responsibility Framework and, if so, will have implemented this by the end of Q3 2022/23.	Deputy Chief Executive	This action will be progressed via the *Our Family, Our Future, Our Focus* programme. The programme has recently focused on the development of a Civility Charter, based on feedback from staff engagement, and the development of a Responsibility Framework will be progressed in the coming months. A break between the two activities has been built in the programme to avoid seeking concurrent feedback and potentially diluting focus.	

№ 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 February 2022 and at Executive Team and NED team meetings during February and March 2022, the assurance committee terms of reference have been updated so that core attendees are now listed as the Committee Chair, specified board members and a governor observer. 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. We have received examples of best practice committee reporting in the form of 'AAA' reports and these have now been introduced for Board meetings. The updated terms of reference are being presented to today's meeting for approval.	

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
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. A panel consider the applications during March 2022 and membership of the Shadow Board has now been confirmed, with 15 senior managers participating in the programme. The first training module for the Shadow Board is scheduled to take place on 24 May 2022 and its first meeting is scheduled to take place on 7 June 2022. The review of Divisional Assurance Meetings has commenced.	
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 with effect from today's meeting. The Executive Team has considered a revised BAF format which has been shared with NEDs. The intention is to implement this for 2022/23. The Board development session on best practice in the use of the BAF and CRR is provisionally scheduled for 20 April 2022.	

№ 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 30 March 2022. It is intended for this to be shared with the Quality and Safety Committee on 6 June 2022.	
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 is provisionally scheduled for 6 July 2022.	

№ 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 currently under development, with lead executive and non-executive directors contributing to the development of metrics alongside the sign-off of corporate objectives which are being presented to today's meeting. The increase in statutory and other reporting requirements places an additional demand on the Data Analytics and Assurance Team which, unless resourced, may create a risk to the pace of delivery.	
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 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.	

№ 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	Engagement with the Council of Governors will take place during Q1 and Q2 2022/23.	
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. Work on the second part of the action plan is ongoing as part of the new place-based operating model currently being developed.	

№ 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.	Director of Workforce	The Leadership Development Framework has been agreed and relaunch is taking place during March and April 2022. The talent programme has been prioritised for development from April 2022. This will include identification of potential, talent pathways and development programmes. The design element of the talent programme will be completed by the end of Q1 2022/23 and phased implementation for organisational tiers will commence in Q2 2022/23.	

Title of report:	2022/23 Corporate Objectives
Presented to:	Trust Board
On:	6th April 2022
Presented by:	Richard Mundon
Prepared by:	Chris Clark, Assistant Director of Planning
Contact details:	E: chris.clark@wwl.nhs.uk

Executive summary

The report outlines the proposed corporate objectives for 2022/23.

The corporate objectives set out what the Trust plans to achieve during the financial year 2022/23 and what the organisation will prioritise and focus on during the year to progress the longer-term ambitions within the strategy.

The corporate objectives have been refined over the last two weeks reflecting the discussions at the Trust Board workshop on the 23 February and the Informal Trust Board on the 2 March. The key changes since the version presented to Trust Board are as follows.

- Reviewing the wording of all objectives to reflect the role of partnership working in their delivery, where this is relevant.
- Inclusion of additional objectives in the "Patients" domain: one focussing on ensuring that patients and their families receive personalised care in the last days of life, facilitated by integrated working across community and acute services; and the other on listening to patient experience and responding to complaints in a timely manner.
- Creating separate objectives around health and wellbeing and learning rather than having these rolled into one.
- Adding specific targets/measures and considering the balance of input/process measures with outcomes measures across all objectives.

The objectives are presented under the four Ps, therefore ensuring effective oversight of the delivery of the corporate objectives through the committee structure, with an allocated director for each, and assurance to Board being provided through the committee structure. Where there are specific KPIs referenced within the corporate objectives, the intention is that these are brought into the Integrated Performance report which is currently under development.

Link to strategy

The corporate objectives outline the priorities for 2022/23 to progress the longer-term ambitions within the strategy.

Risks associated with this report and proposed mitigations

None

Financial implications

None

Legal implications

None

People implications

None

Wider implications

None

Recommendation(s)

Trust Board are recommended to approve the proposed corporate objectives for 2022/23.

Patients		Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience			
No.	**Purpose of the objective**	**Scope and focus of objective**	**How will be know if it has been achieved**	**Lead Exec.**	**How will assurance be provided**
1	**To improve the safety and quality of clinical services**	Continue the work from 2021/22 to reduce mortality related to sepsis, and sustain the improvements made to mortality related to AKI.	- 25% reduction in mortality related to sepsis from the position at the end of 2020/21 - Maintain the reduced level of mortality achieved in 2021/22 related to AKI	SA	Integrated Performance Report
Draft detailed objective for inclusion in the BAF		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.			
2	**To ensure patients and their families receive personalised care in the last days of life**	Work with partners across the system to ensure that patient choice on their preferred place of death is honoured, through: - Auditing to understand the reasons where this has not happened and establishing an improvement trajectory linked to targeted actions; and - Rolling out an Electronic Co-ordination system to improve information sharing across partners	- Baseline audit completed to identify the % of patients who die in their Preferred Place of Death and to identify the reasons why this has not happened - Following baseline audit agree improvement trajectory increase in the % of patients who die in their Preferred Place of Death - Roll-out of the Electronic Palliative Care Co-ordination system across our acute and community services (noting that implementation across all partners required to maximise benefit)	SA	Quarterly update to Trust Board
Draft detailed objective for inclusion in the BAF		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.			
3	**To improve the delivery of harm-free care**	Continue the work from 2021/22 to reduce Hospital Acquired Category 3 and 4 pressures ulcers and reduce serious incidents relating to deteriorating patients, extending this to include zero preventable Community Acquired Category 3 and 4 pressure ulcers. Continuing the roll out of human factor training will be a key enabler to this objective.	- Zero Preventable Hospital Acquired Category 3 and 4 pressures ulcers Zero Preventable Community Acquired Category 3 and 4 pressure ulcers for patients on the District Nursing Caseload - 100% accurate completion of NEWS, PEWS, MEWS reducing the likelihood of a failure to recognise a deteriorating patient - 400 clinical staff to have completed human factors training	RT	Integrated Performance Report

Draft detailed objective for inclusion in the BAF		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.			
4	**To improve the quality of care for our patients**	Continue and build upon the accreditation programme within clinical areas, ensuring progress within clinical areas from bronze to silver and increase the reach of the programme to cover additional clinical areas.	- 7 of our in-patient wards progressing to achieving a rating at silver with all others maintaining accreditation at bronze level. - To extend the scope of the accreditation programme to A&E; Maternity Unit and the Jean Heyes Reablement Unit, through the development and piloting of the accreditation framework.	RT	Integrated Performance Report
Draft detailed objectives for inclusion in the BAF		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.			
5	**Listening to our patients to improve their experience**	Deliver timely responses to complaints raised by patients, friends and families	85% of complaints responded within our agreed time frame	RT	Integrated Performance Report
Draft detailed objectives for inclusion in the BAF		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			

People		To create an inclusive and people centred experience at work that enables our WWL family to flourish			
	Purpose of the objective	**Scope and focus of objective**	**How will be know if it has been achieved**	**Lead Exec.**	**How will assurance be provided**
6	**To make working at WWL a positive experience through a just and learning culture that is compassionate and where everyone has a voice that matters**	Develop and embed a culture with compassionate leadership, civility and psychological safety.	- Engagement score within Your Voice Survey (4.00) and National Staff Survey (7.11) - Improve response rates to Your Voice and National Staff Surveys, by demonstrating actions in response to feedback - Psychological safety measure within Your Voice survey (3.75) - Reduction of concerns raised via dignity at work / grievance linked to lack of compassion or breach of Trust values - FTSU activity managed in accordance with KPIs	AB	Integrated Performance Report
Draft detailed objectives for inclusion in the BAF		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.			
7	**Supporting the health and wellbeing of our people**	Having a comprehensive range of evidence-based well-being activities and services that are accessible to our people.	- Range of stepped care well-being services – from prevention and health promotion to support for complex needs - Well-being score within Your Voice Survey (3.25) - All divisions have a well-being plan that includes how they will ensure their employees can access services that are beneficial for their well-being - Team stress management programme rolled out to 4 cohorts in the year - Positive individual impact scores for those accessing mental health services - Sickness absence (stress and MSK) reducing by 5% - Full roll out of the Empactis absence management system	AB	Integrated Performance Report
Draft detailed objectives for inclusion in the BAF		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.			

8	**ED & I – To ensure inclusion and belonging for all**	Implement our ED&I strategy, including the launch of Staff Networks for protected groups. Undertake work to pursue inclusive recruitment and selection processes, address our pay gaps, amplify diverse voices and reduce bullying, harassment, discrimination, and violence (BHDV).	- Implement and / or extend the remit of colleague diversity networks for the following protected groups:
			  ○ BAME
			  ○ LGBTQIA+
			  ○ Disability & long-term conditions
			- Positive action to increase diversity and improve experience at all levels and within all staff groups, including leadership roles
			- Improvements in the WRES, WDES and gender pay gap outcomes
			- Delivery of the in-year actions as defined by the following programmes:
			  ○ Rainbow Badge Scheme
			  ○ Disability confident Scheme
			  ○ Race Equality Standards
				AB	Biannual report to People Committee and regulatory reports

Draft detailed objectives for inclusion in the BAF		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.			
9	**To create an environment where we are always learning and everyone can flourish**	Implement our learn and grow strategy, where all colleagues have a personal development plan underpinned by a Trust wide learning needs analysis and talent management programme	- Personal development measure within Your Voice survey (3.5) - 95% of our people having a quality personal development review (Route Plan) - A Trust wide prioritised learning needs analysis and delivery plan that addresses organisational and personal development requirements - Talent management programme that includes talent identification, assessment of potential and support - 75% of employees undertaking personal development beyond mandatory training - To increase the number of Quality Improvement Champions at Bronze level to 555 by March 2023 (March 2022 – 430)	AB	Integrated Performance Report
Draft detailed objectives for inclusion in the BAF		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			

Performance		Our ambition is to consistently deliver efficient, effective and equitable patient care			
	Purpose of the objective	**Scope and focus of objective**	**How will be know if it has been achieved**	**Lead Exec.**	**How will assurance be provided**
10	**To deliver our financial plan, providing value for money services**	Delivery of the agreed capital and revenue plan for 2022/23.	- Delivery of agreed I&E position - Ensure maximum revenue received from ERF delivery / overperformance - Delivery of planned efficiency (reducing costs from run rate and budget) - Delivery of the agreed capital investments within the agreed capital plan for 2022/23	IB	Integrated Performance Report
Draft detailed objectives for inclusion in the BAF		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.			
11	**To minimise harm to patients through delivery of our elective recovery plan**	Delivery of more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards, working in partnership with providers across Greater Manchester to maximise our collective assets and ensure equity of access.	- To eradicate 104 week waits by the end of June 2022 (unless patients have chosen to wait longer) - To deliver an increase in elective activity delivered when compared to 2019/20 baseline, aligned to the agreed operational plan, noting the national *target t*o achieve >110% of 2019/20 elective activity (104% by value). - Sustainably reduce the number of patients on a 62-day pathway that are waiting 63 days or more to pre-pandemic levels (21 patients) by March 2023.	MF	Integrated Performance Report
Draft detailed objectives for inclusion in the BAF		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) • Increase elective activity delivered to 110% of the 2019/20 baseline (104% by value) • Sustainably reduce the number of patients on a 62-day that are waiting 63 days or more to pre-pandemic levels			

12	**To improve the responsiveness of urgent and emergency care**	Working with our system partners, we will continue reforms to community and urgent and emergency care to deliver safe, high-quality care by preventing inappropriate attendance at EDs, improving timely admission to hospital for ED patients and reducing length of stay.	- To reduce 12-hour waits in EDs to 2% - To sustainably reduce the number of 'no right to reside' patients to pre-pandemic levels (39 patients in total with no more than 15 on the acute site) by March 2023 working with local authority partners and supported by the Better Care Fund and the investment in virtual wards.	MF	Integrated Performance Report
Draft detailed objectives for inclusion in the BAF		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.			
13	**To make progress towards becoming a Net Zero healthcare provider**	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.	- Set and quantify our NHS Carbon Footprint Plus baseline - Develop our Net Zero Strategy for NHS Carbon Footprint Plus and deliver identified in year actions - Develop divisional Greener WWL plans that align to the Trust Green Plan - Embed sustainability impact assessments into business case and service change processes, with 100% completion adherence - Include sustainability impact in our risk appetite statement	AB	Quarterly update to Finance and Performance Committee
Draft detailed objectives for inclusion in the BAF		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.			

Partnerships		To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester			
	Purpose of the objective	**Scope**	**How will be know if it has been achieved**	**Lead Exec.**	**How will assurance be provided**
14	**To have a positive impact on the socio-economics of our Borough, through our position as an Anchor Institution**	Working with key partners, including Wigan Council and Wigan and Leigh College, we will develop our role as an anchor institution have a positive impact on the socio-economics of our Borough through: • increasing access to high quality employment (working with our education and training partners); • increasing the amount of local spend	- Active participation in community wealth building groups - Finalising the WWL Care for Talent Strategy (by end of Quarter 1 - Increase in the number of T level placements from x to y by March 2023 (number to be confirmed after above strategy finalised) - Creation of a Youth Apprenticeship Scheme, creating x apprenticeship posts by March 2023 (number to be confirmed after above strategy finalised) - Development of proposal to become a "real living wage" employer - Increase in the number of people employed with a Wigan postcode - Baseline non-pay spend with local authority partner, identifying influenceable spend which could be spent locally, and setting target to increase this (by Quarter 2) - Participate in 'meet the buyer' events with our local partners, providing local business with advice and support to help them succeed in tendering for work	RM	Six monthly reports to Trust Board
Draft detailed objective for inclusion in the BAF		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.			

15	**To develop effective partnerships within the new statutory environment**	Develop effective relationships across the Wigan locality and the wider Greater Manchester Integrated Care Board, supporting delivery of our other corporate objectives.	- Active contribution and influence of the Wigan Locality Plan and ICB workplan - Aligned transformation priorities and programmes of work	RM	Six monthly reports to Trust Board
Draft detailed objective for inclusion in the BAF		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.			
16	**To make progress towards our ambition to be a University Teaching Hospital**	Continuation of this three to five year strategic objective	- Delivery of year 2 objectives detailed in project plan	SA	Quarterly programme updates to Research Committee
Draft detailed objective for inclusion in the BAF		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.			

Title of report:	Safe Staffing Report Summary Period Jan – Feb 2022
Presented to:	Trust Board
On:	6 April 2022
Presented by:	Rabina Tindale, Chief Nurse
Prepared by:	Deputy Chief Nurse and Divisional Directors of Nursing and Allied Health Professionals
Contact details:	T: 01942 82 2176 E: allison.luxon@wwl.nhs.uk

Executive summary

The purpose of this summary report is to provide the Board assurance of the ongoing monitoring of nurse staffing levels and the triangulation of staffing levels with quality, safety and patient experience across inpatient areas in line with national requirements. Detail of each month can be found in the accompanying appendices.

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

The Board are asked to note

- The ratio of registered nurses to unregistered remains 55:45 as agreed by Trust Board in 2018 with the exception of the assessment areas which are staff at a ratio of 60:40. This ratio remains out with national recommendations of 70:30 and the Trust flags as an outlier in this regard on every publication of the CQC Insight Report as presented to Quality and Safety Committee. The Trust also remains an outlier for the uplift of nursing and midwifery establishment levels. The Trust agreed uplift is 20% against an advised 25%. Recommendations to uplift these levels were made in the Bi-annual staffing review received by Trust Board in January 2022 and it was agreed the Chief Nurse and Chief Financial Officer will work in collaboration to develop a three year strategy working on a prioritisation order.

- Additional clinical areas have remained escalated within both months which has resulted in the requirement to reduce staffing ratios on some inpatient wards. The lack of ability to flex the workforce to meet increased pressures associated with capacity and demand is related to the escalation of areas in the Emergency Village to support patient flow and appropriate segregation of patients, and an escalated unfunded inpatient area, as well as vacancy factors and a lack of appropriate staffing uplift.

- The Jean Heyes Reablement Unit (JHRU) remained open with a combination of redeployed substantive staff and staff recruited specifically for the area. Wrightington site returned to their substantive area of work at the end of the month and temporary staff, including block bookings, are being utilised to mitigate staffing shortfalls. Leigh staff redeployed to the area are scheduled to return to their substantive roles W/C 21 March 2022 to enable the further progression of the Elective Recovery Programme.

- There continues to be pressures across the nursing and midwifery workforces associated with vacancies and short notice absence. Of note are ED, Maternity Service, District Nursing, ICU and Theatres. All vacancies are being appropriately managed within the pertinent services.

- Overall vacancies have seen a marginal increase. These vacancies are impacting on the ability of the workforce to respond to workload increases as previously mentioned, and in turn is negatively impacting on staff wellbeing, patient care and experience, and waiting times. The Trust continues to mitigate the impact of this with the use of temporary staff and block bookings to promote continuity of care and team building. This is impacting on temporary spend and is reflected in the increase in agency spend in month.

- GTEC have offered a total of 68 posts during the months of January and February. 11 IN's are in the country already with placements allocated in theatres for 5 staff and across the assessment areas in the Division of Medicine for the remaining 6 staff. 2 staff have already commenced in Theatres on the Wrightington site.

- The benefits of the approval of the Supernumerary Ward Leader Business Case have not been fully realised in month due to the inability to backfill their clinical hours and the requirement to staff escalated areas and backfill short notice sickness.

- Maternity services continue to suspend the Continuity of Carer (CoC) pathway in order to address staffing gaps in higher risk areas of the service which have arisen through vacancy and short notice absence of staff. 1 midwife has been successfully recruited for the Trust via GTEC and the staff member is due to commence with the Trust in July 2022.

- Of the 38 nurses recruited in January , 7 have since withdrawn. It is believed that the candidates have accepted alternative offers in London where a joining incentive is being offered to IN's, and others have declined the placement with GTEC due to the retention premium associated with our contracts of employment.

- As the Board is aware, GTEC were awarded the contract for Greater Manchester to recruit International Midwives to assist is addressing workforce gaps within the profession. WWL was allocated 1 midwife via this funding stream and this post has been recruited to in month. The successful candidate is scheduled to arrive in the country in July 2022.

- A scoping exercise with year 3 IN's has been completed to understand their intentions at the end of their contract with GTEC. Of the 16 nurses in scope, 15 have indicated that they wish to continue working with WWL. Most of these nurses are currently working within the Division of Medicine. Agreement is required on how future visa costs are addressed to support retention of this valued workforce.

- The trust is proactively working with GTEC to market the benefits of working in the North West and what WWL can offer.

- District Nurses caseloads continue to be above optimal levels. A risk stratification approach remains in place to reduce the frequency of face-to-face visits, and other community services were asked to provide a wraparound service to assist in maintaining patient safety. The Queen's Nursing Institute (QNI) released guidance of District Nurse staffing levels and red flags for the service which are currently being considered by the Division. It is hoped that these will be reflected in the March Safe Staffing Report.

- In terms of harms, an increase was seen during January which correlates with the increase in activity, short staffing and increased redeployment..

Harm	**January**	**February**
CDT	1	4
Pressure Ulcers escalated to StEIS	6 (2 community, 3 Medicine Division)	3 (All within the community division)
Falls with Severe or Moderate harm	3 (medicine division)	0
Medication Administration Errors	6	0

All pressure ulcer incidents and subjected to a rigorus panel review, lapses in care are STEIs

Of the six medicine administration errors that resulted in harm to patients in January, 2 of which involved the administration of Insulin and Glucose. Both cases have been reviewed by the Executive Scrutiny Panel and have been escalated to StEIS due to the level of harm that occurred. Concise investigation is ongoing, however the Chief Nurse has further assurance that patients requiring insulin and glucose are being appropriately managed in order to mitigate the risk of further harm. The Trust has also issued an internal safety notice to all clinical areas highlighting the incidents and providing direction for staff to appropriate guidelines and support

Focus on the months ahead remains in stabilising the nursing workforce over the coming months, with a strong focus on; recruitment; retention and supporting ward leaders and wider leadership team in delivering safe and quality care.

Link to strategy

Delivery of safe care

Risks associated with this report and proposed mitigations

- Registered and unregistered nurse recruitment is being proactively managed.
- Registered staff vacancies within theatres, district nursing services and maternity present risk to patient safety and experience and the overall Trust Covid recovery plan
- The report highlights improvements required to deliver effective staff rostering and use of Safe Care.

- The report identifies risks relating to the ability to sustain safe staffing levels as a consequence of the increased escalation of areas/unfunded areas, a reduced uplift in staffing when benchmarked against National Quality Board (NQB) standards, vacancy rates and a reliance on temporary staffing
- There is a risk to that, due to changes to the recruitment of International Nurses business case, the staggering of staff arriving at clinical services may not be possible.

Financial implications

- Temporary staffing costs related to sickness/absence and vacancy levels, and backfill requirements, and to support additional staffing to support patient flow within ED, the escalation ward, and the acuity of patients on the CPAP medical area. This has been further compounded in month with the required escalation of smaller inpatient areas to mitigate overcrowding in the Emergency village and to meet the demand for inpatient services.

Legal implications

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

People implications

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

Wider implications

- Increased scrutiny from Commissioners and Regulators

Recommendation(s)

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

Title of report:	January 2022 Safe Staffing Report (Appendices 1)
Presented to:	Trust Board
On:	6.4.22
Presented by:	Rabina Tindale, Chief Nurse
Prepared by:	Deputy Chief Nurse and Divisional Directors of Nursing and Allied Health Professionals
Contact details:	T: 01942 82 2176 E: allison.luxon@wwl.nhs.uk

Executive summary

The purpose of this report is to provide the Board to provide assurance of the ongoing monitoring of nurse staffing levels and the triangulation of staffing levels with quality, safety and patient experience across inpatient areas in line with national requirements.

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

The Board are asked to note

- The ratio of registered nurses to unregistered remains 55:45 as agreed by Trust Board in 2018 with the exception of the assessment areas which are staff at a ratio of 60:40. This ratio remains out with national recommendations of 70:30 and the Trust flags as an outlier in this regard on every publication of the CQC Insight Report as presented to Quality and Safety Committee. The Trust also remains an outlier for the uplift of nursing and midwifery establishment levels. The Trust agreed uplift is 20% against an advised 25%. Recommendations to uplift these levels will be made in the Bi-annual staffing review due to Trust Board in January 2022.

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

- The Jean Heyes Reablement Unit (JHRU) was opened at the beginning of January 2022, and Ward A at Wrightington was escalated with a care home staffing model to assist in relieving

capacity pressures within ED, and to provide additional capacity to accommodate patients who were unable to be discharged due to the closure of care homes within the Borough.

- There continues to be pressures across the nursing and midwifery workforces associated with vacancies and short notice absence. Of note are ED, Maternity Service, District Nursing, ICU and Theatres. All vacancies are being appropriately managed within the pertinent services.

- Overall vacancies have increased in month following the inclusion of the vacancies associated with Winter Pressures and Elective Recovery Programme and following Board approval to fund the Jean Heyes Reablement Unit and the now funded ward in Medicine. These vacancies are impacting on the ability of the workforce to respond to workload increases, and in turn is negatively impacting on staff wellbeing, patient care and experience, and waiting times.

- The benefits of the approval of the Supernumerary Ward Leader Business Case have not been fully realised in month due to the inability to backfill their clinical hours and the requirement to staff escalated areas and backfill short notice sickness.

- Maternity services continue to suspend the Continuity of Carer pathway in order to address staffing gaps in higher risk areas of the service which have arisen through vacancy and short notice absence of staff. The service went on divert on 2 occasions in month due to shortfalls in staffing despite redeployment of staff to support the high-risk areas within Maternity.

- District Nurses faced considerable pressure in month with caseloads escalating to between 18 and 25 per registered nurse. A risk stratification approach was taken to reduce the frequency of face-to-face visits, and other community services were asked to provide a wrap around service to assist in maintaining patient safety.

- In January 1 CDT was reported. All CDT's have been subject to investigation and Executive Reviews. Increased scrutiny is planned on PPE usage in the forthcoming months as audits have indicated poor compliance in this regard across the Trust.

- In month 3 falls with harm occurred. All the falls were reviewed by the Falls Scrutiny Panel and the fall that occurred on ED was escalated to StEIS.

- In January 5 pressure ulcers were reported to StEIS that developed whilst patients were in the care of the community team, on MAU and on Standish ward. These are currently subject to concise investigation and triangulation, and it is yet unknown whether staffing levels were a factor in these harms occurring.

- There were 6 medicine administration errors that resulted in harm to patients, 2 of which involved the administration of insulin to patients. Both these harms have been escalated to StEIS and are subject to concise investigation. Whilst the investigation is ongoing an Internal Patient Safety Notice has been issued to all clinical areas, and a review of the management of patients has been requested by the Chief Nurse.

- The percentage of shifts not sent to bank increased in month despite the pressures on ward leaders to work clinically.

- The Trust has committed to funding the recruitment of 180 International Nurses by the end of 2022. 38 Nurses have been recruited in month with skills to support high risk areas within the Trust.

Link to strategy

Delivery of safe care

Risks associated with this report and proposed mitigations

- Registered and unregistered nurse recruitment is being proactively managed.
- Registered staff vacancies within theatres, district nursing services and maternity present risk to patient safety and experience and the overall Trust Covid recovery plan
- The report highlights improvements required to deliver effective staff rostering and use of Safe Care.
- The report identifies risks relating to the ability to sustain safe staffing levels as a consequence of the increased escalation of areas/unfunded areas, a reduced uplift in staffing when benchmarked against National Quality Board (NQB) standards, vacancy rates and a reliance on temporary staffing
- There is a risk to that, due to changes to the recruitment of International Nurses business case, the staggering of staff arriving at clinical services may not be possible.

Financial implications

- Temporary staffing costs related to sickness/absence and vacancy levels, and backfill requirements, and to support additional staffing to support patient flow within ED, the escalation ward, and the acuity of patients on the CPAP medical area. This has been further compounded in month with the required escalation of smaller inpatient areas to mitigate overcrowding in the Emergency village and to meet the demand for inpatient services.

Legal implications

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

People implications

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

Wider implications

- Increased scrutiny from Commissioners and Regulators

Recommendation(s)

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

Safe Staffing Report – January 2022.

1.0 INTRODUCTION

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

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

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

2.0 CURRENT POSITION – January 2022

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

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

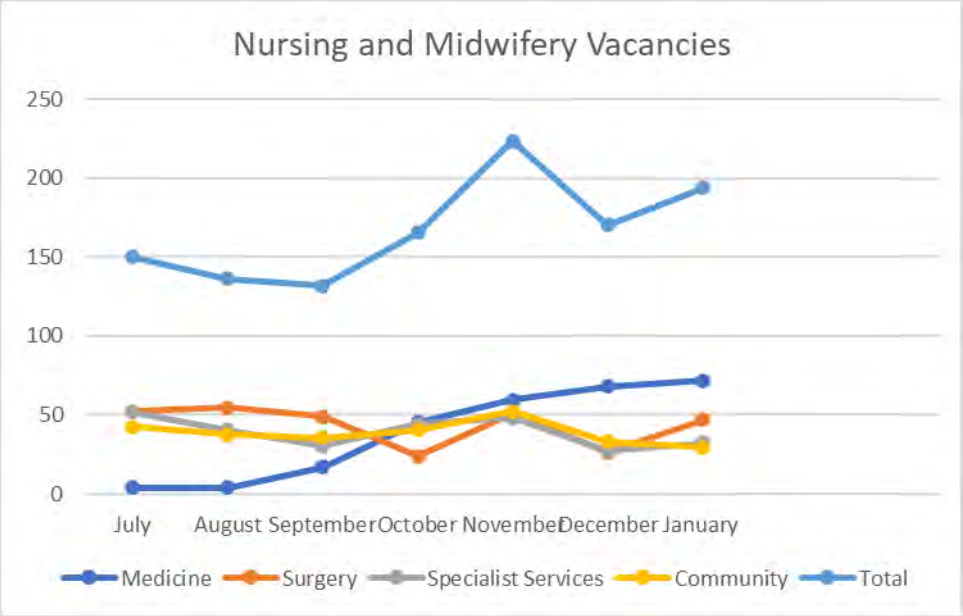
2.3 The Trust also remains an outlier for the uplift of nursing and midwifery establishment levels. The Trust agreed uplift is 20% against an advised 25%, and a SNCT minimum recommended level of 23%.

2.4 The RCN (2015) also recommended that Ward Leaders posts should be fully supervisory to clinical practice to ensure adequate time for leadership, management, patient safety and experience, and quality improvement. The Trust funded the uplift in Ward Leader time in October 2021 however due to staffing and skills gaps, and the ongoing redeployment of staff to support escalated areas, the ward leaders are not always able to be released from direct clinical time to undertake these duties.

2.5 In month, in response to operational pressures, the Jean Heyes Reablement Unit (JHRU) was opened, and Ward A at Wrightington was escalated to support patient flow and the relief of congestion with ED. Staff were redeployed from substantive roles to support the opening of the unit and was achieved by the agreement of Gold Command to pause the elective programme. Ward A at Wrightington was staffed to a nursing home model. This model was subject to a Quality Impact Assessment (QIA) and was approved by the Chief Nurse.

3.0 Vacancies

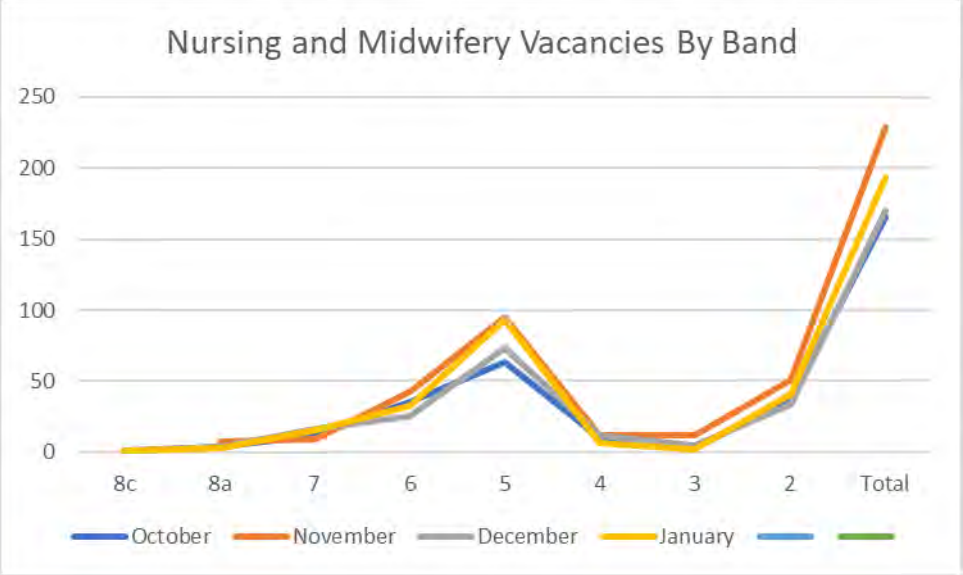
3.1 Divisional data indicates that there were 193.78 WTE nursing and midwifery vacancies in January. The split of the vacancies is demonstrated in Chart 1. As described in the previous months report there are also additional vacancies from the addition of winter pressures monies to support the increased footprint of ED.



	July	August	Septembe	October	Novembe	Decembe	January
Medicine	3.74	3.74	16.87	45.22	59.31	68.09	71.58
Surgery	52	54.63	48.78	23.96	50.76	26.08	47
Specialist Services	51.59	40.24	30.25	44	48.23	27.08	32.46
Maternity				11.88	12.88	16	13.4
Community	42.49	37.51	35.68	40.45	52.21	33.04	29.34
Total	149.82	136.12	131.58	165.51	223.39	170.29	193.78

Chart 1

3.2 The greatest number of vacancies are at B5 and B2 level as demonstrated in Chart 2. The majority of B6 vacancies are associated with Maternity Services.



	October	Novembe	Decembe	January
8c	1		1	1
8a	3.5	7.8	3.67	2.47
7	11.9	8.89	16.4	15.13
6	35.42	42.6	25.18	32.85
5	63.51	94.73	73.65	92.85
4	9.82	12.2	12.09	6.9
3	3.3	11.84	4.79	1.83
2	37.06	50.47	33.51	40.75
Total	165.51	228.53	170.29	193.78

Chart 2

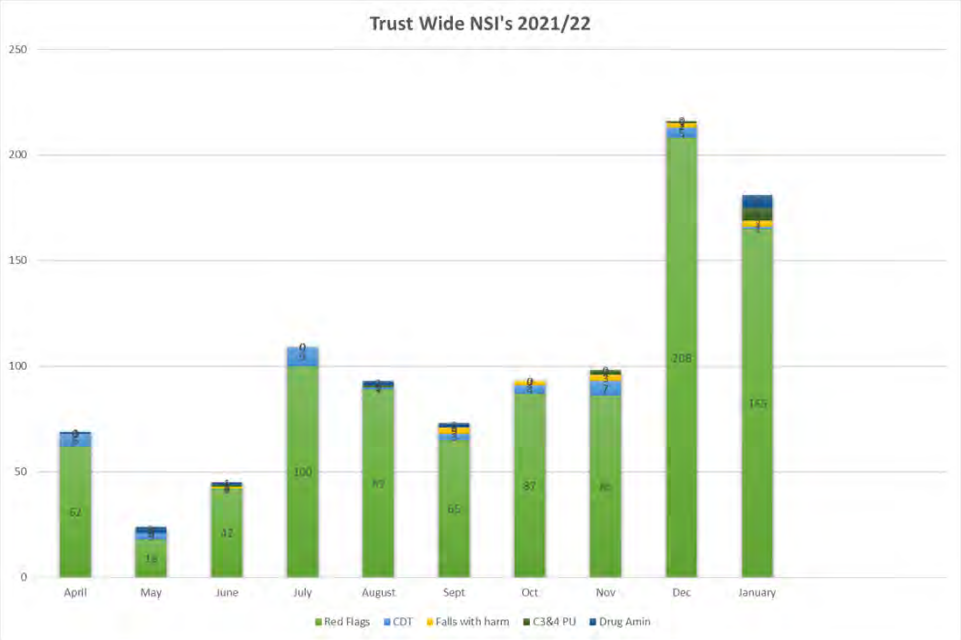
3.3 Areas of particular concern remain District Nursing Services, ED, (due to Winter Pressures Funding), Theatres and Maternity Services.

4 Nurse Sensitive Indicators (NSI's)

4.1 NSI's are outcome measures that are captured and are indicators of actual or potential harm to patients. These measures are frequently linked to staffing levels or skill mix, and form one of the metrics that allow similar Trusts to benchmark performance.

4.2 Chart 3 provides details of the NSI's captured for the purpose of this report.

4.3 Staffing incidents are captured via Nursing or Midwifery Red Flags as per NICE guidance. Currently there is no mechanism for recording Red Flags within Theatres or Community settings and therefore these incidents are usually reported via the Datix Incident Reporting System.



	April	May	June	July	August	Sept	Oct	Nov	Dec	January
Red Flags	62	18	42	100	89	65	87	86	208	165
CDT	6	3	0	9	1	3	4	7	5	1
Falls with harm	0	0	1	0	0	3	2	3	2	3
C3&4 PU	0	0	1	0	1	0	0	2	1	6
Drug Amin	1	3	1	0	2	2	0	0	0	6

Chart 3

4.4 Within the acute setting 165 Nursing Red Flags and 5 Midwifery Red Flag were raised in January. 81% of the red flags raised are associated with a reduction of 25% of the registered nurse workforce and are reflective of the vacancy position, short notice sickness, escalation of clinical areas, and staff absence related to the Omicron Covid-19 variant, this is a 7% reduction from the previous months report.

4.5 The Midwifery Flags raised related to a delay in care for a woman requiring sutures following the birth of her baby, the unit being on divert on 2 occasions in month, an inability to maintain 1:1 care in established labour and the inability for the co-ordinator to remain supervisory to practice. No harm was reported on any of the days the red flags were raised. Continuity of Care remains suspended at the time of the report due to the number of vacancies within the service. This has enabled staff to be deployed to high risk areas of the service to mitigate, where possible, any risks to service delivery and harm to women and babies.

4.6 Shortfalls in staffing were mitigated by the internal movement of staff where possible, however the Board should note that there were times in month where registered staffing fell below Trust agreed ratios in order to support escalated areas and staffing in ED and maintain patient safety.

4.7 In January 1 CDT was reported which was attributed to Bryn Ward. An investigation and Executive Review have been scheduled to determine whether there were any lapses in care and learning from this incident.

4.8 In month 3 falls with harm occurred on ED, Winstanley Ward and Standish Ward. Review of the falls indicated that the fall that occurred within ED met the requirement for escalation to StEIS due to the severity of the harm that occurred.

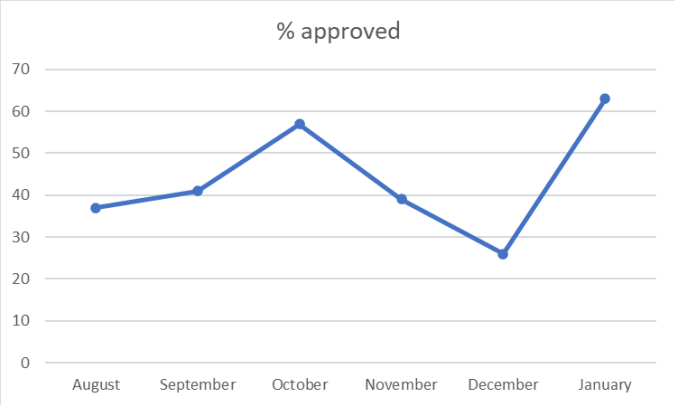
4.9 All pressures ulcers reported across the Trust are reviewed by a scrutiny panel to determine whether all appropriate actions to mitigate the risk of skin damage have been undertaken and to assist in determining whether a patient has come to avoidable harm whilst in our care. In January 6 pressure ulcers were verified by the Tissue Viability Nurses (TVN) as meeting the criteria for moderate to severe harm. 5 of the these have been escalated to StEIS as lapses in care were determined by the panel members. Of these 2 were identified within the Community Division, 2 on MAU and 1 on Standish Ward. The 6th case, which occurred on Swinley Ward, was not reviewed by the panel in January and therefore, if lapses in care are identified, will be escalated to StEIS in February, The Board should note that throughout January there were considerable pressures on the District Nursing (DN) workforce associated with short notice absence, including loss of B6 and B7 staff, and there are high numbers of newly qualified staff within the service who are still requiring support to achieve their competencies. DN ratios were between 1:19 and 1:25 throughout the month. Pressures on staffing were mitigated by further risk stratification, reduction of face-to-face visits to telephone consultation, and with the wraparound of staff from other services to relieve pressures. The impact on staffing and this harm occurring will be further explored in the concise investigation commissioned by the Trust.

4.10 There were 6 medicine administration errors that resulted in harm to patients reported in January. Of these 2 involved use of insulin and the management of diabetes via sliding scale. These incidents were escalated appropriately at the time and are subject to concise investigation. A

programme of work around insulin prescribing and administration has been requested by the Chief Nurse.

5 Effective Rostering

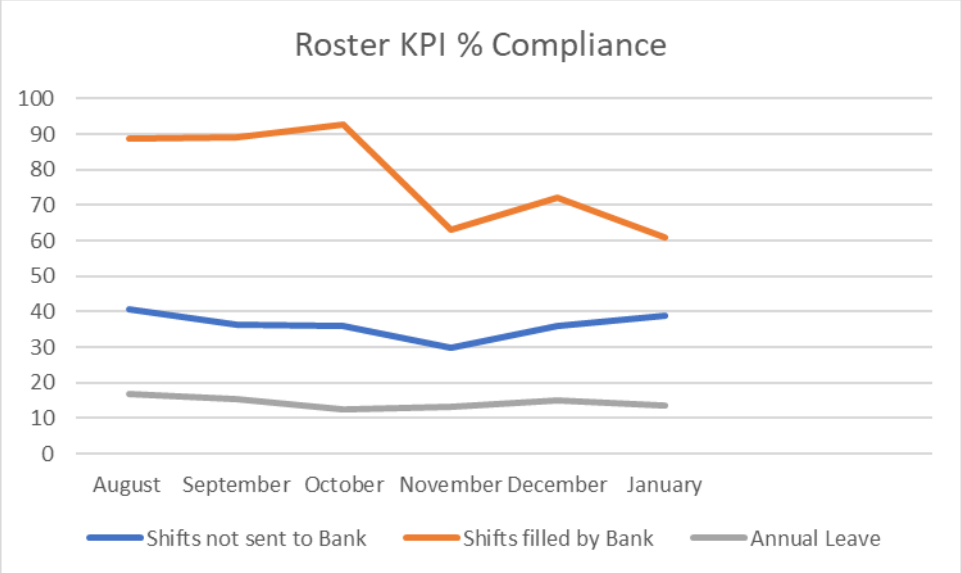
5.1 There has been sustained scrutiny on improvement is roster approval 6 weeks prior to shifts being worked (Chart 3). Compliance with roster approval significantly improved from the previous months reported despite ongoing challenges with the redeployment of staff and ward leaders working clinically within their respective areas.



Rosters Approved Within 6 Weeks						
	August	Septembe	October	Novembe	Decembe	January
% approved	37	41	57	39	26	63

Chart 4

5.2 Chart 4 provides detail of key roster metrics that provide assurance of effective rostering.



	August	Septembe	October	Novembe	Decembe	January
Shifts not sent to Ba	40.8	36.5	36	30	36	39
Shifts filled by Bank	88.7	89.2	92.6	63	72	61
Annual Leave	16.8	15.5	12.6	13.2	15	13.6

Chart 5

5.3 The percentage of shifts not sent to bank increased by 3 % in month (Chart 5) and is linked to the issues raised in 5.1. The greatest gains could be achieved by improving shifts sent to bank across all theatres within the Trust and within District Nursing Services.

5.4 Bank fill rate, based on the shifts released to NHSP, decreased to 72%.

5.5 Annual leave for the month remained within the expected parameters.

6 International Nurse Recruitment (INR)

6.1 International Nurses Recruitment figures for the forthcoming financial year have been scoped by the Deputy Chief Nurse and Divisional Directors of Nursing and the Trust has agreed to recruit an additional 111 IN's this financial year. As NHSE/I funding for recruitment runs from January to December this will result in 180 additional international nurses joining the Trust before the end of December 2022 and should significantly contribute to the overall resilience of the nursing workforce.

6.2 The clinical divisions are continuing to work in partnership with GTEC and have provided staff to assist in the recruitment process. This initiative will ensure front line staff are engaged with our International Nurses and increase the interview capacity for WWL within the GTEC team.

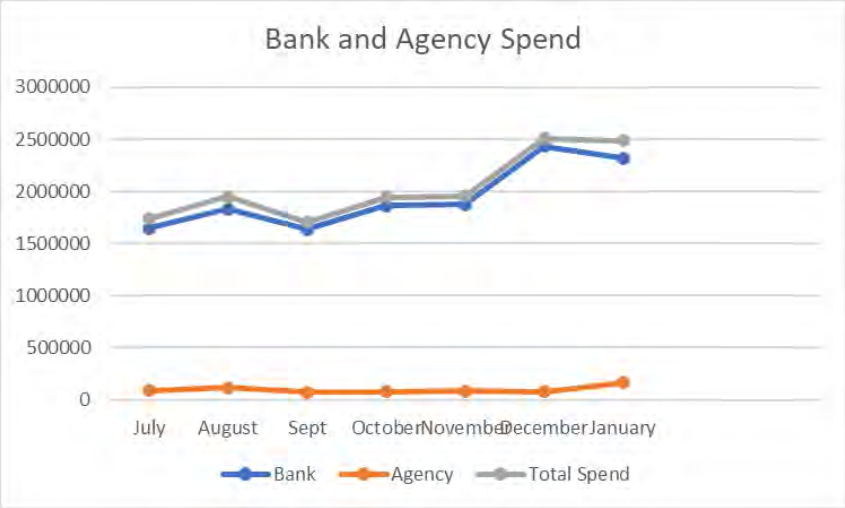
6.3 In January 54 interviews were undertaken by the GTEC team and offers made to 38 staff. These staff are currently going through the recruitment processes and 5 nurses are already in the country. One of the nurses has an OSCE date booked for 31 January and will be placed on Jean Heyes Reablement Unit if the OSCE is passed.

6.4 The GTEC teams are working with the Clinical Divisions to match skills to shortfalls in staffing in high-risk areas. From a specialty perspective 6 staff have been recruited for Theatres, 3 with respiratory skills, 3 with critical care skills and 7 with ED experience.

6.4 Work continues to progress recruitment plans for Midwives and ODP's conjunction with the national and regional programmes of work.

7 Bank and Agency Utilisation

7.1 There has been a slight decreasein temporary spend in January, as demonstrated in Chart 6, of £24.4k, despite there being a 17% increase in demand for shift in month.



	July	August	Sept	October	Novembe	Decembe	January
Bank	1645934	1827818	1632970	1864093	1872876	2430015	2317199
Agency	93024	120000	74204	78799	82528	80133	168548
Total Spend	1738958	1947947	1707174	1942892	1955404	2510148	2485747

Chart 6

7.2 Some of the additional expenditure has been incurred due to the escalation of additional areas to support patient flow, the ongoing requirement for additional staff to support enhanced observations, and the requirement for additional staff for ED.

7.3 Temporary spend in ED is partly offset by Winter Pressures monies allocated to the service.

7.4 The average lead in time for shifts placed with NHSP prior to roster commencement was 31 days in January.

7.5 NHSP have continued the programme of work across all sites to recruit both substantive and multi-post holders to the bank and have held focused events at Boston House and on the Wrightington Site.

7.6 Agency spend increased in month as NHSP assisted in securing block booking for agency staff to mitigate staffing gaps and provide continuity of care across vulnerable services.

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

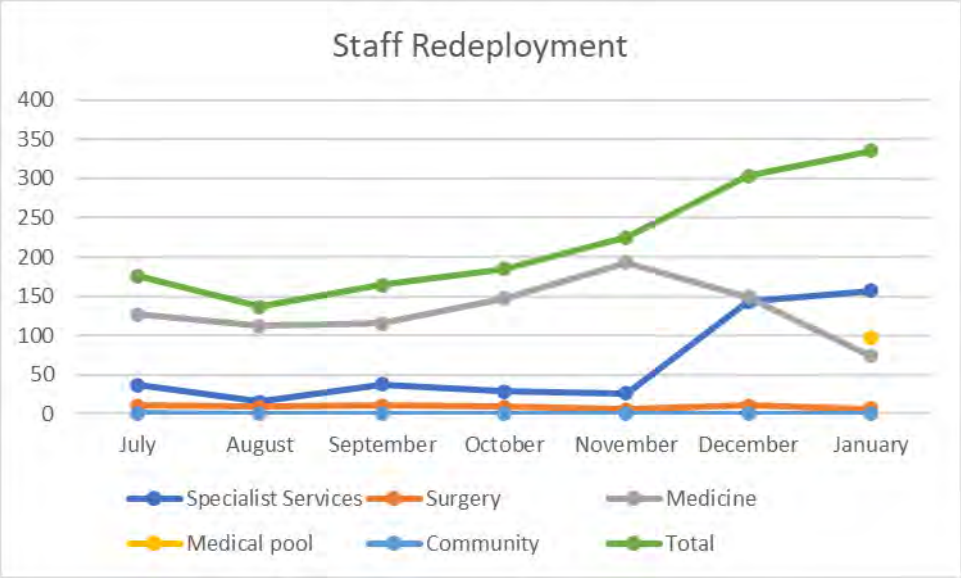
7.8 Demand for temporary staffing remains higher than forecast and can be linked to increased adherence to the Enhanced Observation Policy associated with the reduction of harm free care, vacancies, and a lower uplift in nurse staffing than the national average with associated reduction in skill mix of the nursing workforce. These factors directly impact on the Trusts ability to respond to additional pressures without recourse to temporary staffing to maintain safe staffing ratios across clinical areas.

8 Staff Redeployment

8.1 Throughout January short term redeployment of staff continued to support demand in ED and the increased requirement for inpatient beds. This deployment was undertaken based on skills and staff volunteering to assist the pressures being experienced by staff.

8.2 The staff opened the Jean Heyes Reablement Unit, and Ward A at Wrightington to accommodate patients requiring nursing home care in order to release bed capacity on the acute site. These areas remained open throughout the course of the month, however there are plans to de-escalate the beds on the Wrightington in February 2022.

8.3 Chart 7 provides detail of the numbers of staff redeployed from divisions is response to organisational need in December.



	July	August	Septembe	October	Novembe	Decembe	January
Specialist Services	37	16	38	29	26	143	157
Surgery	11	9	11	9	6	11	7
Medicine	127	112	115	147	193	149	74
Medical pool							97
Community	1	0	0	0	0	0	0
Total	176	137	164	185	225	303	335

Chart 7

8.2 With regards to data on SafeCare there have been 335 staff temporary redeployments to other areas in response to patient acuity, short notice absence and the escalation of additional inpatient areas for overnight stay patients. This is an increase of 32 redeployments from the previous reporting period.

8.3 The greatest increase in staff redeployment to assist with short term absence was seen within Specialist Services. Redeployment from this area continued through January where staff were sent to assist with additional areas of escalation within ED and the opening of additional inpatient areas. Staff were able to be released due to reduced elective activity on the Wrightington site and their assistance was greatly received.

9 Staffing Risks

9.1 There is an increase in the number of vacancies reported within the Trust in month for both registered and unregistered staff. This is negatively impacting on the ability to maintain agreed staffing ratios within ED and inpatient areas. Staffing gaps in ED are currently being mitigated by the temporary and permanent deployment of staff from inpatient areas and by the use of temporary staffing, however there are insufficient resources to fully mitigate this risk.

9.2 Staffing challenges also remain within District Nursing Services where caseloads remain above desirable levels; the service is currently operating at OPEL level 3 and all appropriate actions have been made within the Community Division to deploy staff from other services to support the service. There is a risk that the increased caseload numbers will impact on the ability to maintain the quality of service that would usually be expected, and the Division and service leads continue to risk stratify caseloads to ensure care is received by those most at risk. Additionally, there remain pressures around staffing for the Treatment Rooms.

9.3 Vacancies within the Maternity service have also impacted on service delivery, and the Continuity of Carer (CoC) model remains suspended until these vacancies are filled.

9.4 Theatre staffing remains a challenge with shortfalls of staff across anaesthetic and recovery services. Risk has been mitigated on the acute site by the closure of Leigh Theatres and the transfer of staff from that site and from the Wrightington site to support essential work being undertaken.

9.5 The impact of the Supernumerary Ward Leader funding has not been felt due to the vacancies and the inability to backfill the time via temporary staffing and the increased operational pressures which will negatively impact on assessment of benefits realisation following investment in the service.

10 Summary and Next Steps

10.1 There continues to be pressures across the nursing and midwifery workforces associated with vacancies and short notice absence. Of particular note are ED (following investment via Winter Pressures Monies), Maternity Service, District Nursing, ICU and Theatres. All vacancies are being appropriately managed within the pertinent services.

10.2 Overall vacancies have increased in month following the inclusion of the vacancies associated with Winter Pressures, Elective Recovery Programme, JHU and Bryn. These vacancies are impacting on the ability of the workforce to respond to workload increases which is negatively impacting on staff wellbeing, patient care and experience, and waiting times.

10.3 The benefit of investment in Supernumerary Ward Leaders has not been realised within month due to inability to fully release staff as a consequence of lack of backfill available.

10.4 5 Midwifery Red Flags were raised in January, 2 of which related to the unit going on divert as a result of reduced staffing numbers. The closure of the unit was undertaken in accordance with agreed protocols. There were no reports of any adverse incidents occurring during this time.

10.5 CoC remains suspended within Maternity Services to mitigate risk within high-risk areas of the service.

10.6 In January 1 CDT was reported on Bryn Ward which will be subject to investigation and Executive Reviews scheduled or undertaken to determine lessons learnt. Increased scrutiny is planned on PPE usage in the forthcoming months as audits have indicated poor compliance in this regard across the Trust.

10.7 In month 3 falls with harm occurred on ED, Winstanley and Standish. Review of the falls indicated that the fall in ED met the requirement for escalation to StEIS due to the severity of the harm that occurred.

10.8 In January there were 5 pressure ulcers escalated to StEIS which occurred within the Community Division, Standish and MAU. It should be noted that at the time the harm occurred the District Nursing Teams were operating with increased caseload numbers requiring teams to risk stratify patients and review remotely.

10.9 There were 6 medicine administration errors that resulted in harm to patients, 2 of which involved the administration of Insulin and Glucose. Both cases have been reviewed by the Executive Scrutiny Panel and have been escalated to StEIS due to the level of harm that occurred. Concise investigation is ongoing, however the Chief Nurse has requested further assurance that care of the diabetic patient is being appropriately managed in order to mitigate the risk of further harm, as a result a Diabetes Steering Group will be established. The Trust has also issued an internal safety notice to all clinical areas highlighting the incidents and providing direction for staff to appropriate guidelines and support.

10.10 There has been an increase in overall demand for temporary staffing in month which triangulates with the increase in vacancies, short term absence, and the requirement to open additional inpatient areas to support increasing pressures within ED, and increased length of stay in hospital associated with the transmission of COVID within the care home sector.

10.11 Redeployed staff remain in their temporary areas in month in response to the surge in the Omicron variant within ED, JHRU and Ward A on the Wrightington site. The Trust is currently reviewing the de-escalation of Ward A and substantive recruitment to JHRU to support the release of staff back to their usual areas of work.

10.12 GTEC have recruited 38 nurses in month and are aiming for all recruits to be in the country before the end of March 2022. Recruitment has been targeted at high-risk areas including Theatres, ED, Critical Care and Respiratory Medicine.

10.13 In response to operational pressures, JHRU was opened and Ward A on the Wrightington site temporarily escalated to provide additional inpatient capacity and relieve congestion in ED. Staffing for these areas was supported by the redeployment of staff and an agreed alternative staffing model on Ward A to support the provision of care to care home type residents. This change in staffing model was subject to a QIA and approved by the Chief Nurse.

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

Title of report:	February 2022 Safe Staffing Report (Appendices 2)
Presented to:	Trust Board
On:	6 April 2022
Presented by:	Rabina Tindale, Chief Nurse
Prepared by:	Deputy Chief Nurse and Divisional Directors of Nursing and Allied Health Professionals
Contact details:	T: 01942 82 2176 E: allison.luxon@wwl.nhs.uk

Executive summary

The purpose of this report is to provide the Board assurance of the ongoing monitoring of nurse staffing levels and the triangulation of staffing levels with quality, safety and patient experience across inpatient areas in line with national requirements.

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

The Board are asked to note

- The ratio of registered nurses to unregistered remains 55:45 as agreed by Trust Board in 2018 with the exception of the assessment areas which are staff at a ratio of 60:40. This ratio remains out with national recommendations of 70:30 and the Trust flags as an outlier in this regard on every publication of the CQC Insight Report as presented to Quality and Safety Committee. The Trust also remains an outlier for the uplift of nursing and midwifery establishment levels. The Trust agreed uplift is 20% against an advised 25%. Recommendations to uplift these levels were made in the Bi-annual staffing review received by Trust Board in January 2022.

- Additional clinical areas have remained escalated within month which has resulted in the requirement to reduce staffing ratios on some inpatient wards. The lack of ability to flex the workforce to meet increased pressures associated with capacity and demand is related to the escalation of areas in the Emergency Village to support patient flow and appropriate segregation of patients, and an escalated unfunded inpatient area, as well as vacancy factors and a lack of appropriate staffing uplift.

- The Jean Heyes Reablement Unit (JHRU) remained open with a combination of redeployed substantive staff and staff recruited specifically for the area. Wrightington site returned to their substantive area of work at the end of the month and temporary staff, including block bookings, are being utilised to mitigate staffing shortfalls. Leigh staff redeployed to the area are scheduled

to return to their substantive roles W/C 21 March 2022 to enable the further progression of the Elective Recovery Programme.

- There continues to be pressures across the nursing and midwifery workforces associated with vacancies and short notice absence. Of note are ED, Maternity Service, District Nursing, ICU and Theatres. All vacancies are being appropriately managed within the pertinent services.

- Overall vacancies have increased in month. These vacancies are impacting on the ability of the workforce to respond to workload increases as previously mentioned, and in turn is negatively impacting on staff wellbeing, patient care and experience, and waiting times. The Trust continues to mitigate the impact of this with the use of temporary staff and block bookings to promote continuity of care and team building. This is impacting on temporary spend and is reflected in the increase in agency spend in month.

- The benefits of the approval of the Supernumerary Ward Leader Business Case have not been fully realised in month due to the inability to backfill their clinical hours and the requirement to staff escalated areas and backfill short notice sickness.

- Maternity services continue to suspend the Continuity of Carer (CoC) pathway in order to address staffing gaps in higher risk areas of the service which have arisen through vacancy and short notice absence of staff. 1 midwife has been successfully recruited for the Trust via GTEC and the staff member is due to commence with the Trust in July 2022.

- District Nurses caseloads continue to be above optimal levels. A risk stratification approach remains in place to reduce the frequency of face-to-face visits, and other community services were asked to provide a wraparound service to assist in maintaining patient safety. The Queen's Nursing Institute (QNI) released guidance of District Nurse staffing levels and red flags for the service which are currently being considered by the Division. It is hoped that these will be reflected in the March Safe Staffing Report.

- In February 4 CDT's were reported.

- There were no reported falls in month resulting in moderate or severe harm

- Three pressure ulcers were reported to StEIS that developed whilst patients were in the care of the community team, all were verified as unstageable by the Tissue Viability Nurses. These are currently subject to concise investigation and triangulation, and it is yet unknown whether staffing levels were a factor in these harms occurring.

- There were no medicine administration errors that resulted in harm to patients reported in month.

- GTEC have offered posts to a further 30 IN's following recruitment in February. 11 IN's are in the country already with placements allocated in theatres for 5 staff and across the assessment areas in the Division of Medicine for the remaining 6 staff. 2 staff have already commenced in Theatres on the Wrightington site.

Link to strategy

Delivery of safe care

Risks associated with this report and proposed mitigations

- Registered and unregistered nurse recruitment is being proactively managed.
- Registered staff vacancies within theatres, district nursing services and maternity present risk to patient safety and experience and the overall Trust Covid recovery plan
- The report highlights improvements required to deliver effective staff rostering and use of Safe Care.
- The report identifies risks relating to the ability to sustain safe staffing levels as a consequence of the increased escalation of areas/unfunded areas, a reduced uplift in staffing when benchmarked against National Quality Board (NQB) standards, vacancy rates and a reliance on temporary staffing
- There is a risk to that, due to changes to the recruitment of International Nurses business case, the staggering of staff arriving at clinical services may not be possible.

Financial implications

- Temporary staffing costs related to sickness/absence and vacancy levels, and backfill requirements, and to support additional staffing to support patient flow within ED, the escalation ward, and the acuity of patients on the CPAP medical area. This has been further compounded in month with the required escalation of smaller inpatient areas to mitigate overcrowding in the Emergency village and to meet the demand for inpatient services.

Legal implications

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

People implications

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

Wider implications

- Increased scrutiny from Commissioners and Regulators

Recommendation(s)

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

Safe Staffing Report – February 2022.

1.0 INTRODUCTION

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

2.0 CURRENT POSITION – February 2022

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

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

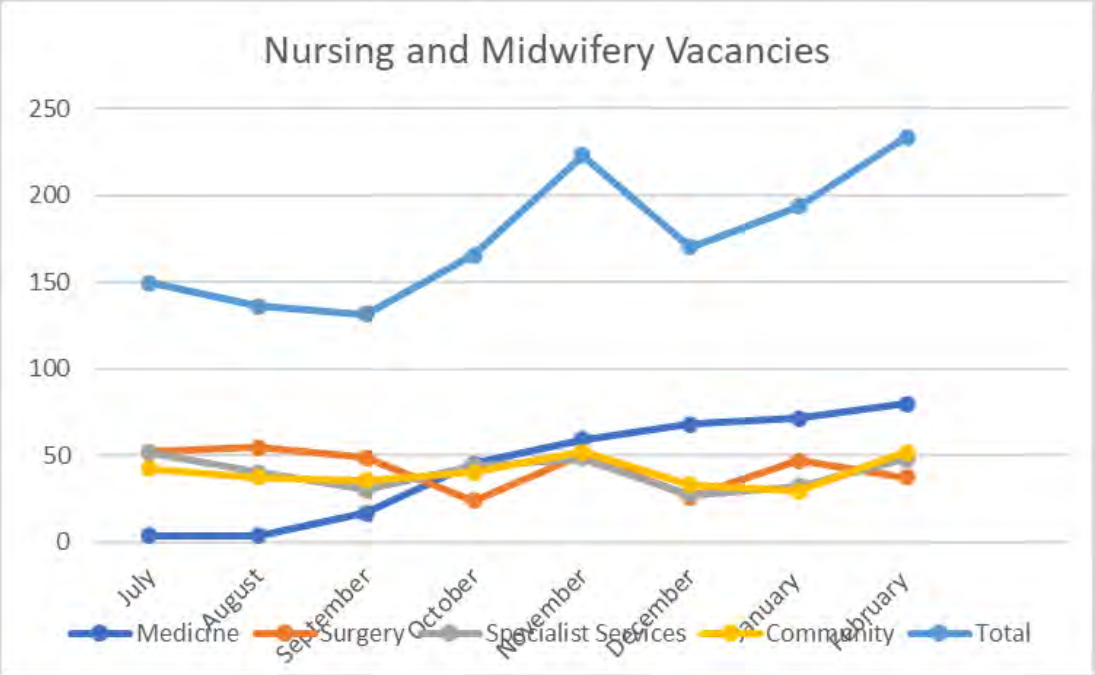
2.3 The Trust also remains an outlier for the uplift of nursing and midwifery establishment levels. The Trust agreed uplift is 20% against an advised 25%, and a SNCT minimum recommended level of 23%.

2.4 The RCN (2015) also recommended that Ward Leaders posts should be fully supervisory to clinical practice to ensure adequate time for leadership, management, patient safety and experience, and quality improvement. The Trust funded the uplift in Ward Leader time in October 2021 however due to staffing and skills gaps, and the ongoing redeployment of staff to support escalated areas, the ward leaders are not always able to be released from direct clinical time to undertake these duties.

2.5 In month, in response to operational pressures, the Jean Heyes Reablement Unit (JHRU) was opened, and Ward A at Wrightington was escalated to support patient flow and the relief of congestion with ED. Staff were redeployed from substantive roles to support the opening of the unit and was achieved by the agreement of Gold Command to pause the elective programme. Ward A at Wrightington was staffed to a nursing home model. This model was subject to a Quality Impact Assessment (QIA) and was approved by the Chief Nurse.

3.0 Vacancies

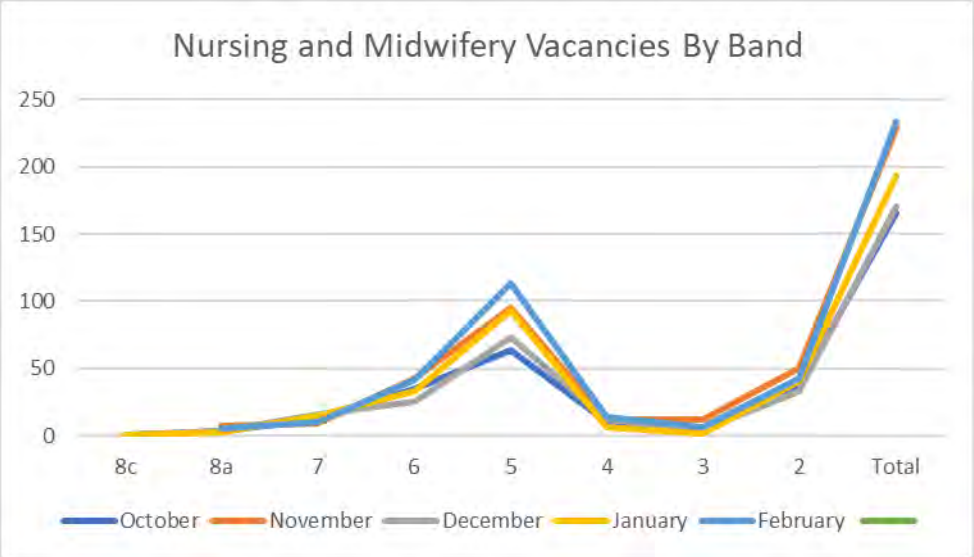
3.1 Divisional data indicates that there were 233.67 WTE nursing and midwifery vacancies in February and increase of 17% from the previous months report. The split of the vacancies is demonstrated in Chart 1.



	July	August	Septembe	October	Novembe	December	January	February
Medicine	3.74	3.74	16.87	45.22	59.31	68.09	71.58	79.65
Surgery	52	54.63	48.78	23.96	50.76	26.08	47	37.48
Specialist Services	51.59	40.24	30.25	44	48.23	27.08	32.46	47.9
Maternity				11.88	12.88	16	13.4	16.59
Community	42.49	37.51	35.68	40.45	52.21	33.04	29.34	52.05
Total	149.82	136.12	131.58	165.51	223.39	170.29	193.78	233.67

Chart 1

3.2 The greatest number of vacancies are at B5 and B2 level as demonstrated in Chart 2. The majority of B6 vacancies are associated with Maternity Services.



5/13

	October	Novembe	December	January	February
8c	1		1	1	
8a	3.5	7.8	3.67	2.47	6
7	11.9	8.89	16.4	15.13	9.89
6	35.42	42.6	25.18	32.85	41.35
5	63.51	94.73	73.65	92.85	113.64
4	9.82	12.2	12.09	6.9	13.82
3	3.3	11.84	4.79	1.83	6.62
2	37.06	50.47	33.51	40.75	42.35
Total	165.51	228.53	170.29	193.78	233.67

Chart 2

3.3 Areas of particular concern remain District Nursing Services, ED, (due to Winter Pressures Funding), Theatres and Maternity Services.

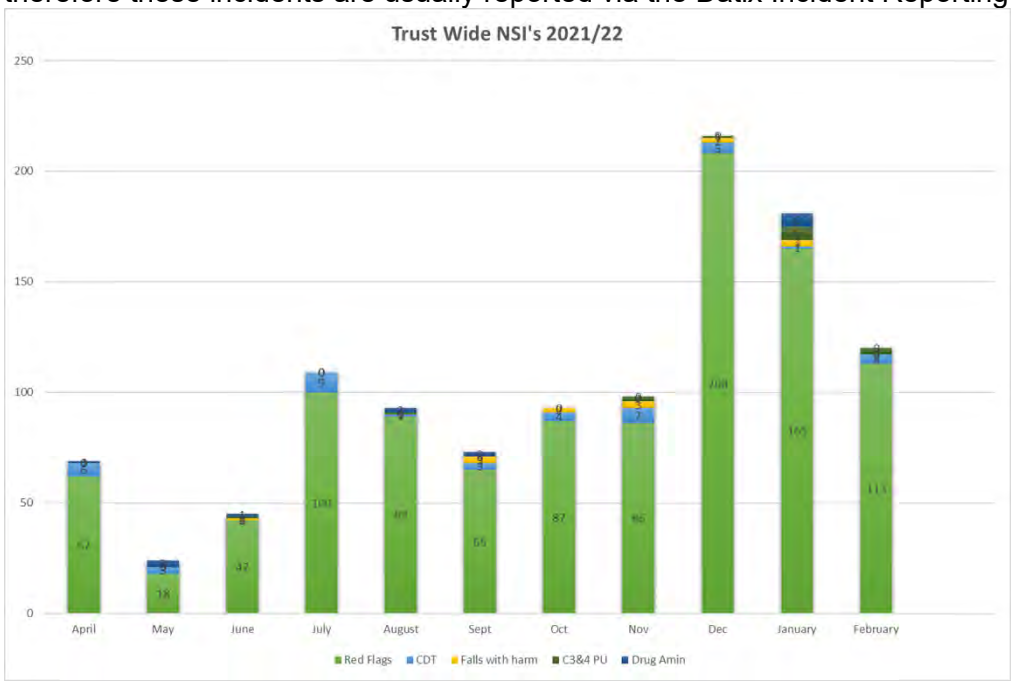
3.4 WWL is currently receiving support from NHSE/I due to the number of B2 vacancies across the Trust. A successful recruitment event was held in Month supported by Indeed. Staff recruited are scheduled to commence with the Trust in the next 4-6 weeks.

4 Nurse Sensitive Indicators (NSI's)

4.1 NSI's are outcome measures that are captured and are indicators of actual or potential harm to patients. These measures are frequently linked to staffing levels or skill mix, and form one of the metrics that allow similar Trusts to benchmark performance.

4.2 Chart 3 provides details of the NSI's captured for the purpose of this report.

4.3 Staffing incidents are captured via Nursing or Midwifery Red Flags as per NICE guidance. Currently there is no mechanism for recording Red Flags within Theatres or Community settings and therefore these incidents are usually reported via the Datix Incident Reporting System.



	April	May	June	July	August	Sept	Oct	Nov	Dec	January	February
Red Flags	62	18	42	100	89	65	87	86	208	165	113
CDT	6	3	0	9	1	3	4	7	5	1	4
Falls with harm	0	0	1	0	0	3	2	3	2	3	0
C3&4 PU	0	0	1	0	1	0	0	2	1	6	3
Drug Amin	1	3	1	0	2	2	0	0	0	6	0

Chart 3

4.4 Within the acute setting 113 Nursing Red Flags and 0 Midwifery Red Flags were raised in February. 81% of the red flags raised are associated with a reduction of 25% of the registered nurse workforce and are reflective of the vacancy position, short notice sickness, escalation of clinical areas, and staff absence related to the Omicron Covid-19 variant, this percentage remains unchanged from previous months report.

4.5 Shortfalls in staffing were mitigated by the internal movement of staff where possible, however the Board should note that there were times in month where registered staffing fell below Trust agreed ratios in order to support escalated areas and staffing in ED and maintain patient safety.

4.6 In February 4 CDT's were reported and were attributed to Orrell, Winstanley, MAU and Lowton wards. An investigation and Executive Review have been scheduled to determine whether there were any lapses in care and learning from this incident.

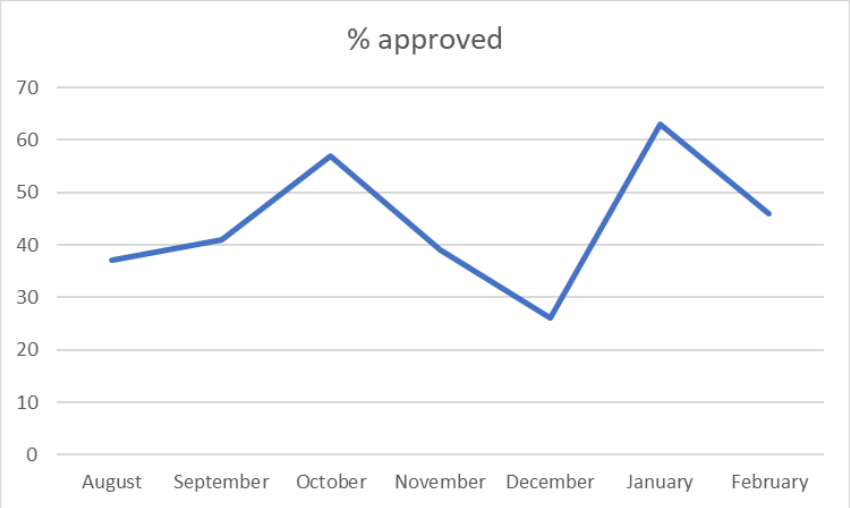
4.7 In month there were no falls reported that resulted in moderate or severe harm.

4.8 All pressures ulcers reported across the Trust are reviewed by a scrutiny panel to determine whether all appropriate actions to mitigate the risk of skin damage have been undertaken and to assist in determining whether a patient has come to avoidable harm whilst in our care. In February 3 pressure ulcers were verified by the Tissue Viability Nurses (TVN) as meeting the criteria for moderate to severe harm. All of the cases were categorised as Deep Tissue Injuries (DTI's)5 of the these have been escalated to StEIS as lapses in care were determine and occurred within the Community. The Board should note that there remain considerable pressures on the District Nursing (DN) workforce associated with short notice absence, including loss of B6 and B7 staff, and there are high numbers of newly qualified staff within the service who are still requiring support to achieve their competencies. Although active recruitment remains ongoing, turnover within the services remain high and there are significant pressures on staff.

4.9 There were 0 medicine administration errors that resulted in moderate harm to patients reported in February.

5 Effective Rostering

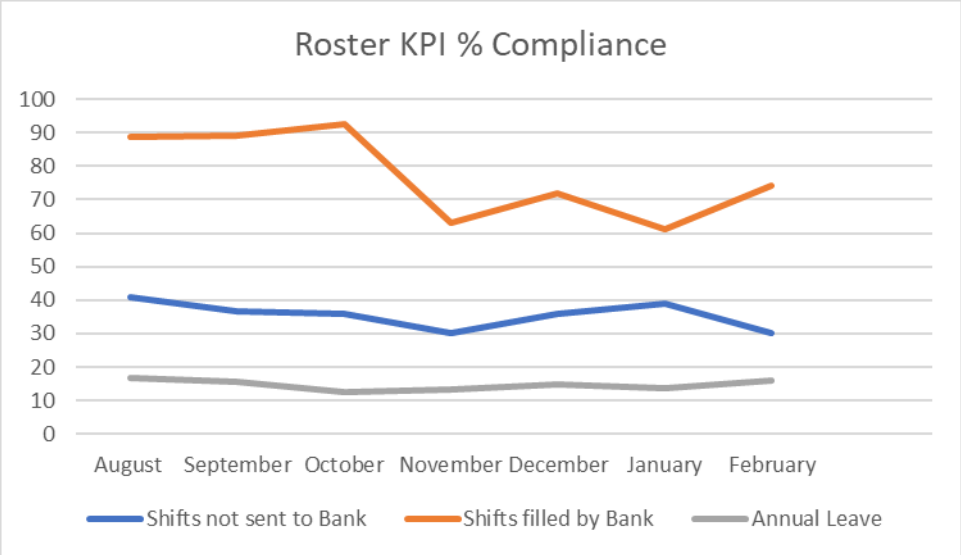
5.1 Compliance with roster approval decreased from the previous months reported associated with the ongoing challenges with the redeployment of staff and ward leaders working clinically within their respective areas (Chart 4).



Rosters Approved Within 6 Weeks							
	August	Septembe	October	Novembe	December	January	February
% approved	37	41	57	39	26	63	46

Chart 4

5.2 Chart 5 provides detail of key roster metrics that provide assurance of effective rostering.



	August	Septembe	October	Novembe	December	January	February
Shifts not sent to Banl	40.8	36.5	36	30	36	39	30
Shifts filled by Bank	88.7	89.2	92.6	63	72	61	74
Annual Leave	16.8	15.5	12.6	13.2	15	13.6	16

Chart 5

5.3 The percentage of shifts not sent to bank decreased by 9 % in month (Chart 5) The greatest gains could be achieved by improving shifts sent to bank across all theatres within the Trust and within District Nursing Services.

5.4 Bank fill rate, based on the shifts released to NHSP, increased by 2% in month to 74% to 72%.

5.5 Annual leave for the month was 16% and, from a KPI perspective, is a red trigger. In moth there was significant variation in the level of annual leave allocated with the lowest level being District Nursing Blood Transfusion (2.2%) and the highest being 19.4% on Standish Ward. It is recognised that staff have cancelled leave throughout the course of the year in response to workload pressures and staff shortages

6 International Nurse Recruitment (INR)

6.1 The clinical divisions continue to work in partnership with GTEC and are actively supporting the recruitment process.

6.2 In February 39 interviews were undertaken by the GTEC team and offers made to 30 staff. More interviews have been scheduled but did not take place due to connectivity issues or applicants failing to attend for interview.

6.3 Of the 38 nurses recruited last month, 7 have since withdrawn. It is believed that the candidates have accepted alternative offers in London where a joining incentive is being offered to IN's, and others have declined the placement with GTEC due to the retention premium associated with our contracts of employment.

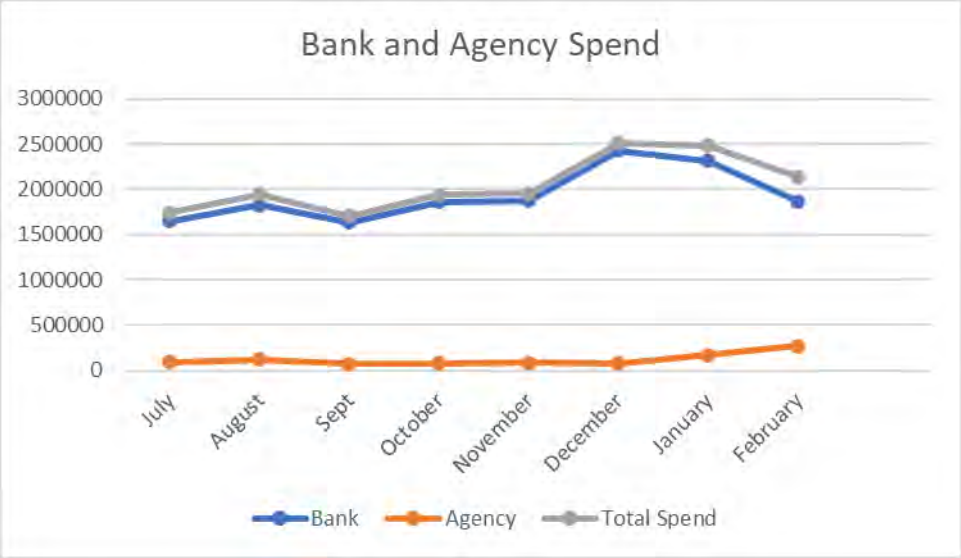
6.4 There are currently 11 IN's in the UK. 2 have already commenced in Theatres at Wrightington, 3 are planned to be placed in theatres on completion of OSCE training and the remaining 6 have been allocated placement on the assessment units in the Division of Medicine, MAU, Lowton and Bryn Ward.

6.5 As the Board is aware, GTEC were awarded the contract for Greater Manchester to recruit International Midwives to assist is addressing workforce gaps within the profession. WWL was allocated 1 midwife via this funding stream and this post has been recruited to in month. The successful candidate is scheduled to arrive in the country in July 2022.

6.5 A scoping exercise with year 3 IN's has been completed to understand their intentions at the end of their contract with GTEC. Of the 16 nurses in scope, 15 have indicated that they wish to continue working with WWL. Most of these nurses are currently working within the Division of Medicine. Agreement is required on how future visa costs are addressed to support retention of this valued workforce.

7 Bank and Agency Utilisation

7.1 There has been a further decrease in temporary spend in February, as demonstrated in Chart 6, of £350.



	July	August	Sept	October	Novembe	December	January	February
Bank	1645934	1827818	1632970	1864093	1872876	2430015	2317199	1870124
Agency	93024	120000	74204	78799	82528	80133	168548	265776
Total Spend	1738958	1947947	1707174	1942892	1955404	2510148	2485747	2135900

Chart 6

7.2 Some of the additional expenditure has been incurred due to the escalation of additional areas to support patient flow, the ongoing requirement for additional staff to support enhanced observations, and the requirement for additional staff for ED.

7.3 Temporary spend in ED is partly offset by Winter Pressures monies allocated to the service.

7.4 Agency spend continued to increase in month and is associated with the block booking of staff to provide a sustainable nursing model both within ED and the JHRU.

7.5 NHSP have recruited an additional 76 staff to their services; 31 are already Trust employees, 45 are working exclusively for NHSP. 63% of the new starters booked to work a shift in the first week they were employed.

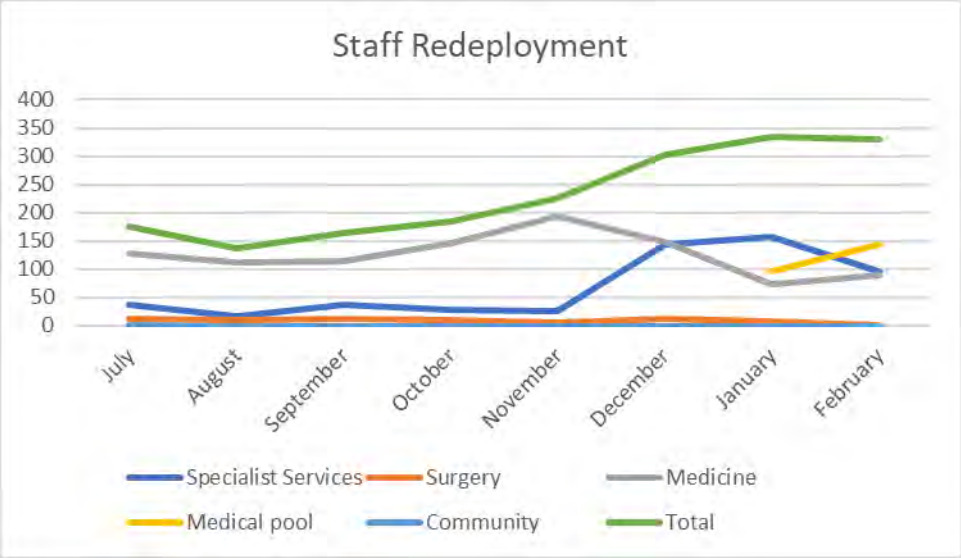
7.6 The Trust continues to provide an enhanced rate of pay for NHSP staff in Critical Care, Maternity, District Nursing Services, the Emergency Department and across Theatres where there are shortfalls in staffing due to vacancies and a lack of resilience in the staffing models.

8 Staff Redeployment

8.1 In February short term redeployment of staff to support ED ended and staff returned to their substantive areas of work.

8.2 Jean Heyes Reablement Unit has remained open throughout February supported by staff from Ward 3 at Leigh and Wrightington Nursing staff. Staff from Wrightington returned to their substantive roles on 28 February.

8.3 Chart 7 provides detail of the numbers of staff redeployed from divisions is response to organisational need in February.



	July	August	Septembe	October	Novembe	December	January	February
Specialist Services	37	16	38	29	26	143	157	96
Surgery	11	9	11	9	6	11	7	1
Medicine	127	112	115	147	193	149	74	89
Medical pool							97	143
Community	1	0	0	0	0	0	0	0
Total	176	137	164	185	225	303	335	329

Chart 7

8.4 Data on Safe Care indicates that there were 329 temporary redeployments of staff to other areas in response to patient acuity, short notice absence and the escalation of additional inpatient areas for overnight stay patients. This is an decrease of 6 redeployments from the previous reporting period.

8.5 The greatest increase in staff redeployment to assist with short term absence remains within Specialist Services, however, except for 1 occasion, this reflects the movement of staff within their own division.

8.6 There continues to be good pick up for staff on the Medical Pool via NHSP. Staff choosing to work on the pool are aware that they will be allocated a clinical area to work on on arrival. This reduces the requirement to deploy staff away from areas they have chosen to work and should have a positive impact on morale and patient safety.

9 Staffing Risks

9.1 There is an increase in the number of vacancies reported within the Trust in month. This is negatively impacting on the ability to maintain agreed staffing ratios within ED and inpatient areas. Staffing gaps in ED are currently being mitigated by the use of temporary staff, some of which have been block booked, and augmented by the short-term deployment of staff from other areas of the Trust in response to need. Despite these actions being taken, there remain gaps in staffing most notably in the afternoon.

9.2 Staffing challenges also remain within District Nursing Services where caseloads remain above desirable levels. There is a risk that the increased caseload numbers will impact on the ability to maintain the quality of service that would usually be expected, and the Division and service leads

continue to risk stratify caseloads to ensure care is received by those most at risk. Additionally, there remain pressures around staffing for the Treatment Rooms.

9.3 Vacancies within the Maternity service have also impacted on service delivery, and the Continuity of Carer (CoC) model remains suspended until these vacancies are filled.

9.4 Theatre staffing remains a challenge with shortfalls of staff across anaesthetic and recovery services. Risk has been mitigated on the acute site as Leigh Theatres remain closed and staff have been deployed appropriately to both the RAEI and Wrightington sites in order to maintain theatre lists. Leigh Theatres are scheduled to reopen once refurbishment work has been completed at the end of March 2022.

9.5 The impact of the Supernumerary Ward Leader funding has not been felt due to the vacancies and the inability to backfill the time via temporary staffing and the increased operational pressures which will negatively impact on assessment of benefits realisation following investment in the service.

10 Summary and Next Steps

10.1 There continues to be pressures across the nursing and midwifery workforces associated with vacancies and short notice absence. Of note are ED (following investment via Winter Pressures Monies), Maternity Service, District Nursing, ICU and Theatres. All vacancies are being appropriately managed within the pertinent services.

10.2 Overall vacancies have increased in month following the inclusion of the vacancies associated with Winter Pressures, Elective Recovery Programme, JHU and Bryn. These vacancies are impacting on the ability of the workforce to respond to workload increases which is negatively impacting on staff wellbeing, patient care and experience, and waiting times.

10.3 The benefit of investment in Supernumerary Ward Leaders has not been realised within month due to inability to fully release staff because of lack of backfill available.

10.4 CoC remains suspended within Maternity Services to mitigate risk within high-risk areas of the service.

10.4 February saw the reporting of 4 CDTs which were attributed to MAU, Lowton, Orrell and Winstanley wards. All cases will be subject to investigation and Executive Reviews scheduled or undertaken to determine lessons learnt.

10.5 There were no falls in month that resulted in moderate or severe harm to patients.

10.6 In February there were 3 pressure ulcers escalated to StEIS which occurred within the Community Division. All were verified as deep tissue injuries. It should be noted that at the time the harm occurred the District Nursing Teams were operating with increased caseload numbers requiring teams to risk stratify patients and review remotely.

10.7 There were 0 medicine administration errors that in moderate harm or severe harm to patients.

10.8 Staff redeployed to the JHRU returned to their substantive roles on the Wrightington site on 28 February 2022. The remaining staff redeployed from the Leigh site will return to their roles W/C 21 March in preparation for the re-opening of theatres and re-commencement of elective activity on the Leigh site.

10.9 In February 39 interviews were undertaken by the GTEC team and offers made to 30 staff. More interviews have been scheduled but did not take place due to connectivity issues or applicants

failing to attend for interview. Of the 38 nurses recruited last month, 7 have since withdrawn. It is believed that the candidates have accepted alternative offers in London where a joining incentive is being offered to IN's, and others have declined the placement with GTEC due to the retention premium associated with our contracts of employment.

10.10 There are currently 11 IN's in the UK. 2 have already commenced in Theatres at Wrightington, 3 are planned to be placed in theatres on completion of OSCE training and the remaining 6 have been allocated placement on the assessment units in the Division of Medicine, MAU, Lowton and Bryn Ward.

10.11 the Community Division are currently reviewing the District Nursing Red Flags published in February 2022 by the QNI. It is hoped that these will be incorporated into the March Safe Staffing Report to Board.

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

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Maternity Dashboard Report
Presented to:	Trust Board
On:	30.03.2022
Presented by:	Rabina Tindale Chief Nurse
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Executive summary

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

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

The key performance targets are measured using a RAG system which reflects national, regional, and local performance indicators. These are under constant review and may change on occasion following discussion and agreement.

• Green – Performance within an expected range.

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

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

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

Recommendation(s)

The board are asked to note the February 2022 dashboard and overview of indicators as outlined below.

Maternity Dashboard February 2022

Introduction

The Maternity Dashboard provides a monthly overview of the Maternity Directorate performance against a defined set of key performance and safety indicators. Each month data is collated from the Maternity Information System Euroking to monitor outcomes against key performance metrics. These metrics are regularly reviewed against local and national standards.

February 2022 Exception report
Summary

Februarys Maternity dashboard remains green or amber with improving metrics demonstrated.

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

Steis reportable Incidents

There were 0 stillbirths in February and the total for 2021 was low at 6 stillbirths in total. This gives an initial and unadjusted figure of 2.4 per one thousand births. This figure is likely to be lower when cases are reviewed by MBRACE and figure adjusted for . There were no Maternity Diverts in February.

Green

The Midwife to Birth ratio currently remains static at 1:28. Despite the ongoing challenges with staffing and elevated levels of activity and acuity the service has been able to maintain good standards of care with good outcomes demonstrated. Work to recruit staff remains an ongoing priority.

Skin -Skin. The percentage of babies receiving skin to skin within 1 hour of birth remains green, but February has seen a slight drop from January's figure. It does however remain at a level not seen since August 2021.

Term admissions to NNU. These numbers have fallen again in February to 1.16%. The results of the ATAIN (Avoiding Term Admissions into Neonatal Unit) audit currently being collated for all 2021 term admissions and findings will be presented to Board upon completion as per CNST requirements.
In order to make the audit process less onerous weekly meetings have been set up between NNU and Maternity staff to review all term admissions weekly and have more real time audit data to share.

All infants with Apgar's less than 7. After a spike in numbers in December there has been a drop in February and only one baby had an Apgar of less than 7. The case was appropriately managed and care given as recommended . The parameter for this indicator was discussed at Clinical Cabinet in February and it was agreed that it needed to be changed as WWL was not an outlier with this metric and the dashboard target was set too low. The agreed new metric will be applied in the next dashboard.

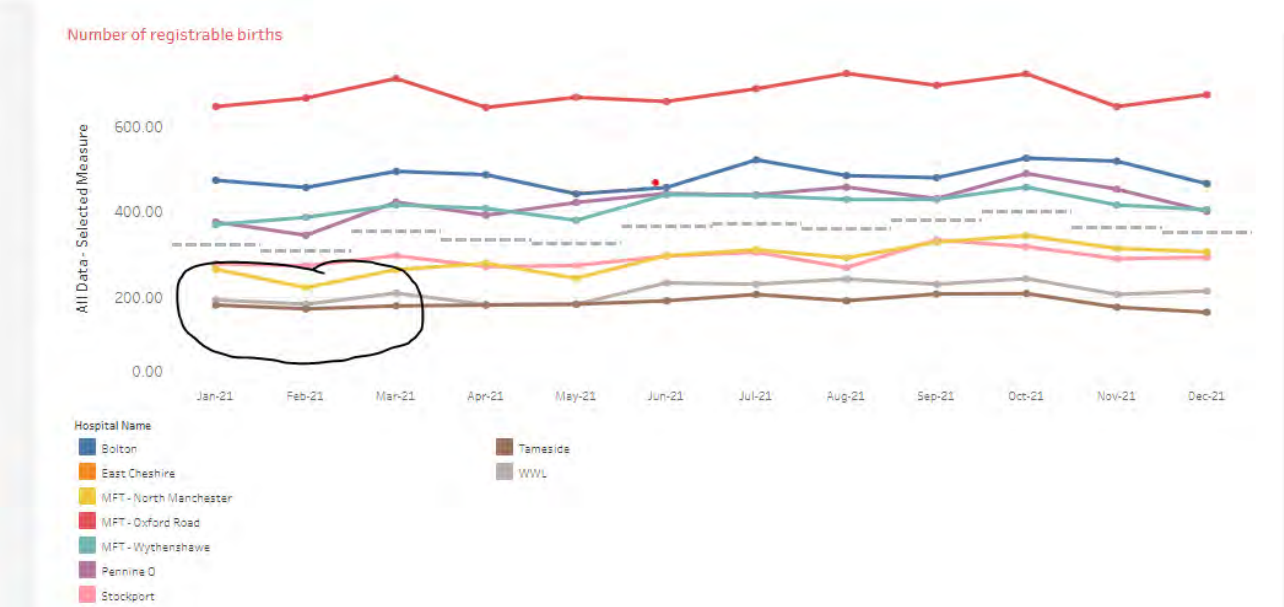
Re-admissions of babies within 30 days This remains at normal levels in February. The majority of babies were readmitted with Jaundice. There was also an admission for chicken pox and one for covid. The remining admissions were for infection. All cases were managed appropriately.

Women readmitted within 28 days of Delivery. There was one readmission in February (secondary PPH) which was appropriately managed and there were no concerns identified or omissions in care. The parameter for this indicator was also discussed at Clinical Cabinet in February and it was agreed that it needed to be amended as WWL was not an outlier with this metric and the dashboard target was set too low. The agreed new metric will be applied in the next dashboard.

Supernumerary Shift coordinator There were no shifts where it was not possible for the shift coordinator to remain supernumerary.

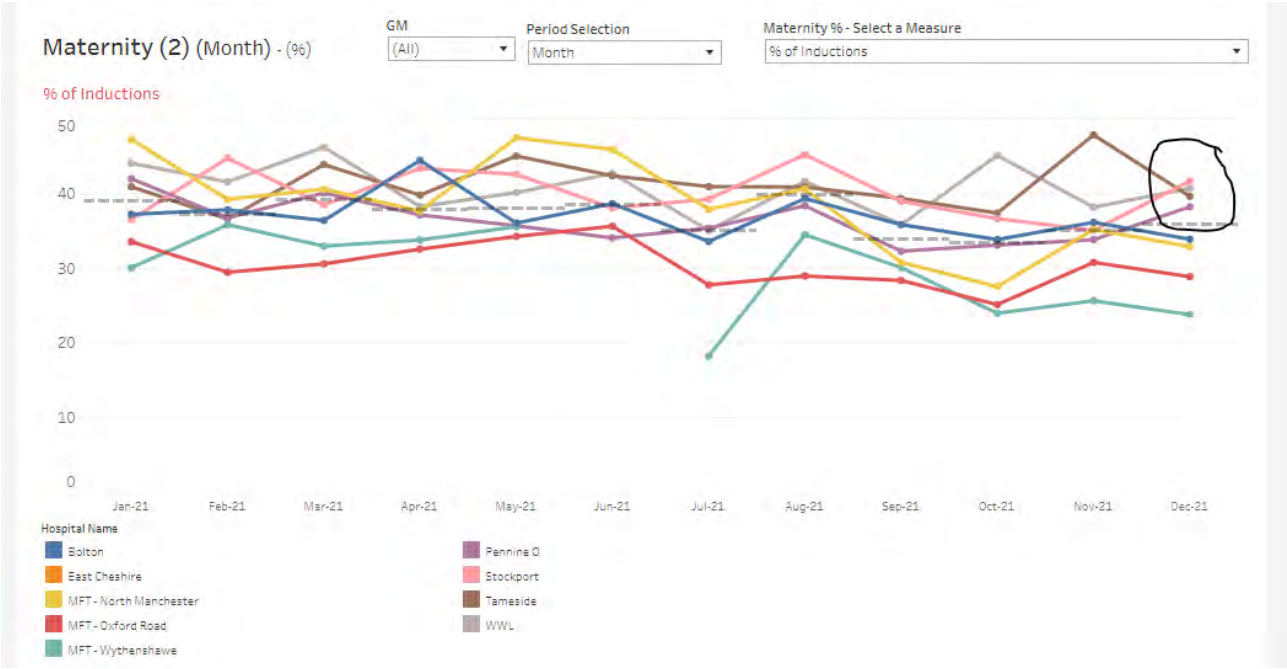
Amber

Number of registerable births. The number of registerable births is amber for the second consecutive month. However, the same pattern can be seen for the same months in 2021. Births then increased in the rest of the year.



Women booked by 12+6 weeks This remains just below the national standard. On investigating the reasons for delay this was not due to omissions in care. The main reasons for the delay in booking was maternal choice or transfer to the area.

Induction of Labour (IOL) – This has increased from previous months to over 40%. All cases continue to be reviewed for appropriate medical reasons, gestations, and outcomes. As can be seen below however WWL has one of the highest rates in GM for induction of labour so this figure will need to be closely observed going forward.



The overall Caesarean section – this is at its lowest rate since November 2021. This has meant that the normal birth rate has increased back to amber levels. As was seen last month we have one of the lowest CS rates across GM. Work to promote normality and optimise birth outcomes continues across the maternity service. Instrumental deliveries have remained green for the third consecutive month

England and NHS Improvement said hospitals should no longer use "total caesarean section rates as a means of performance management" as this may lead to targets being pursued that "may be clinically inappropriate or unsafe in individual cases." Trusts are to use the Robson Criteria which WWL are still waiting for the system provider (Euroking) to install within the electronic workflows. Once this action is facilitated this will be applied to the dashboard and going forward the RAG rating will be removed.

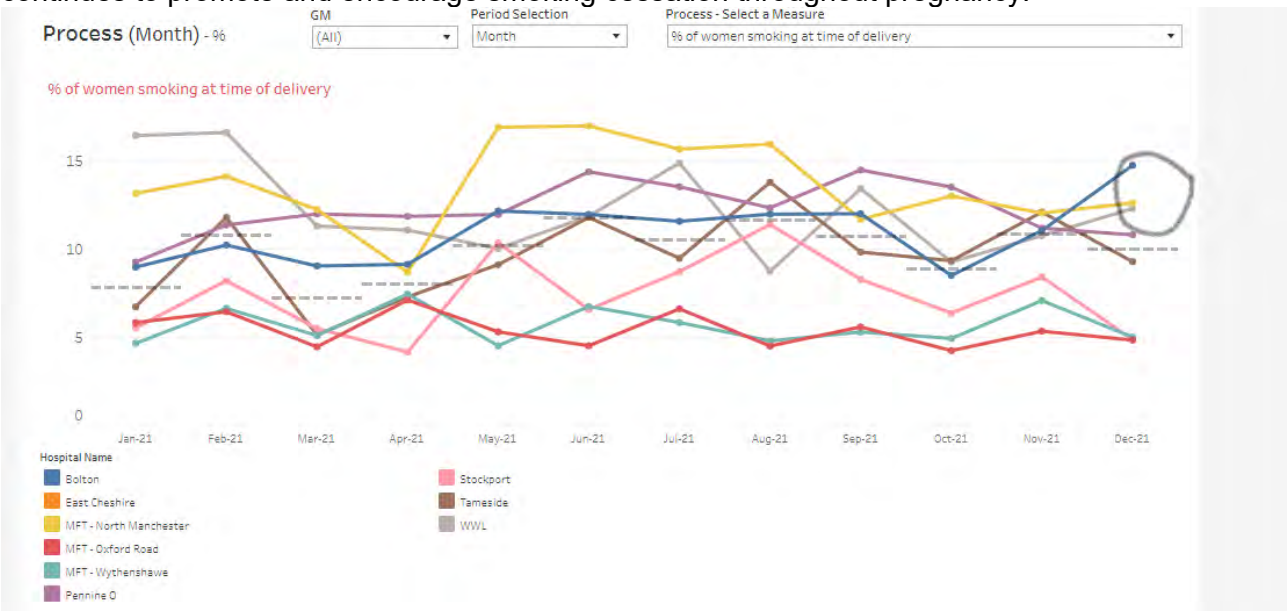
Red

Maternal steroids - given to mature the fetal lungs when premature labour is suspected, or premature delivery is required. There were three eligible mothers in February. One Mother had a complete course prior to delivery. The other two Mothers did not receive any steroids. One presented at the unit fully dilated and the other was found to require immediate delivery. There were no omissions in care noted.

The requirement within the Saving Babies Lives Standards (SBL V2) which are also replicated within the Maternity Incentive Scheme is that the process indicator measured is the percentage of singleton live births less than 34+0 weeks gestation who receive a full course of antenatal corticosteroids within 7 days of birth. (a full course id defined as two does 24 hours apart). It is not clear that all units within GM are recoding this in the same way and this has been raised at the Regional Dashboard Steering Group for further clarification and standardisation of reporting.

The number of mothers who have opted to breastfeed –The breastfeeding rates reached a new all-time high in January with a rate of 58.29%. However, this has seen a drop in February to just 48%. Work continues to encourage breastfeeding so that this figure can be improved upon.

Smoking at the time of Delivery (SATOD). There was a significant reduction in January to a low figure of 9.23%. However, there has been a large jump in figures to 17.12% in February. Work continues to promote and encourage smoking cessation throughout pregnancy.



Conclusion

There are normal variation and fluctuations with the figures this month and several positive factors have been sustained. No issues are raised with care given or in the management of cases. The figures show green and amber indicators with very few red areas. These red areas will be closely observed. The maternity dashboard continues to be reviewed quarterly by GM at the Maternity Dashboard steering group. The figures for the parameters to be changed will be decided upon at the next Clinical Cabinet. These numbers will be based on patterns across GM. These will then be implemented on the next dashboard.

	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of Women Delivered	241	224	238	205	212	195	184										
Number of Registerable Births	241	229	242	205	213	198	187										
Number of Bookings(retrospective 1 month)	222	242	227	244	233	271	235										
Normal Births as % of births	137	127	143	112	116	103	109										
% of Successful Planned Home Births	2	2	1	1	4	1	2										
Instrumental Deliveries as % of births	29	26	19	27	23	22	19										
Total Caesarean Sections as % of births	75	76	80	61	73	72	59										
% Emergency Caesaean Sections	36	36	57	38	41	39	32										
% Elective Caesarean Sections	39	40	23	23	32	33	27										
Number of successful VBAC deliveries	6	7	5	4	4	4	3										
%of Caesarean Sections at Full Dilatation	2	4	7	7	3	5	5										
Induction of Labour as % of women delivered	100	80	107	78	86	68	78										
% of women induced when RFM is the only indication <39 weeks	4	3	0	0	0	2	3										
% of women induced for Suspected SGA	16	28	27	23	15	19	18										
Average Postnatal Length of Stay	1.2	1.3	1.4	1.6	1.6	1.6	1.5										
Number of In-utero transfers in from other units	1	3	1	0	0	0	0										
Number of In-utero transfers out to other units	0	0	2	0	0	1	0										
%of Women Smoking at Booking	11.20%	13.83%	13.02%	13.93%	12.90%	13.65%	13.61%										
% of Women Smoking at Delivery	8.60%	12.50%	9.24%	10.73%	12.26%	9.74%	16.75%										
Babies in Skin-to-Skin within 1 hour of birth	192	170	183	148	166	159	148										
Percentage of Women Initiating Breastfeeding	114	110	134	103	104	109	87										
Percentage of Women booked by 12+6 weeks	198	228	206	215	215	230	205										
Prospective Consultant hours on Delivery Suite	60	60	60	60	60	60	60										
Midwife: Birth Ratio	28	28	28	28	28	28	28										
1:1 Care in Labour	200	184	215	204	100%	99%	100%										
Percentage of shifts where shift Co-ordinator able to remain supernumerary	95%	93%	95%	100%	100.00%	98%	100%										
Diverts: Number of occasions unit unable to accept admissions	0	1	0	0	1	1	0										
Diverts: Number of women during period affected by unit closure	0	1	0	0	1	0	0										
Number of Midwives in Post	144	145		130	128	129	128										
Attendance at Skills Drills/Mandatory Training	12	12	12	0	15	0	14										
3rd/4th Degree Tear as % of births	3	4	5	8	7	4	1										
with unassisted births (normal)	2	1	3	7	5	3	1										
with assisted births (Instrumental)	1	3	2	1	2	1	0										
Episiotomies in Normal Birth	10	5	10	6	3	4	3										
PPH >2.5L as % of births	0	0	0	1	0	1	1										
Number of Blood Transfusions > 4 Units	0	0	1	0	0	0	0										
Number of Women Requiring Level 2 Critical Care	4	0	1	1	2	3	1										
Number of Women Requiring Level 3 Critical Care	1	0	0	0	0	0	0										
Maternal Deaths	0	0	0	0	0	0	0										
Number of women re-admitted within 28 days of delivery	1	3	1	2	3	2	1										
Stillbirths **	1	0	0	0	2	0	0										
Early Neonatal Deaths (before 7 days)	0	0	0	0	0	0	0										
Number of Neonates with Apgars <7 at 5 minutes (>37 weeks gestation)	3	1	1	1	4	2	0										
HIE 2 &3 > 37 weeks (reported retrospectively)	0	0	0	0	0	0	0										
Shoulder Dystocia	1	4	1	2	0	1	2										
Singleton Babies born <30 weeks gestation	1	0	0	2	0	0	2										
% whose mother received magnesium sulphate	1	0	0	2	0	0	0										
Singleton Babies born <34 weeks gestation	5	3	6	3	4	4	3										
% whose mother received full course steriods (1 week prior to delivery)	3	2	4	1	1	2	1										
Births >37 weeks gestation	223	211	214	179	190	171	175										
Unexpected Term Admissions to NNU as % of births > 37 weeks gestation.	10	10	12	1	6	4	2										
Number of babies re-admitted with 28 days of birth	28	18	12	15	19	11	14										
Number of indicents reported	65	46	74	57	51	47	35										
Number of Concise Investigations	0	1	1	0	0	0	0										
Number of StEIS Reported Incidents	0	2	0	0	0	0	0										
Number of Midwifery Red Flags Reported	3	4	3	3	0	4	0										
Number of Complaints	0	0	0	1	2	3	2										
Number of Letters of Claim Received	0	0	0	0	0	0	0										
Live Births	240	229	242	204	211	198	187										#VALUE!
REGIONAL METRICS																	
Number of Live Births born ≥16 weeks to <24 weeks	0	0	0	0	0	0	0										
Number of Live Births born ≥24 weeks to <37 weeks	16	18	27	21	22	24	12										
Number of Live Births born ≥24 weeks to <34 weeks	5	3	6	3	4	6	3										
Number of Live Births ≥38 weeks	203	180	194	165	169	150	153										
Number of Live Births ≥39 weeks	163	147	164	131	136	127	124										
Number of Episiotomies performed	37	30	27	30	19	21	15										
Number of babies born <3rd centile	9	8	8	6	11	15	10										
Number of Major Haemorrhages ≥ 2500mls	0	0	0	1	0	1	1										
Intrapartum Stillbirths	0	0	0	0	0	0	0										
Number of Early Neonatal Deaths 20+0 to 23+6 weeks	0	0	0	0	0	0	0										
Number of Early Neonatal Deaths > 24 weeks	0	0	0	0	0	0	0										
Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received magnesium sulphate	4	3	4	3	2	5	1										
Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received steroids	5	2	6	3	2	4	1										
Number of babies less than 3rd centile delivered >38 weeks	5	1	1	1	3	7	3										
Number of women smoking at the time of booking	27	31	31	34	30	37	32										
Number of women smoking at delivery	21	28	22	22	26	19	31										
Friends & Family Test:Q2 Birth:Percentage returned complete																	
Friends & Family Test:Q2 Birth:Percentage of completed surveys returned as recommended																	
Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were symptomatic	2	2	2	2	22	54	4										
Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were asymptomatic	5	2	1	2	2	9	1										
Number of babies born at Home Midwife NOT present	1	1	0	0	4	1	1										
Number of babies born in Other location Midwife NOT present	1	1	0	1	1	0	0										
Episiotomies with Episcissors	32	26	21	28	14	21	14										

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Maternity Dashboard 2022

		Goal	Red Flag	Measure	2021 Data Aug	Sept	Oct	Nov	Dec	2022 Data Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD	Trend
Activity	Number of Registerable Births	>200	<180	2020 Births	241	229	242	205	213	198	187											385				385	
	Number of Bookings(retrospective 1 month)	≥240	≤200	2020 Bookings	222	242	227	244	233	271	235											506				506	
	Normal Births as % of births	>=60%	<55%	Nat Standard	56.85%	55.46%	59.09%	54.63%	54.46%	52.02%	58.29%											55.06%				55.06%	
	% of Successful Planned Home Births			Births/month	0.83%	0.87%	0.41%	0.49%	1.88%	0.51%	1.07%											0.78%				0.78%	
	Instrumental Deliveries as % of births	<12%	>15%	Nat Average	12.03%	11.35%	7.85%	13.17%	10.80%	11.11%	10.16%											10.65%				10.65%	
	Total Caesarean Sections as % of births	<29%	≥34%	GM Average	31.12%	33.19%	33.06%	29.76%	34.27%	36.36%	31.55%											34.03%				34.03%	
	% Emergency Caesaean Sections				14.94%	15.72%	23.55%	18.54%	19.25%	19.70%	17.11%											18.44%				18.44%	
	% Elective Caesarean Sections				16.18%	17.47%	9.50%	11.22%	15.02%	16.67%	14.44%											15.58%				15.58%	
	Number of successful VBAC deliveries			Births/month	6	7	5	4	4	4	3										.	7				7	
	%of Caesarean Sections at Full Dilatation			Births/month	2.67%	5.26%	8.75%	11.48%	4.11%	6.94%	8.47%											7.63%				7.63%	
	Induction of Labour as % of women delivered	<38%	>=42%	Births/month	41.49%	34.93%	44.21%	38.05%	40.38%	34.34%	41.71%											37.92%				37.92%	
	% of women induced when RFM is the only indication <39 weeks				1.66%	1.31%	0.00%	0.00%	0.00%	1.01%	1.60%											1.30%				1.30%	
	% of women induced for Suspected SGA				6.64%	12.23%	11.16%	11.22%	7.04%	9.60%	9.63%											9.61%				9.61%	
	Average Postnatal Length of Stay	≤1.5	≥1.8	Births/month	1.2	1.3	1.4	1.6	1.6	1.6	1.5											1.6				1.6	
	Number of In-utero transfers in from other units				1	3	1	0	0	0	0															0	
	Number of In-utero transfers out to other units				0	0	2	0	0	1	0											1				1	
	%of Women Smoking at Booking			2020 Bookings = 17%	14.00%	13.83%	13.02%	13.93%	12.90%	13.65%	13.61%											9.09%				2.27%	
	% of Women Smoking at Delivery	14%	17%	2020 Births	8.60%	12.50%	9.24%	10.73%	12.26%	9.74%	16.75%											8.83%				2.21%	
	Percentage of Babies in Skin-to-Skin within 1 hour of birth	≥80%	≤70%	Regional average	80.00%	74.24%	75.62%	72.55%	78.67%	80.30%	79.14%											79.74%					
	Percentage of Women Initiating Breastfeeding	≥55%	≤50%	2020 Births	47.50%	48.03%	55.37%	50.49%	49.29%	55.05%	46.52%											50.91%					
	Percentage of Women booked by 12+6 weeks	≥90%	≤80%	Nat Standard	89.19%	94.21%	90.75%	88.11%	92.27%	84.87%	88.12%											85.97%				85.97%	
Workforce	Prospective Consultant hours on Delivery Suite	60 hours	< 60 hours	Nat Standard	60	60	60	60	60	60	60											120				120	
	Midwife: Birth Ratio	≤ 1:28	≥1:24	WTE/Births	1.28	1.28	1.28	1.28	1.28	1.28	1.28											1.56				1.56	
	1:1 Care in Labour	100%	<100%	Nat Standard	98.59%	99.42%	98.99%	98.80%	100.00%	99.35%	100.00%											99.68%				99.68%	
	Percentage of shifts where shift Co-ordinator able to remain supernumerary	100%	<100%	Nat Standard	95.16%	93.33%	95.16%	100.00%	100.00%	98.38%	100.00%															99.19%	
	Diverts: Number of occasions unit unable to accept admissions				0	1	0	0	1	1	0											1	0	0	0	1	
	Diverts: Number of women during period affected by unit closure				0	1	0	0	1	0	0											0	0	0	0	0	
	Attendance at Skills Drills/Mandatory Training	≥8%	<8%	Training Database	8.33%	8.28%		0.00%	11.72%	0.00%	10.94%											5.45%				5.45%	
Maternal Morbidity	3rd/4th Degree Tear as % of births	<3%	≥4%	2020 Births	1.24%	1.79%	2.10%	3.90%	3.30%	2.05%	0.54%											1.32%				1.32%	
	with unassisted births (normal)			2020 Births	0.83%	0.45%	1.26%	3.41%	2.36%	1.54%	0.54%											1.06%				1.06%	
	with assisted births (Instrumental)			2020 Births	0.41%	1.34%	0.84%	0.49%	0.94%	0.51%	0.00%											0.26%				0.26%	
	% of Episiotomies in Normal Birth			Births/month	7.30%	3.94%	6.99%	5.36%	2.59%	3.88%	2.75%											3.30%				3.30%	
	Episiotomies with Episcissors				86.49%	86.67%	77.78%	93.33%	73.68%	100.00%	93.33%																
	PPH >2.5L as % of births			Births/month	0.00%	0.00%	0.00%	0.49%	0.00%	0.51%	0.53%											0.52%				66.67%	
	Number of Blood Transfusions ≥ 4 Units			Births/month	0	0	1	0	0	0	0															0	
	Number of Women Requiring Level 2 Critical Care			Births/month	4	0	1	1	2	3	1											4				4	
	Number of Women Requiring Level 3 Critical Care			Births/month	1	0	0	0	0	0	0															0	
	Maternal Deaths			Nat rate per 1000	0	0	0	0	0	0	0															0	

	Number of women re-admitted within 28 days of delivery	≤1	>2	16 in 2020	1	3	1	2	3	2	1											3				3	
Neonatal Morbidity & Mortality	Stillbirths **			Nat rate 3.5 per 1000 births	1	0	0	0	2	0	0															0	
	Early Neonatal Deaths (before 7 days)			Nat rate per 1000 births	0	0	0	0	0	0	0															0	
	Number of Neonates with Apgars <7 at 5 minutes (≥37 weeks gestation)	≤1	>2	GM av 10 per 1000	3	1	1	1	4	2	1											2				2	
	HIE 2 &3 > 37 weeks (reported retrospectively)			GM av 1.95 per 1000	0	0	0	0	0	0	0															0	
	Shoulder Dystocia as % of births			Births/month	0.41%	1.75%	0.41%	0.98%	0.00%	0.51%	1.07%											0.78%				0.78%	
	Singleton Babies born <30 weeks gestation			Births/month	1	0	0	2	0	0	2											2				2	
	% whose mother received magnesium sulphate	100%	90%	Rolling% of eligible babies	100.00%		0.00%	100.00%	N/A	N/A	0.00%																
	Singleton Babies born <34 weeks gestation			Births/month	8	3	7	2	2	4	2											2				2	
	% whose mother received full course of steriods (1 week prior to delivery)	100%	90%	Rolling% of eligible babies	60.00%	66.67%	66.67%	33.33%	25.00%	50.00%	33.33%											42.86%				42.86%	
	Unexpected Term Admissions to NNU as % of births > 37 weeks gestation.	3.50%	>4.5%	Births> 37 weeks /month	4.48%	4.74%	5.61%	0.56%	3.16%	2.34%	1.16%											1.73%				1.73%	
	Number of babies re-admitted with 28 days of birth	<16	>20	194 in 2020	28	18	12	15	19	11	14											25				25	
Risk Management	Number of indicents reported				65	46	74	57	51	47	35											82				82	
	Number of Concise Investigations				0	1	1	0	0	0	0											0	0	0	0	0	
	Number of StEIS Reported Incidents				0	2	0	0	0	0	0											0	0	0	0	0	
	Number of Midwifery Red Flags Reported				3	4	3	3	0	4	0											4	0	0	0	4	
	Number of Complaints				0	0	0	1	2	3	2											5	0	0	0	5	
	Number of Letters of Claim Received				0	0	0	0	0	0	0											0	0	0	0	0	

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

			2021 Data					2022 Data												
		Indicator	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
DENOMINATOR Metrics	1	Number of Bookers	222	242	227	244	233	271	235											506
	2	Number of Registrable Births	241	229	242	205	213	198	187											385
	3	Number of Women Delivered	241	224	238	205	212	195	184											379
	4	Number of Successful Planned Home Births	2	2	1	1	4	1	2											3
	5	Number of Midwifery Led Unit births	241	224	238	205	212	195	184											379
	6	Number of Live Births at any gestation	241	229	242	205	213	198	187											385
	7	Number of Live Births born ≥16 weeks to <24 weeks	0	0	0	0	0	0	0											0
	8	Number of Live Births born ≥24 weeks to <37 weeks	16	18	27	21	22	24	12											36
	9	Number of Live Births born ≥24 weeks to <34 weeks	5	3	6	3	4	6	3											9
	10	Number of Live Births ≥37 weeks	223	211	214	179	190	171	175											346
	11	Number of Live Births ≥38 weeks	203	180	194	165	169	150	153											303
	12	Number of Live Births ≥39 weeks	163	147	164	131	136	127	124											251
	13	Number of Episiotomies performed	37	30	27	30	19	21	15											36
	14	Episiotomies with Episcissors	32	26	21	28	14	21	14											35
	15	Number of babies born <3rd centile	9	8	8	6	11	15	10											25
MATERNAL Morbidity and Mortality Metrics	16	Number of Maternal Deaths	0	0	0	0	0	0	0											0
	17	Number of Blood Transfusions ≥ 4 Units	0	0	1	0	0	0	0											0
	18	Number of Women Requiring Level 2 Critical Care	4	0	1	1	2	3	1											4
	19	Number of Women Requiring Level 3 Critical Care	1	0	0	0	0	0	0											0
	20	Number of Major Haemorrhages ≥ 2500mls	0	0	0	1	0	1	1											2
	21	Number of Women readmitted to same Obstetric unit within 30 days of delivery	1	3	1	2	3	2	1											3
	22	Number of 3rd and 4th degree tears	3	4	5	8	7	4	1											5
	23	Number of Episiotomies in normal birth	10	5	10	6	3	4	3											7
	24	Number of Emergency LSCS	36	36	57	38	41	39	32											71
	25	Number of Elective LSCS	39	40	23	23	32	33	27											60
	26	Number of LSCS at Full Dilatation	2	4	7	7	3	5	5											10
	27	Number of Operative Vaginal Deliveries	29	26	19	27	23	22	19											41
	28	Number of Normal Vaginal Deliveries	137	127	143	112	116	103	109											212
	29	Number of Inductions (excluding augmentations)	100	80	107	78	86	68	78											146
	30	Number of women induced only when RFM is the only indication < 39 weeks	4	3	0	0	0	2	3											5
PERINATAL Morbidity and Mortality Metrics	31	Number of Stillbirths	1	0	0	0	2	0	0											0
	32	Number of Intrapartum Stillbirths	0	0	0	0	0	0	0											0
	33	Number of Early Neonatal Deaths 20+0 to 23+6 weeks	0	0	0	0	0	0	0											0
	34	Number of Early Neonatal Deaths > 24 weeks	0	0	0	0	0	0	0											0
	35	Number of Neonates with suspected HIE Grade 2 and 3, ≥ 37 Weeks	0	0	0	0	0	0	0											0
	36	Number of Neonates with Apgars <7 at 5 Minutes, ≥ 37 Weeks	3	1	1	1	4	2	1											3
	37	Number of admissions to Neonatal Unit ≥ 37 Weeks	10	10	12	1	6	4	2											6
	38	Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received magnesium sulphate	4	3	4	3	2	5	1											6
	39	Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received steroids	5	2	6	3	2	4	1											5
	40	Number of babies less than 3rd centile delivered >38 weeks	5	1	1	1	3	7	3											10
PROCESS	41	Average Postnatal Length of Stay for Women	1.2	1.3	1.4	1.6	1.6	1.6	1.5											3.1
	42	Number of In-utero Transfers In	1	3	1	0	0	0	0											0
	43	Number of In-utero Transfers Out	0	0	2	0	0	1	0											1
	44	Diverts: Number of occasions the unit has been unable to accept admissions	0	1	0	0	1	1	0											1
	45	Diverts: Number of women during the period affected by the units closures	0	1	0	0	1	0	0											0
	46	Number of women booked by 12 + 6 weeks	198	228	206	215	215	230	205											435
	47	Number of women smoking at the time of booking	27	31	31	34	30	37	32											69
	48	Number of women smoking at delivery	21	28	22	22	26	19	31											50
	49	Number of women initiating breast feeding including attempted and expressed	114	110	134	103	104	109	87											196
	50	Number of babies that received Skin to Skin contact within 1 hour of birth	192	170	183	148	166	159	148											307

	51	Number of successful VBAC deliveries	6	7	5	4	4	4	3												7
Patient Experience	52	Friends & Family Test:Q2 Birth:Percentage returned complete																			0
	53	Friends & Family Test:Q2 Birth:Percentage of completed surveys returned as recommended																			0
Workforce	54	Number of women receiving 1:1 midwifery in labour	200	184	215	204	180	165	152												317
	55	Midwife to Birth Ratio	28	28	28	28	28	28	28												56
COVID -19	56	Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were symptomatic	2	2	2	2	22	54	4												58
	57	Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were asymptomatic	5	2	1	2	2	9	1												10
Safety	58	Number of babies born at Home Midwife NOT present	1	1	0	0	4	1	1												2
	59	Number of babies born in Other location Midwife NOT present	1	1	0	1	1	0	0												0

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Board Provider Report
Presented to:	Trust Board
On:	06 April 2022
Presented by:	Rabina Tindale Chief Nurse
Prepared by:	Cathy Stanford Interim Divisional Director of Midwifery and Neonates
Contact details:	T: 01942 773107 E: cathy.stanford@wwl.nhs.uk

Executive summary

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

For January/ February there have been no Steis incidents to report or completed Steis investigations to provide oversight on.

Incident exception reporting.

At this time no babies have been diagnosed with HIE 2 or 3,and no cases met the criteria for referral to HSIB or NHS Resolution Early Notification Scheme.
No Maternity Diverts were necessary. There has been 100% Supernumerary shift co-ordinator in place and 100% 1-2-1 care in labour provided.

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

- The Trust has had 0 maternal deaths in Q3 2021-22, and 0 neonatal deaths.

- No stillbirths have occurred in Jan/ Feb 2022. The overall rate for 2021 was low (6) which gives an approx. 2.5 unadjusted rate. There were no Neonatal deaths at WWL in 2021.

Recommendation(s)

The board are asked to review the provider template for January/ February 2022

Report

Ockenden Next steps update

See attached Ockenden compliance submission papers, which have been submitted to the Regional and National teams prior to the publication of Ockenden 2 as requested to benchmark where Trusts are up to with the implementation and sustaining of the 7 Immediate and Essential Actions (IEA'S). Ockenden 2 report was due to be published on 22 March 2022 however this has now been delayed due to Parliamentary process. The report is expected to focus on workforce and training.

The East Kent report is expected to be published in Summer 2022 and will have additional recommendations for all providers. Additionally, Trusts were asked to revisit their Kirkup action plans to ensure compliance with actions and recommendations following the Morecombe Bay report**. (See attached paper).**

The Maternity self-assessment Tool

Trust Boards are asked to review this document to benchmark the organisation in the core principles of good safety standards within Maternity services

The Safety Self-assessment tool has been provided to enable maternity providers to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements. Organisations are asked to use the tool to inform the trust's maternity quality improvement and safety plan and to update the Trust Board and Commissioners of their current position.

The tool was developed in response to national review findings, and recommendations for good safety principles within maternity services. This version of the tool has been further influenced by the findings of the Ockenden review, 7 features of safety culture and the emerging themes from services on the safety support programme and the areas CQC found to be outstanding in other maternity services across England.

See attached document

Maternity Staffing

Staffing levels at present remain stable, this is partly due to the pause in Continuity of Carer teams and some successful recruitment. Current vacancies remain at 11.2. and recruitment remains ongoing. Interviews are scheduled this month for WWL Student Midwives due who qualify in May and late summer 2022, with the expectation that they will be in post in July - September 2022.

Maternity Incentive Scheme Year 4 Update

See attached document for compliance update Year 4

Continuity of Carer

The building blocks paper was presented to Board in February and Continuity of Carer teams will be recommenced as soon as staffing levels allow. Staff engagement and feedback sessions are being arranged for the coming months in preparation for this.

Maternity Risks

There are no Maternity risks scoring 15 or above and there are currently 4 Maternity risks on the divisional risk register which are all being proactively managed within the service.

Midwifery Staffing Shortages

CTG Misinterpretation

Collection and submission of Maternity Services Data Set (MSDS)

Delivery Suite Co-ordinators should be supernumerary at all times

Summary

A robust training programme remains in place to meet the requirements of CNST and Saving Babies Lives recommendations. Rates are not currently at the expected targets due to cancellations of training in November and January due to Covid sickness. Plans are in place to catch up and additional sessions are being facilitated.

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

Staffing levels have been less challenging due to reduced sickness levels and some recruitment and no maternity diverts have been necessary.

Title of report:	Maternity Incentive scheme Year 4 Progress report and update
Presented to:	Trust Board
On:	06 April 2022
Presented by:	Rabina Tindale Chief Nurse
Prepared by:	Cathy Stanford Interim Divisional Director of Midwifery and Neonates
Contact details:	T: 01942 773107 E: cathy.stanford@wwl.nhs.uk

Executive summary

This paper is to update the Trust Board on the ten maternity safety actions included in the NHS Resolution Maternity Incentive Scheme Year 4 which was launched on 9 August 2021. On the 27 September 2021 NHS Resolutions decided to extend the Scheme's interim deadlines to support trusts due to the current Covid-19 Pandemic. There were also revisions to some of the safety actions' sub-requirements.

NHS Resolution (NHSR) is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to support the delivery of safer maternity care. As in previous years, as a member of the CNST Wrightington Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL) will contribute an additional 10% of the CNST maternity premium to the scheme. If WWL can demonstrate they have achieved full compliance of all the ten safety actions, then the Trust will recover their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. However, if the Trust cannot demonstrate full compliance with the 10 safety actions, then the Trust will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help make progress towards meeting the requirements of the actions that were not achieved. This discretionary payment would be at a much lower level than the 10% contributed.

The Trust must submit their completed Board declaration form the NHS Resolution by 12 noon on 30 June 2022 signed and dated by the Trust's Chief Executive Officer (CEO) confirming that The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required standard as set out in the 'Ten maternity safety actions with technical guidance' document .

The content of the declaration form must be discussed with the commissioner of the Trust's maternity services.

Confirm there are no reports covering either this year (2021/22) or 2022/23 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g., Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). Any such reports should be brought to the MIS team's attention before 30 June 2022.

This paper outlines the required standards for each of the ten safety actions along with the current evaluation of the compliance status and level of risk for each standard. The Board are asked to note that there have been significant changes to many of the 10 Safety Standards requirement in comparison to the Maternity Incentive Scheme year 3.

Report

Safety Action 1
Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?

- All eligible deaths to be notified to MBRACE-UK within seven working days and the surveillance information where required must now be completed within one month of the death rather than four months.
- A review using the PMRT of 95% of all deaths of babies, suitable for review must have been started within two months of each death

- There is further clarification regarding the multi-disciplinary review and individuals to be involved.

Current status. Fully compliant

Safety Action 2
Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

- The Trust has a Maternity Information System complying with the forthcoming commercial framework (published by NHSX) and are complying with Information Standard Notices
- Attend at least one engagement session organised by NHSX.

These will require the implementation of some digital changes to the existing system.

- Provide assurance that 9 out of 11 Clinical Quality Metrics (CQIMS) have passed the associated data quality criteria of the national Maternity Services Dashboard.
- Continuity of carer data regarding the proportion of women placed on CoC pathway by the 28 weeks antenatal appointment and receiving CoC .
- Personalised Care and Support planning at three stages in the pregnancy which includes antenatal care plan by 16+1 weeks gestation, birth care plans by 34+1 weeks gestation and postpartum care plans by 36+1 weeks gestation.

Current status. Partially compliant

Safety Action 3
Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into the Neonatal units Programme?

- Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies.

- The pathways of care have been fully implemented and will be audited quarterly. Audit findings are to be shared with the neonatal safety campion, Local Maternity and Neonatal Systems (LMNS), commissioners and Integrated Care Systems (ICS) quality surveillance meeting each quarter.

- A data recording process for capturing existing transitional care activity regardless of place is in place(BadgerNet)
- LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development to TC to minimise separation of mother and baby.
- Review of term admissions to the neonatal unit to include the number of admissions that would have met the current TC admissions criteria but were admitted to the neonatal unit due to capacity or staffing issues.
  The review needs to include the number of babies that remained or were admitted to the Neonatal Unit because of their need for nasogastric tube feeding but could have been for on a TC if nasogastric feeding was supported there.

Current status. Partially compliant

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

- Obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their services.
- To monitor the compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person.
- A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should always have clear lines of communication to the supervising anaesthetic
- consultant. They should be able to delegate care for their non-obstetric patients to be able to attend immediately to obstetric patients.
- The Trust Board should evidence progress against the action plan developed in year 3 of MIS as well as include new relevant action to address deficiencies for the Neonatal medical and nursing workforce to meet the British Association of Perinatal Medicine (BAPM) national standards for junior medical staffing and nursing standards.

Current status. Partially compliant

Safety Action 5
Can you demonstrate an effective system of midwifery workforce planning to the required standard?

- Systematic evidenced based process to calculate midwifery staffing establishment is completed
- Submit a staffing report every 6 months to the Trust Board
- Supernumerary Shift Coordinator in place
- All women in active labour receive 1-2-1 Care.

Current status. Fully compliant

Safety Action 6
Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
80% compliance is required for all metrics within all 5 elements or the Trust will fail

Submission of the quarterly care bundle surveys to the Trust Board.

- **Element 1**- Carbon Monoxide(CO) measurement at booking and 36 weeks is recorded.80% compliance required
- **Element 2**-fetal growth restriction monitoring
- **Element 3**- reduced fetal movement monitoring. If the process indicator scores are less than 95%, action plan is required to achieve >95%.
- **Element 4** – Fetal Monitoring. The Trust Board to confirm that 90% of eligible staff have attended local multi-professional training annually and have a dedicated Lead Midwife (0.4 WTE) and lead Obstetrician (0.1 WTE) appointed by the end of 2021.
- **Element 5** – Premature labour, has been extended to include:

The percentage of singleton live births occurring more than 7 days after completion of first course of corticosteroids
Audit of women booked have been risk assessed for premature labour and referred to the appropriate care pathway.
The risk assessment and management in multiple pregnancy complies with NICE guidance or a variant that has been agreed with local commissioners following advice from the provider's clinical network.

The Trust should specifically confirm that they have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention.
Current status. Fully compliant

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

- Terms of reference for MVP in place
- Minutes of meetings demonstrating feedback
- MVP is prioritising hearing the voices of women from Black, Asian and minority ethnic backgrounds and women living in areas of high deprivation
- Written confirmation that The MVP Chair is being renumerated which reflects the time commitment and requirements of the role given and remuneration should take place in line with agreed Trust processes.
- Members and chair of MVP can claim out of packet expenses and childcare costs
- MVP work programme in place , and minutes of meeting where it was agreed and ratified by the LMS

Current status. Partially compliant

Safety Action 8
Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?

In addition, can you evidence at least 90% of each maternity unit staff group have attended an 'in-house' one day multi-professional training day which includes:

- Training plan to cover all six core modules of the Core Competency Framework that will span a 3-year time period.
- Multi-professional 'in-house' training day with attendance of 90% of each identified maternity staff groups.
- All staff involved in the immediate resuscitation of the new-born and management of the deteriorating infant should attend local neonatal life support training every year.
- Fetal Monitoring and surveillance should be consistent with the Ockenden Report (2021).

There have been changes made to the content of the multi-professional maternity emergencies as set out in the Core Competency Framework. All core competencies should be covered in the three-year period. One of the competencies to include a learning from excellence case study and at least one of the four emergency scenarios should be conducted in the clinical area ensuring full attendance from the relevant wider multi-professional team.

Current status. Partially compliant

Safety Action 9
Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

- Evidence that the revised pathway developed in year 3 that describes how safety intelligence is shared from frontline staff, Board safety champions, between each other, the Board, new local maternity, and neonatal systems (LMNS), regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action and support is provided for areas of concern or need in line with the perinatal quality surveillance model.
- Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by Board Level safety champions at Trust level quality meeting each quarter, beginning no later than quarter 3.
- Evidence of an action plan that describes how the maternity service will work towards CoC being the default model of care offered to all women by March 2023.
- Insights from culture surveys undertaken have been used to informal local quality improvement plans by April 2022.

Current status. Partially compliant

Safety Action 10
Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification scheme for 2021/22?

Current status. Fully compliant

Summary

NHS Resolution and the Collaborative Advisory Group (CAG) have continued to monitor Trusts position in relation to Covid-19, staffing and acuity and the challenges faced by Trusts in achieving the Scheme's safety actions.
In recognition of the current pressures on Maternity Services and the NHS as a whole most of the reporting requirements relating to the maternity incentive scheme 10 safety actions have been paused for a minimum of 3 months, commencing in December 2021. Trusts are asked to continue to apply the principles of the 10 safety actions in order to continue to deliver safe maternity care, especially in relation to workforce and oversight provided by the Board level maternity and neonatal safety champions.
Every effort will be made to continue where possible with all the recommendations and to continue to apply this principle. Planned reporting periods will now be subject to change and may potentially be extended further, confirmation of this will be received in due course.

Recommendations

The Board are asked to note the contents of the update report and the risk associated with the achievement of year 4 requirements due to the increasing recommendations within the standards and note the actions in place to progress towards delivery of these. Where p[atrial compliance has been documented in some instances this will mean that full compliance cannot be declared until the reporting period has concluded.

NHS

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Maternity services assessment and assurance tool

JANSection 1							
Immediate and Essential Action 1: Enhanced Safety Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight. • Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months. • External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. • All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months							
Link to Maternity Safety actions: **Action 1:** Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? **Action 2:** Are you submitting data to the Maternity Services Dataset to the required standard? **Action 10:** Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?							
Link to urgent clinical priorities: (a) A plan to implement the Perinatal Clinical Quality Surveillance Model All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB							
What do we have in place currently to meet all requirements of IEA 1?	**Describe how we are using this measurement and reporting to drive improvement?**	**How do we know that our improvement actions are effective and that we are learning at system and trust level?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will mitigate risk in the short term?**	**RAG**
Safety in Maternity units to be strengthened by increasing partnerships between Trusts and within local networks							

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

Action Plans Monitored at the Obstetrics and Gynaecology Clinical Cabinet and or Serious Incident Requiring Review Panel(SIRI) if the incident has been reported to StEIS	Any improvement actions including actions from the Saving Babies Lives care bundle (V 2.0) are discussed in this review.	provided in agreement with the family in a format that is agreed. Reduction in avoidable harms and reduction in numbers of stillbirths Recommendations are implemented	A multi-disciplinary action plan would be developed and monitored through the appropriate forums dependent on the issue identified.				
Report case to HSIB that meet the criteria for external review	All babies that meet the Each baby counts criteria are referred to HSIB and NHSR for consideration and review	Cases reported via the incident reporting system (Datix)/ Immediate review undertaken (IPIR) Case discussed at weekly PMRT meeting	Cases escalated to Trust executive Scrutiny Group (ESG) IPIR presented and discussed. Any identified shared learning is cascaded through Divisional and Corporate Trust teams.	Cathy Stanford Acting Divisional Director of Midwifery. Head of Governance Maternity and Child Health		Cases going forward will also be escalated to the Regional Safety Improvement Group (SIG)	
Maternity Dashboards	Maternity Dashboards are completed monthly and submitted to Trust Board for the monthly performance report. Additionally, WWL submits data to the	Quarterly GM dashboard meetings are held, and data is reviewed. Any units that may be an outlier with any of the metrics are asked to review and provide actions.	There is a National Maternity Dashboard launched (However not real time as 3–4-month time lag) which will pull data from MSDS submissions which WWL will continue	Cathy Stanford Acting Divisional Director of Midwifery. Head of Governance Maternity and Child Health	Digital Midwife to support the increasing demands for reporting and move towards complete digital maternity records.	Continue with Head of Governance and facilitator incorporating this into their roles, which is a pressure on the Governance requirements	

	GM regional dashboard		to contribute to through the Euroking Maternity Information System.			Business case for Digital Midwife to be completed for consideration if cannot be identified from existing staffing establishment.	
Data is submitted to the Maternity Services Dataset monthly	Any discrepancies in the data when the reports are generated, or the score cards received are investigated and solutions sought with the help of BI and the MIS provider Any data input issues are fed back directly to staff. Any service level issues will be rectified with the appropriate team, BI, IT or the provider.	The Trust receives a MSDS scorecard monthly outlining compliance with all criteria	Risk assessment has been completed for MSDS submission and support required.	Cathy Stanford Acting Divisional Director of Midwifery. Head of Governance Maternity and Child Health	Digital Midwife to support the increasing demands for reporting and data quality issues and the move towards a complete digital maternity record. Additionally, a Digital Midwife will support the Governance agenda with Documentation standards and compliance with data entry and data security.	Continue with Head of Governance and facilitator incorporating this into their roles, which is a pressure on the Governance requirements. **January 2022 Update** Digital Midwife now in place to improve submission and data quality compliance	Successful submission of all criteria. confirmation received from NHSX and regional Chief Midwife.

WWL has reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution Early Notification Scheme	Independent reviews are received from HSIB and any recommendations for improvement are incorporated into an action plan which is monitored for compliance via the Trust Governance forums.	All cases that meet the criteria are reported to HSIB, Each Baby Counts and MBRRACE and NHS Resolution.	The Maternity Service are aware of the 5 Quality Surveillance principles and have advised the Trust Board of the requirement to have a Quarterly board review of Perinatal Safety.	Cathy Stanford Acting Divisional Director of Midwifery. Head of Governance Maternity and Child Health		System in place for reporting.	
Serious Incidents are discussed at: -Maternity Clinical Issues group. -Obstetrics and Gynaecology Clinical Cabinet -Surgical Divisional Quality Executive Group -Executive Scrutiny Group -Serious Incidents Requiring Review Panel(SIRI)	All serious incidents will be submitted to Trust Board for oversight and review on a monthly or quarterly basis as agreed. This will be commenced and a regular report as per the Serious Incident Framework will be submitted to Trust Board.	Serious incidents from all GM trusts will feed into the LMS Serious Incident Group (SIG) going forward. Terms of reference to be defined and agreed. Challenge is received at all Governance forums in terms of any lessons learned and recommendations for improvements	The Trust is committed to implementing the regional proposals for the Quality Surveillance Model that will be circulated in early 2021 and will commit to implementing this. Further Guidance is required in regards to the submission to the LMS as to how and when this will be implemented.	Shatha Attarbashi Clinical Director/ Consultant Obstetrician and Gynaecologist Cathy Stanford Acting Divisional Director of Midwifery. Head of Governance Maternity and Child Health	GAP analysis will be undertaken on the proposed Quality Surveillance model. Dedicated time for Clinicians and Nursing and Midwifery staff to undertake investigations and meet the requirements within the model.	Will continue to report to the Executive Scrutiny Group (ESG) all serious incidents Quality Surveillance Paper V2.docx TOR Safety SIG.docx **February 2021 update**	Action compliant February 2021

						Safety SIG has now commenced and will be meeting monthly. Template for reporting has been received **January 2022 Update** External reviews for all cases are very difficult to arrange. All concise investigations are discussed and agreed to Executive Scrutiny Group. Not GM wide process in place for reciprocal arrangements to review all serious incidents. All mod and above are discussed in safety SIG but this is not an independent review. Work continues to identify a suitable arrangement with a buddy Trust or a GM wide approach.	

Immediate and essential action 2: Listening to Women and Families

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

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

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

Link to Maternity Safety actions:

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

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

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

Link to urgent clinical priorities:

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

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

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

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

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

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

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

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

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

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

Information related to accessing the safety champions is visible in the clinical area for staff and prior to the COVID-19 Pandemic, regular monthly walkabouts were performed by the safety champions to talk with staff. These have now been reinstated and feedback from staff from several issues has been received which will be Actioned and updates fed back to staff.

Service user feedback from Friends and Family Test has been now been reinstated and the Trust participate in the National Maternity Survey which gives the Trust the opportunity to receive women's views on service provision and put in place any improvement measures where shortfalls have been identified.

The Independent Senior advocate role is not currently in place as National guidance is awaited on the development and implementation of this role within individual Trusts or LMS 's.

Established Maternity Voice Partnership in place with BI-monthly meetings. Patient feedback boards in place across the unit.	Feedback has been obtained on leaflets and visiting. 15 steps walk about undertaken by service users Patient stories have been circulated to staff to communicate the Voice of the Woman.	Service user feedback has been used to make changes and improvements across the maternity floor Consultation was also sought when changes to visiting times was introduced in the past CNST Safety Action 7 compliance. Feedback from MVP members	It is recognised that greater involvement of service users' needs to be implemented and lay representation on Directorate meetings sought.	Anne-Marie Goodall Out-Patient Matron 30 March 2021 Cathy Stanford Acting Divisional Director of Midwifery. Head of Governance Maternity and Child Health	New Chair has been appointed since last meeting. Further 15 steps challenge to be requested, as 2 years since last one undertaken. However due to Covid restrictions we will need to review how we undertake this.	Bimonthly meetings will continue. Meeting held with the Chair and CCG leads to discuss how we can improve service user involvement and consider how we can increase diversity with	

					March 21 Update. Active recruitment in process by MVP chair. open evening planned	the membership. **April 21 Update.** Remains ongoing. Recruitment drive in place. 1 service user attended last meeting	
Trust website and Facebook page	Service users have been involved in the interview process for Bereavement Midwife MVP minutes.	Increased involvement from service users MVP Charter in production from LMS	Review of Maternity website and access to information to be requested from the MVP group to identify any areas for improvement from the woman's perspective.	Sam Whelan Quality and Safety Midwife Comms Team	MVP requested to support website development	**April 21 Update.** Meeting arranged with Comms team to identify requirements	
Demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally	Board Level Safety Champions in place in addition to Divisional level Safety Champions. Bi Monthly meetings are scheduled.	The Maternity and Neonatal Safety Champions are: • Clinical Director for Obstetrics and Gynaecology. • Divisional Medical Director/ Consultant Paediatrician	Agenda to be formulated for meetings going forward	Ongoing/ Continual All safety Champions 30 March 2021	reporting mechanism to board to be formulated and agreed in regard to reports received and feedback / escalation from NED and Safety Champions.	Remains ongoing **February 2021 update .** Formal Agenda completed and will be utilised at next scheduled bi-monthly	

identified issues the identification of an Executive Director with specific responsibility for maternity service	Non-Executive Director (NED) for Maternity attends these meetings.	• Divisional Director of Midwifery and Neonates. Staff are able to identify the Safety Champions Safety Dashboard and notice boards already in place and visible in clinical areas.				meeting , with minutes/ notes taken / action Matrix developed. **January 2022 Update** Bi monthly meetings in place and embedded	
Confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard	Role Descriptor for non-exec board safety champion has been received and has been circulated to relevant safety champions. Non-Executive Director (NED) for Maternity attends Safety Champions meetings. Bi Monthly meetings in place to discuss ongoing issues and challenges	Achieve compliance with CNST safety action 9.	Feedback to be requested from NED	Ongoing/ Continual Director of Corporate Affairs	The role will be reviewed in line with new requirements	**January 2022 Update** Non-Executive Director (NED) for Maternity attends Safety Champions meetings. Bi Monthly meetings in place to discuss ongoing issues and challenges Monthly exec walkabouts have occurred and will continue.	
Independent	This role is	Trusts must create an independent	External Advocate	This role is not part	There will be a	It will require	

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

Immediate and essential action 3: Staff Training and Working Together

Staff who work together must train together

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

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

Link to Maternity Safety actions:

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

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

Link to urgent clinical priorities:

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

The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place							
What do we have in place currently to meet all requirements of IEA 3?	**What are our monitoring mechanisms?**	**Where will compliance with these requirements be reported?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**	
Staff who work together must train together Daily ward rounds have been in place and are embedded in practice. With the recommendations from the report a second round was commenced in the evening, prior to the "Hot Week" Consultant leaving site at 19.00 hrs. currently there is no second round in place at weekends only a virtual 22.00 call to the Registrar and shift coordinator on duty. There is a guideline in place for handover of care and that outlines the process for all handovers and Consultant ward round requirements. Additionally, GM LMS have produced guidance on process and frequency for the ward rounds across GM which is still under review and consideration. Any additional requirements for further rounds within WWL may require revised job plans or further staffing, Twice daily safety huddles take place on the Maternity Floor to communicate acuity and activity levels and improve oversight of all areas. Multi- disciplinary training is robustly monitored and facilitated by the practice education leads and is on target to achieve the 90% of all relevant staff groups for CTG management and training and skills drills. Monthly updates of compliance are reported to the Head of Governance and circulated on Dashboards. Monthly training dates are scheduled for all relevant staff groups to attend. There are currently two Consultant Clinical leads for simulation – one Consultant Obstetrician and one Consultant Anaesthetist, who are supported by the Practice Education Lead. The Trust has recently funded a group of 15 staff to attend the Practical Obstetric Multi-Professional Training (PROMPT) course. CNST ring fenced funding has been agreed in principle and over the last 2 years maternity and Neonatal service have benefited from financial investments as Neonatal Nurses where employed to staff the Transitional care unit, and the Maternity service have installed a centralised CTG monitoring system and IT equipment for community Midwifery teams.							
Consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week	Compliance is not currently reported.	Consultant meetings Audit meetings.	Ward round book will be completed until actions are embedded.	Ongoing/ Continual Clinical Director and Consultant body.	Job plans and remuneration for on-call may need to be amended.	Continue with twice daily ward rounds as planned.	

Second round has been implemented with On Call Consultant present and leading. This will be undertaken at 7pm prior to on call Consultant leaving the unit.	Attendance at rounds by the MDT. Documentation of management plans and ongoing monitoring arrangements. 7 day rotas are in place with Consultant on call cover	Obstetric and Gynaecology Clinical Cabinet Compliance with CNST Safety Action 8.	Standardised audit forms to be created by the LMS which will be circulated. TW19-048 SOP 15 Maternity Communication and Hand Over of Care have been updated to reflect this.	Sanjay Arya Medical Director	Additional staffing may be required. Awaiting National Directive and HR advice re job plan and changes in working practices. **May 2021 Update** Morning and evening ward rounds in place mon-Friday. At 9am and 7pm before Hot week Consultant leaves. 10pm Virtual call with Night Registrar and shift coordinator. Weekend daily ward round AM and evening virtual call with Night Registrar and shift coordinator. Additional funding requested through Ockenden Investment fund to implement weekend evening and rounds.	Weekday ward rounds x2 daily in place with additional virtual evening round in place at 10pm Escalation policy/ process in place. **February 2021 Update** Guidance received from GM regional steering group that ward round should be 12 hours apart. This will require Job Planning and review of Consultant hours and clinical commitments. **March 2021 Update.** Will continue with x2 daily rounds however will not be 12 hours apart and not x2 daily at weekends. **April 21 Update** Remain non- compliant with GM standard of 12 hrly rounds and twice at weekend	August 2021

					If changes are needed to weekday 2nd round then will need considerable investment as Job Plans will need reviewing and amending, with theatre and Outpatient templated affected.	MD to meet with LMs Consultant Lead to discuss. **May 2021 Update** Bid submitted to Maternity Investment fund which includes funding for additional Consultant PA **August 2021 Update** X2 daily ward rounds are in place	
A MDT training as part of annual Mandatory training schedule is in place which includes: Monthly MDT PROMPT training Monthly CTG training and competency assessment. Human Factors Sepsis Recognition of deteriorating patient.	Full MDT programme of training in place and compliant with CNST current recommendations. Data Base of attendance and compliance for all staff groups in place. Quarterly updates from Leads presented at Governance forums	Data base of attendance in place to monitor the 90% compliance of all staff groups	Training and competency passports currently being rolled out to all midwifery staff. Regional CTG Training and competency package to be fully introduced fop all staff grades .	Ongoing/ Continual Keeley Jones Practice Development Midwife. Joanne Birch CTG Champion Midwife. Farina Kidwai Consultant Obstetrician PROMPT and CTG training is currently delivered virtually via interactive sessions	Continued support of the Multidisciplinary team in allocating staff to attend training Funding for ongoing training requirements. Increase CTG Champion Midwife to 0.4 WTE from 0.2 to deliver addition required training and support. Appropriate % staffing uplift to incorporate	Continue with comprehensive training package in place **February 2021 Update** Funding has been requested to secure places for cohort of staff on next PROMPT training. Plans in place to resume face to face training in June 2021 if Government guidelines allow. **January 2022 Update** TNA has been reviewed and trajectory for	

Covid updates/ training Ad hoc/ monthly skills simulations for Obstetric emergencies	Attendance logs and feedback/ debrief sheets.				all Maternity and Obstetric training needs. Consultant SPA sessions to be reviewed for training and Governance requirements.	compliance added along with plans for any noncompliance with all aspects of training .	
Evidence of submission to LMS of MDT and working.	Will be monitored through LMS CTG steering group.	Obsteric and Gynaecology Clinical Cabinet LMS Steering group? Dashboard	Awaiting feedback from LMS regarding reporting mechanisms for this	TBC Keeley Jones Practice Education Lead midwife Joanne Birch CTG Champion Midwife Amit Verma Obstetric Consult CTG Champion.	None **March 21 Update.** Still awaiting confirmation from LMS	Will continue with Data Base of attendance and compliance for all staff groups in place. **February 2021** No further update received. **<u>January 2022 Update.</u>** no system in place from LMS as yet to receive Trust maternity training compliance.	
Confirmation that funding allocated for maternity staff training is ring-fenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for	Maternity incentive scheme refund is not currently ring fenced, although Funding has been received from year 1 to implement transitional care and employ Neonatal Nurses.	Trust Board Executive team meeting	Agreement to be sought from Trust Board in regards to ring fencing CNST refunds	Director of Finance. Chief executive.	Statement of commitment that year 3 CNST incentive scheme refunds will be ring-fenced for maternity. Agreement has been received in principle however further	Business case development for additional funding for either staffing or resource requirement. Paper submitted to board outlining all training and development needs of	

improving maternity safety	In year 2 the Maternity Service also received money to install a centralised CTG monitoring system to improve patient safety.				clarification of the spend needs to be discussed with DoF and new Chief Nurse when in post. **March 21 Update.** Finance update given re maternity investments over last 2 years of CNST	staff groups in order to comply with CNST AND SBL v2 Recommendations.	

Immediate and essential action 4: Managing Complex Pregnancy

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

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

- Women with complex pregnancies must have a named consultant lead

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

Link to Maternity Safety Actions:

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

Link to urgent clinical priorities:

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

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

What do we have in place currently to meet all requirements of IEA 4?	**What are our monitoring mechanisms?**	**Where is this reported?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**	
All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. Robust risk assessments are undertaken at booking to identify women with complex pregnancies. All complex pregnancies are referred to a Consultant Led ANC and assigned a Consultant lead. The Trust has dedicated clinics for women with diabetes, cardiology/ hypertension, endocrinology, perinatal mental health. Additionally, we are currently reviewing the requirement for a dedicated Multiple pregnancy clinic in accordance with NICE recommendations. At these clinics, specific management plans are made and agreed in conjunction with the woman. Any women with complex medical conditions/ risks are referred to tertiary units for ongoing or joint management, such as HIV and renal							

and Liver conditions. Other considerations for the Trust are to look at implementing a monthly MDT meeting, review to review all complex pregnancies that are nearing delivery to improve communications for intrapartum and neonatal care. Currently spot check audits are being undertaken to monitor that women are being seen and assessed by their named Consultant and that appropriate and timely referrals have been made. The greater Manchester LMS are currently reviewing the development of maternal medicine specialist centres with a Hub likely to be within the region that local units will refer into. Current process in place are pathways for referral to the appropriate tertiary unit and guidelines outlining the management and requirements for these women with high risk and complex medical conditions							
Consultant Leads in place for high-risk women with designated medical antenatal clinics for complex medical conditions such as: Hypertension Cardiac problems, Diabetes and Endocrine Mental Health. Multiple pregnancy Previous pre term birth.	Will be audited as part of all clinical incident reviews. Spot check audits to be undertaken.	Will be reported to Obstetric and Gynaecology Audit meeting and audit department as a registered audit	Audits of compliance to be undertaken. Named Consultants to be clearly identified on women's case notes. (Stickers ordered for all Consultants). Work ongoing to improve continuity within Consultant led Clinics. Incorporate into monthly documentation audits	30 April 2021 Quality and Safety Midwife to Audit compliance. Fatima Abu Amna Obstetric Consultant and Gynaecologist Antenatal Clinic Consultant Lead	GM LMS are considering the use of a standardised audit tool for all units to use. **March21 Update** Undertake spot check audit that referral processes are being followed. Support from audit team required **May 2021 Update.** Audit of complex cases to be undertaken to identify that pathways are in place	**Feb 21 update** Spot check audit completed, and findings fed back to Consultant and clinic leads. To be further discussed at clinical cabinet and improvement measures identified. **April 21 Update** further audit undertaken. Findings to be fed back at meeting **May 2021 Update** Monthly audits will continue until compliance sustained **June 2021 Update** Audits continue	
Where a complex pregnancy is identified, there must be early specialist involvement	Pathways in place for referrals to Tertiary units for	No monitoring or reporting processes in place at present	Development of regional Maternal Medicine Centre	Dates TBC. Greater Manchester and Eastern	When regional Maternal Medicine Centre via a hub and spoke model is in	Continue with local pathways until GM agreed pathway is in place	

and management plans agreed between the woman and the team.	highly complex conditions such as : HIV Hepatic conditions Renal conditions. Cardiac Conditions		within the GM network. Review all current pathways in place for referral to tertiary centres for consistency and appropriateness.	Cheshire, Strategic Clinical Network. 30 April 2012 To be identified.	place this will likely be a regional referral pathway developed within the GM LMS. **March 21 Update** Undertake spot audit that pathways are being followed. Support from audit team required **May 2021 Update.** Audit of complex cases to be undertaken to identify that pathways are in place	**April 21 Update** Spot check audit completed. Findings to be fed back at meeting **May 2021 Update** Monthly audits will continue until compliance sustained **June 2021 Update** Audit programme in place to monitor compliance with this action	
Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.	TBC	TBC	Following a meeting held with the national policy team on 7th December, a proposal to agree funding through a system led commissioner model is to be taken through GM commissioning governance and to the joint commissioning board.	For Greater Manchester and Eastern Cheshire, it has been agreed that St Marys Hospital, Oxford Rd Campus will be the Maternal Medicine Centre via a hub and spoke model. Two physicians with special interest in Obstetrics have commenced	Regional pathways to be developed to support all trusts feeding into the Maternity medicine hub. **March 21 Update** Awaiting confirmation of Hub Location/ Trust	**January 2022 Update** Continue with local pathways until GM agreed pathway is in place	

			A request has been made for pump prime funding in Q4, to initiate project support and clinical leadership	Maternal Medicine training.			
Regional integration of maternal mental health services. Antenatal Consultant lead supports all women who have been assessed as Amber Flag for perinatal mental health.	Currently no outcome measurements in place.	Risk assessments are completed for referral to relevant level of service.	Audits to be identified to monitor effectiveness of service Red Flag Perinatal Mental Health Clinic led by Consultant Psychiatrist in place.	Newly developed Vulnerable team in place who will support the Red Flag clinics to provide Midwifery input.	Perinatal Mental Health Midwife funding to be identified and post implemented. **March 21 Update** Vulnerable team in place who provide care for the most vulnerable women who have experience of managing women with mental health needs. Staffing paper to be submitted to board which includes the requirement for a specialist PNMH Midwife	Continue working in conjunction with GM to support the perinatal mental health service. **February 2021 Update.** Funding requested from CCG re recruitment of Perinatal Mental Health Midwife **April 21 Update,** Job description completed. Business case to be developed. Awaiting details of Ockenden funding for Trusts when bid will be submitted. **January 2022 Update.** Perinatal Mental Midwife in place. Pathways for referral are currently under review and further development	

Immediate and essential action 5: Risk Assessment Throughout Pregnancy

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

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

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

Link to Maternity Safety actions:

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

Link to urgent clinical priorities:

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

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

	Plan (PCSP) is updated regular by named Midwives and this is monitored through the Maternity Information System (Euroking) for completion not content. Documentation within maternal case notes and handheld notes should identify that a risk assessment has taken place detailing all physical assessments as well any other issues and discussion with the women around her continued plan of care and appropriate place of birth.	Action plans will be monitored through Clinical Cabinet	Clarification sought from MIS provider(Euroking) if this can be added to core work flows , Perinatal Institute contacted as case note provider for updates in regards to plans to amend risk assessment templates within notes.	Quality and Safety Midwife Fatima Abu Amna Antenatal Clinic Lead Consultant	there are plans to incorporate this within the system as it is a National recommendation. **March 21 Update** Support from audit team required	action is embedded in practice. **February 2021 Update** Risk assessment audit template received from GM Steering group. **April 21 Update** Spot check audit completed. Findings to be fed back at meeting **January 2022 Update** SOP to be developed outlining the process for risk assessment and completion of Personalised care and support plans (PCSP). Options are being reviewed for PCSP 's	

Immediate and essential action 6: Monitoring Fetal Wellbeing

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

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

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

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

Link to Maternity Safety actions:

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

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

Link to urgent clinical priorities:

Implement the saving babies' lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	How will we evidence that our leads are undertaking the role in full?	What outcomes will we use to demonstrate that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?	
Monitoring fetal well-being. Implement the saving babies' lives bundle. The Trust currently has 0.2 WTE fetal surveillance Lead Midwife (CTG Champion) , who has the responsibility to provide regular training to all staff, monitoring of fetal surveillance training compliance, consolidating existing knowledge and raising the profile of monitoring fetal wellbeing within the unit. Additional funding is required to support the increase to a minimum of 0.4 WTE hours for the role. The CTG Champion Midwife leads on CTG review cases in conjunction with the Obstetric Consultant lead and together							

they provide support to the multidisciplinary team. There is an additional requirement for named Consultant Lead for fetal monitoring to have additional sessions for teaching and review of cases within his job plan. There is a dedicated Saving Babies Lives Care Bundle Lead Midwife, who maintains oversight of the SBL actions including Element 4, (training) along with the named Consultant. There is a comprehensive action plan in place with regular meetings of the SBL champions at regional level to monitor and review ongoing compliance with all the recommendations.							
The leads must ensure that their maternity service is compliant with the recommendations of SBL care bundle 2 and subsequent national guidelines.	Regular audit and review in place for all elements of saving babies lives. Feedback from Perinatal institute for compliance and detection levels of small for gestational age infants.	Reduction in Stillbirths. Recognition of the small for gestational age infant. Reduction in pre term birth. Optimisation of pre term infants	Pre term birth guidelines awaiting ratification following review of Regional Guideline.	Sam Whelan Quality and Safety Midwife. Saving babies lives Midwife Lead Amit Verma Saving Babies lives Consultant Obstetrician Lead	Funding to be received for 6 months 0.6 WTE to support saving babies lives care bundle implementation.	Continue working on all elements of the SBL Care Bundle to ensure ongoing compliance.	
Comprehensive action plan in place which is monitored via Clinical Cabinet and submitted to the LMS as requested. Saving Babies Lives lead Midwife in place			Carbon Monoxide (CO) monitoring has been suspended throughout the pandemic and is being re-introduced under risk assessment where appropriate and safe to do so. Smoking cessation Midwife Service has now commenced.	Julie Bancroft Smoking Cessation Lead Midwife. Anne-Marie Goodall Outpatient matron.	Funding will be utilised to support the smoking cessation service and provide training support for recognition of the growth restricted baby.	Case review to be undertaken to determine and act upon all themes related to pre-term birth (prediction, prevention and preparation) that are identified from investigation of incidents, perinatal reviews and examples of excellence	

			Baby Clear Smoking intervention programme has been rolled out.				
CTG Champions in place Centralised CTG monitoring system in place to provide oversight and assurance for Delivery suite Coordinators and Medical staff A second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support.	Ongoing monitoring and review of clinical incidents. Midwife CTG Champion in place who leads on all aspects of CTG training, teaching and compliance in conjunction with Consultant Obstetrician.	Reduced incidence of CTG mis-interpretation. Case note reviews evidencing good practice and appropriate management of the Abnormal CTG Both actively participate in training and development of staff and in the development of guidance, pathways and competencies.	Increase in Midwife CTG Champions hours dedicated to CTG training	Joanne Birch CTG Champion Midwife Amit Verma Obstetric Consultant lead.	Additional hours to be increased from 0.2 to at least 0.4 WTE FOR CTG Champion Midwife. Funding for Baby Life line CTG masterclasses for all core Maternity and Medical staff	Continue with in-house training and competency packages. **February 2021 Update** Finance team asked to attend T&F group to identify costs for implementing recommendations which will include additional hours for CTG Champions. **March 21 Update** Job descriptions to include CTG champion role and requirements. **April 21 Update,** Job description update still to be completed. Business case to be developed. Awaiting details of Ockenden funding for Trusts **January 2022 Update** Fetal surveillance leads in place and receive regular	

						updating to facilitate training requirements. both represent the trust on regional steering group. Advised to keep portfolio of education. Weekly Workshops now in place. Midwife surveillance lead has had hours increased from 0.4 to 0.6 WTE to met all the training requirements needs and be available for in situ support to staff.	
Regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines	Weekly table top meetings in place where incidents are discussed , Monthly clinical issues group reviews in places which focus on serious incidents and CTG issues.	Reduced incidence of CTG mis-interpretation. Case note reviews evidencing good practice and appropriate management of the Abnormal CTG	Introduce regular CTG review sessions on the delivery suite facilitated by CTG Champions.	Joanne Birch CTG Champion Midwife Amit Verma Obstetric Consultant lead.	Dedicated time	Continue with in-house training and competency packages.	

Immediate and essential action 7: Informed Consent

All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

Women's choices following a shared and informed decision-making process must be respected

Link to Maternity Safety actions:

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

Link to urgent clinical priorities:

Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

What do we have in place currently to meet all requirements of IEA 7?	Where and how often do we report this?	How do we know that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?	

Pathways of care are clearly described in written information in formats consistent with NHS policy and posted on the Trust website.

Information is currently available on the Trust website this is reviewed and monitored by the corporate patient information team who ensure that all patient information leaflets are available with working links to National leaflets and that they remain updated.

The Directorate have a monthly guideline meeting to review any new NICE guidelines and to update and review existing guidelines in line with Trust and national recommendations and Policy. All guidelines SOP 's and pathways are published on the Trust intranet and available to all staff. (they are not published externally on the Trust webpages).

Information is available in various formats and languages.

Work has been commenced in looking at the consent process and the information that women receive regarding informed consent. Women must be enabled to participate equally in all decision-making processes and make informed choices about their care, in order to facilitate this the Trust is looking at the IDECIDE model .

Any woman who is requesting a caesarean section will be referred to the Consultant to discuss and understand her reasons for requesting a Caesarean. Women's choices following a shared and informed decision-making process are respected. Any woman who makes a choice which is not in keeping with Trust or National recommendations will be offered the opportunity to discuss these choices with the Lead Midwife for normality and a plan of care agreed following a full and informed discussion. Women's choices will always be respected; however, a risk assessment and plan of care will be put in place as required and shared with all members of the multi-disciplinary team and additional support put in place as necessary.

All leaflets to support informed choice and consent are published to the Trust Internet site. Links to NHS and RCOG patient information available. Signposting to relevant APP's. My Birth Choices website and leaflets available	Leaflets and guidelines are monitored the Obstetric and Gynaecology Guidelines group and Clinical Cabinet. Additional oversight is monitored through Corporate governance for compliance	Monitored through Corporate Quality Executive Group	The Maternity website needs further development and updating and this is progressing to provide more up to date information in an easily accessible format. Pathways, SOP's and Guidelines are not published on the internet. Further guidance is required as to whether this is a requirement.	Clinical Guidelines Lead Consultant Patient & Public Involvement Team. Communications team	Digital Midwife who will support the implementation of digital maternity records and access to patient portals. Will also support guideline and leaflet development and oversight of compliance. Review of Maternity website and access to information to be requested from the MVP group to identify any areas for improvement from the woman's perspective. **May 2021 Update.** Significant review of website and content is required which is currently underway, support from Comms teams in place. Once content agreed they will upload accordingly. Website to be based on Chelsea and	Women who cannot access the website are provided with paper copies for information. Links to additional relevant websites are shared with women **March 21 Update** Informed consent policy and leaflet in development incorporating the IDECIDE principles. **April 21 Update** Remains ongoing **May 2021 Update** Meeting held with comms team who are happy to support the redevelopment of the website. Content currently being looked at. This action will not be compliant in time for evidence submission to the portal. **February 2022 Update**. Website now live with all updates and links to	Feb 2022

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

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

achieve compliance of 51% by March 2022	case load and acuity.	Unable to provide 1-2-1 care in labour Staffing Escalation policy in place		Maternity and Child Health Fiona Bryant Acting Assistant Chief Nurse			

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

The Divisional Director of Maternity and Neonates is responsible and accountable to the Chief Nurse who is an executive Director on the Board.

1) **Every trust or health board delivering maternity care should have a Director of Midwifery, with a Head of Midwifery in every maternity unit within the organisation. Heads of Midwifery focus on the operational delivery of maternity care locally. They will often not have direct input into or responsibility for strategic, board-level decision-making.**

Directors of Midwifery are leaders and advocates for safe, high quality maternity care, managing the strategic and operational delivery of maternity services locally.

April Update

There is a Divisional Director of Midwifery and Neonates in Place, but not a Head of Midwifery

Business case to be developed for funding for additional posts. Awaiting information re Ockenden funding

May Update Unable to submit bid directly to the investment fund for senior posts. Posts requested are for Bands 5/6 as per Birth-rate+ report shortfall.

Feb 2022 Update

There is an Interim Divisional Director of Midwifery and Neonates in Place, but not a Head of Midwifery. Posts are currently under Trust review

2) **A Lead Midwife at senior level in all parts of the NHS, both nationally and regionally**

N/A - Applicable to region / national team

3) More consultant midwives – **WWL does not currently have a Consultant Midwife, however there is a Band 7 lead for normal birth .** **March Update.** **Consider the recruitment of a Consultant Midwife** **May Update.** **Funding not in place for this post** **Feb 2022 Update** **Funding allocated for x2 Senior Midwife roles at 8a to support the leadership and transformation agenda .**	
4) Specialist Midwives in every Trust. **WWL currently has a Specialist midwife in post for Smoking cessation, Bereavement, Infant feeding and Safeguarding(from Corporate Team). There is a further requirement for a lead Perinatal Mental Health Midwife and a Diabetes Specialist Midwife.** **Information from Aqua has now been received for the Safety Culture Programme for Maternity and Neonatal Leaders at Board level and further details and programme will be sent late March 2021** **April Update. Business case to be developed for funding for additional posts. Awaiting information re Ockenden funding** **May Update 50% funding agreed by CCG for Perinatal Mental Health Specialist midwife. Job Description sent for job matching panel review. Awaiting job matching then will commence recruitment for post.** **Feb 2022 Update** **Specialist Perinatal Mental Health Midwife in Post** **Specialist Digital Midwife in Post**	
5) Strengthening and supporting sustainable midwifery leadership in education and research **N/A - applicable to HEIs**	
6) A commitment to fund ongoing midwifery leadership development. **WWL is currently reviewing core training requirements and offers some leadership training. Bespoke leadership programmes would be beneficial. Funding has been identified Nationally to support Maternity Leadership training for senior neonatal and maternity leaders across England. Further details are awaited.**	
7) Professional input into the appointment of midwife leaders. **The recruitment process at WWL is inclusive of Midwives and Clinicians on interview panels and focus groups for senior posts within the organisation.**	
NICE GUIDANCE RELATED TO MATERNITY	

We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.							
What process do we have in place currently?	**Where and how often do we report this?**	**What assurance do we have that all of our guidelines are clinically appropriate?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**	
The Trust has a process whereby all NICE guidance and Quality Standards are coordinated centrally through the Clinical Audit and Effectiveness team who support the Divisions and specialities within these to undertake a review of the guidance or standards and submit their baseline assessments to identify relevance and compliance. Where there is compliance this is evidenced accordingly and any non-compliance is identified, and either mitigated or an action plan is developed to achieve with the recommendations.							
MDT Guideline meeting in place which reviews and updates all Clinical Guidelines and SOP's	Monthly. Corporate Governance oversight in place for monitoring compliance with updating and review			Lead Consultant for guideline development and monitoring. Head of Governance for maternity and Child Health	Admin support	Continue with current embedded processes	

NICE Guidelines are reviewed and implemented with baseline assessments completed Regional Guidelines are reviewed and implemented. Regional steering groups develop specific guidelines. Such as: -Stillbirth pathways -Hypertension -Pre term Birth -Fetal Growth Restriction -Intrapartum Fetal Monitoring -Reduced fetal Movements.	As received. Corporate Governance oversight in place for monitoring compliance with updating These are reviewed within the regional steering groups within the LMS	Discussed and agreed at Directorate clinical Guidelines group. Bench marking is undertaken and baseline assessment completed. % compliance is then recorded MDT regional review	Continue to maintain the MDT guideline and SOP/ policy reviews	Lead Consultant for guideline development and monitoring Head of Governance for maternity and Child Health	Admin support	Continue with current embedded processes	

Classification: Official

Publication approval reference: PAR807

Maternity services system learning

Maternity self-assessment tool

Version 6, 19 July 2021

Where updates have been made to the content of this document since the previous version was published (version 5, February 2020), they have been highlighted in yellow.

Introduction

This Safety Self-assessment tool has been designed for NHS maternity services and private maternity providers to allow them to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements. Organisations can use the tool to inform the trust's maternity quality improvement and safety plan and so keep the trust board and commissioners aware of their current position.

The tool has been developed in response to national review findings, and recommendations for good safety principles within maternity services. This version of the tool has been further influenced by the findings of the Ockenden review, 7 features of safety culture and the emerging themes from services on the safety support programme and the areas CQC found to be outstanding in other maternity services across England.

Please use this tool to as a benchmark for your organisation in the core principles of good safety standards within Maternity services.

The tool

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Directorate/care group infrastructure and leadership	**Clinically led triumvirate**	Trust and service organograms showing clinically led directorates/care groups		Need to agree and develop
		Equal distribution of roles and responsibilities across triumvirate to discharge directorate business such as meeting attendance and decision-making processes		Triumvirate meetings?? NOT currently scheduled . More ad Hoc meetings , do not always include DoM
	Director of Midwifery (DoM) in post	DoM job description and person specification clearly defined		Regional JD under consideration. Local JD under review

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	(Current registered midwife with NMC)	Agenda for change banded at 8D or 9		Not Currently banded at 8d, under review. No head of Midwifery or Deputy in Post Ockenden recommendation is for DoM and HoM 1) Every trust or health board delivering maternity care should have a Director of Midwifery, with a Head of Midwifery in every maternity unit within the organisation. Heads of Midwifery focus on the operational delivery of maternity care locally. They will often not have direct input into or responsibility for strategic, board-level decision-making.
		DoM In post		Interim in post
	Direct line of sight to the trust board	Lines of professional accountability and line management to executive board member for each member of the triumvirate		
		Clinical director to executive medical director		Yes
		DoM to executive director of nursing		DoM directly reports to Chief Nurse professionally
		General manager to executive chief operating officer		
		Maternity services standing item on trust board agenda as a minimum three- monthly Key items to report should always include: • SI Key themes report, Staffing for maternity services for all relevant professional groups • Clinical outcomes such as SB, NND HIE, AttAIN, SBLCB and CNST progress/Compliance. • Job essential training compliance • Ockendon learning actions		Monthly Board reports submitted which include Maternity dashboard and exception report Board Provider report which includes training compliance , Incidents &Training compliance Quarterly CNST compliance reports which includes ATAIN/SBLCB Ockenden Action plan Reports by exception Bi-annual staffing reports

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]		Maternity dashboard and exception report Board Provider report which includes training compliance and exception report Monthly review of Neonatal safety not currently submitted. Dashboard under development to be submitted to next safety Champions meeting
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]		Monthly Board provider report submitted which includes incidents Steis reportable incidents, Red Flags and Training compliance. Feedback and complaints
				Need to add NNU data, Child Health Governance to be incorporated within All maternity Governance roles NNU Dashboard and metrics in development
		There should be a minimum of three PAs allocated to clinical director to execute their role		Currently allocated 1.5
	Collaborative leadership at all levels in the directorate/ care group	Directorate structure and roles support triumvirate working from frontline clinical staff through to senior clinical leadership team		Need to be agreed as Divisional Governance review in place
		Adequate dedicated senior human resource partner is in place to support clinical triumvirate and wider directorate Monthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy and maternity leave		Senior HR Business partner in place.
		Adequate senior financial manager is in place to support clinical triumvirate and wider directorate		Senior Divisional Finance Manager in place

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Monthly meetings with all ward level leaders and above to monitor budgets, ensure updated and part of annual budget setting for each area		Monthly meetings with finance in place
		Adequate senior operational support to the delivery of maternity services in terms of infrastructure and systems that support high quality service delivery aligned with national pathways		Monthly Divisional Performance reviews in place inclusive of Maternity
		From governance and senior management meetings that all clinical decisions are made collaboratively by multi-professional groups		Clinical Cabinet. Clinical Issues and guidelines groups are all MDT and documents agreed and ratified through these forums.
		Forums and regular meetings scheduled with each professional group are chaired by the relevant member of the triumvirate, eg senior midwifery leadership assembly		
		Leadership culture reflects the principles of the '7 Features of Safety'. 1. Commitment to safety and improvement at all levels, with everyone involved 2. Technical competence, supported by formal training and informal learning 3. Teamwork, cooperation, and positive working relationships 4. Constant reinforcing of safe, ethical, and respectful behaviours 5. Multiple problem-sensing systems, used as basis of action 6. Systems and processes designed for safety, and regularly reviewed and optimised 7.Effective coordination and ability to mobilise quickly		
	Leadership development opportunities	Trust-wide leadership and development team in place		
		Inhouse or externally supported clinical leadership development programme in place		In Development for ward managers trust Wide
		Leadership and development programme for potential future talent (talent pipeline programme)		Succession planning needs to be developed and formalised

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Credible organisations provide bespoke leadership development for clinicians/ frontline staff and other recognised programmes, including coaching and mentorship		Modules and programmes can be accessed Coaching being rolled out for Clinical Matrons
	Accountability framework	Organisational organogram clearly defines lines of accountability, not hierarchy		Needs to be agreed
		Organisational vision and values in place and known by all staff		Needs to be reviewed and updated
		Organisation's behavioural standards framework in place: Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction. [Perinatal Surveillance model]		Monthly HR meetings in place with senior Business partner for Division to discuss all ongoing issues for Maternity and Neonates
	Maternity strategy, vision and values	Maternity strategy in place for a minimum of 3–5 years		Was developed but Trust overarching Strategy now in place. Need to review Maternity Strategy and update to include below item's
		Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan		See above
		Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.		Will need to review strategy to include MVP as co-producers
		Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services [Ockenden Assurance]		Service user feedback mechanism in place. Established MVP in place.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Maternity strategy aligned with trust board LMNS and MVP's strategies		
		Strategy shared with wider community, LMNS and all key stakeholders		
	Non-executive maternity safety champion	Non-executive director appointed as one of the board level maternity safety champions and is working in line with national role descriptor		NED in place
		Maternity and neonatal safety champions to meet the NED and exec safety champion to attend and contribute to key directorate meetings in line with the national role descriptor		Bimonthly meetings in place
		All Safety champions lead quality reviews, eg 15 steps quarterly as a minimum involving MVPs, service users, commissioners and trust governors (if in place)		To be arranged quarterly with MVP. First one commenced 17/09/21 Bimonthly safety walkabout in place need to increase to monthly
		Trust board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services		Need to submit more evidence for NNU. Need to establish a reporting programme.
		A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks. [MIS]		Pathway in place describing safety champions. Will need review to add local maternity system (LMS) and MatNeoSIP Patient Safety Networks. [MIS]
Multi-professional team dynamics	**Multi-professional engagement workshops**	Planned schedule of joint multi-professional engagement sessions with chair shared between triumvirate, ie quarterly audit days, strategy development, quality improvement plans		Will need to be developed
		Record of attendance by professional group and individual		Quarterly perinatal audit in place. Monthly Maternity Audit meeting

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Recorded in every staff member's electronic learning and development record		Not recorded on ESR
	Multi-professional training programme	Annual schedule of job essential maternity-specific training and education days, that meet the NHS England and NHS Improvement Core Competency framework as a minimum published and accessible for all relevant staff to see		2 Day training programme in place
		A clear Training Needs analysis in place that identifies the minimum hours of training required for each professional group and by grade/ seniority		TNA in pace for maternity and NNU
		All staff given time to undertake mandatory and job essential training as part of working hours		2 protected Mandatory training days in place for Maternity staff ?? NNU staff Medical staff??
		Full record of staff attendance for last three years		Data base held for all medical Midwifery and Nursing staff
		Record of planned staff attendance in current year		In Place
		Clear policy for training needs analysis in place and in date for all staff groups		TNA in place for Maternity.
				NNU TNA in place but requires updating and review.
		Compliance monitored against training needs policy and recorded on roster system or equivalent		Not recorded on e-roster or ESR but held on data base by practice ed leads
		Education and training compliance a standing agenda item of divisional governance and management meetings		Evidence of Maternity compliance.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
				Will need to develop same monitoring for NNU
		Through working and training together, people are aware of each other's roles, skills, and competencies (who does what, how, why and when) and can work effectively together, thus demonstrating "collective competence". [7 Steps]		Multi-professional PROMPT days held monthly and ad hoc drills carries out in-situ, to be scheduled at least monthly Joint working with NNU staff to develop skills drills All shift coordinators to attend difficult airway training with NNU staff
		Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal		
	Clearly defined appraisal and professional revalidation plan for staff	All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation		In place
		Compliance with annual appraisal for every individual		
		Professional validation of all relevant staff supported by internal system and email alerts		In place
		Staff supported through appraisal and clearly defined set objectives to ensure they fulfil their roles and responsibilities		Objectives are agreed with Line Manager/ appraiser aligned to Trust objectives and revalidation
		Schedule of clinical forums published annually, eg labour ward forum, safety summit, perinatal mortality meetings, risk and governance meetings, audit meetings		In place but may need to re visit and have GOV boards in each area with updates

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Multi-professional clinical forums	HR policies describe multi-professional inclusion in all processes where applicable and appropriate, such as multi-professional involvement in recruitment panels and focus groups		Need to check policy. HR involved in recruitment process as applicable
	Multi-professional inclusion for recruitment and HR processes	Organisational values-based recruitment in place		
		Multi-professional inclusion in clinical and HR investigations, complaint and compliment procedures		MDT reviews in place for clinical incidents . HR investigations will be allocated to the appropriate professionals External reviews will be undertaken where necessary
		Standard operating procedure provides guidance for multi-professional debriefing sessions following clinical incidents or complaints		No SOP in place. Will need to be developed
		Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy		Debriefs always offered following complex and traumatic cases both group and individual. After Incident review meetings also be rolled out Trust wide,
		Schedule of attendance from multi-professional group members available		Attendance log held with debrief notes
	Multi-professional membership/ representation at Maternity Voices Partnership forums	Record of attendance available to demonstrate regular clinical and multi-professional attendance.		Good MDT attendance NED, Chief/Deputy Nurse, Medical Director attends
		Maternity Voice Partnership involvement in service development, Quality Improvement, recruitment and business planning through co-production and co-design		MVP and service users have been invited on focus group panels for interviews Evidence of MVP co-design available
		Quality improvement plan (QIP) that uses the SMART principle developed and visible to all staff as well as Maternity Voice Partnership/service users		Need to develop Quality Improvement plans for each area

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Collaborative multi-professional input to service development and improvement	Roles and responsibilities in delivering the QIP clearly defined, ie senior responsible officer and delegated responsibility		Need to develop
		Clearly defined and agreed measurable outcomes including impact for women and families as well as staff identified in the QIP		Need to develop
		Identification of the source of evidence to enable provision of assurance to all key stakeholders		Need to develop
		The organisation has robust repository for collation of all evidence, clearly catalogued and archived that's has appropriate shared access		Governance drive in place for collation of all evidence, clearly catalogued and archived with controlled access.
		Clear communication and engagement strategy for sharing with key staff groups		Weekly senior leader's forum in-place to cascade information. Band 5/6 Forums commenced 1-2-1 with senior team members Labour ward forum (MDT) in place
		QIP aligned to national agendas, standards and national maternity dataset and national maternity quality surveillance model requirements		Need to develop
		Weekly/monthly scheduled multi-professional safety incident review meetings		Monthly meetings in place. With weekly PMRT meeting where cases are discussed if no PMRT relevant cases
	Multiprofessional approach to positive safety culture	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS		Will need to be developed
		Positive and constructive feedback communication in varying forms		Needs further development
		Debrief sessions for cases of unusual or good outcomes adopting safety 2 approach		Do not do formal debriefs for good outcomes will review.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Senior members of staff make sure that more junior staff have opportunities to debrief and ask questions after experiencing complex clinical situations, and that they learn from theirs and others' experience. [7 steps to safety]		Needs to be formalised and documented Professional Midwifery Advocates' (PMA's)in place
		Schedule of focus for behavioural standards framework across the organisation		
	Clearly defined behavioural standards	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month		Trust standards in place
		Unsafe or inappropriate behaviours are noticed and with HR support corrected in real time, so they don't become normalised. [7 steps]		Policy has not always been followed but actions now in place to rectify this
		All policies and procedures align with the trust's board assurance framework (BAF)		
Governance infrastructure and ward-to-board accountability	**System and process clearly defined and aligned with national standards**	Governance framework in place that supports and promotes proactive risk management and good governance		Gov Framework to be reviewed and agreed across maternity and Paediatrics. Recruitment in place to vacant posts
		Staff across services can articulate the key principles (golden thread) of learning and safety		This needs to be shared with staff
		Staff describe a positive, supportive, safe learning culture		Would need to ask staff. Will need to develop a feedback survey
		Robust maternity governance team structure, with accountability and line management to the DoM and CD with key roles identified and clearly defined links for wider support and learning to corporate governance teams		Needs to recruit to vacant posts

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity governance structure within the directorate	Maternity governance team to include as a minimum: • Maternity governance lead (Current RM with the NMC) • Consultant Obstetrician governance lead (Min 2PA's) • Maternity risk manager (Current RM with the NMC or relevant transferable skills) • Maternity clinical incident leads • Audit midwife • Practice development midwife • Clinical educators to include leading preceptorship programme • Appropriate Governance facilitator and admin support		Band 8b Post currently vacant(postholder seconded to Interim DoM) 1 PA only Band 7 Governance and Risk now recruited to and due to start in coming weeks This is covered by the Governance roles in place No Audit Midwife In Post In Post Not in place (Band 4 admin support only which is shared). Out to recruitment for Band 5 Gov Facilitator
		Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member		Not fully compliant as vacancies within the team
		Team capacity able to meet demand, eg risk register, and clinical investigations completed in expected timescales		Not fully compliant at present due to vacancies
		In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF		Needs to be developed

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity-specific risk management strategy	Clearly defined in date trust wide BAF		?????
	Clear ward-to-board framework aligned to BAF	Perinatal services quality assurance framework supported by standardised reporting requirements in place from ward to board		Ask Paul Howard ??? aligned to BAF
		Mechanism in place for trust-wide learning to improve communications		Need further development when staff in post
	Proactive shared learning across directorate	Mechanism in place for specific maternity and neonatal learning to improve communication		Need further development when staff in post
		Governance communication boards		Need further development when staff in post
		Publicly visible quality and safety boards outside each clinical area		Need further development when staff in post
		Learning shared across local maternity system and regional networks		Maternity Safety SIG in place across GM and Neonatal CEG well established
		Engagement of external stakeholders in learning to improve, eg CCG, Strategic Clinical Network, regional Director/Heads of Midwifery groups		Weekly/biweekly HoM/DoM meetings in place with quarterly Northwest Forums held Monthly Maternity Steering Group meetings with CCG Bimonthly Safety Champions Bi Monthly Regional Steering Group Dashboard and Stillbirth group in place
		Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.		Needs to be developed??
		Multi-agency input evident in the development of the maternity specification		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Application of national standards and guidance	**Maternity specification in place for commissioned services**	Approved through relevant governance process		Need to ask CCG if a up to date Maternity Specification in place
		In date and reflective of local maternity system plan		Need to ask CCG if a up to date Maternity Specification in place
		Full compliance with all current 10 standards submitted		Compliant for Year 3, working towards Year 4
	Application of CNST 10 safety actions	A SMART action plan in place if not fully compliant that is appropriately financially resourced.		Year 4 standards under review and actions will assigned to standard leads
		Clear process defined and followed for progress reporting to LMS, Commissioners, regional teams and the trust board that ensures oversights and assurance before formal sign off of compliance		Quarterly board reports submitted. CCG updates as requested and prior to sign off sign off reports submitted to Board Needs to have more divisional oversight
		Clear process for multi-professional, development, review and ratification of all clinical guidelines		Robust embedded processes in place
	Clinical guidance in date and aligned to the national standards	Scheduled clinical guidance and standards multi-professional meetings for a rolling 12 months programme.		Monthly Guidelines meetings in place for Maternity
		All guidance NICE complaint where appropriate for commissioned services		
		All clinical guidance and quality standards reviewed and updated in compliance with NICE		
		All five elements implemented in line with most updated version		
	Saving Babies Lives care bundle implemented	SMART action plan in place identifying gaps and actions to achieve full implementation to national standards.		All elements of SBL compliant
		Trajectory for improvement to meet national ambition identified as part of maternity safety plan		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		All four key actions in place and consistently embedded		
	Application of the four key action points to reduce inequality for BAME women and families	Application of equity strategy recommendations and identified within local equity strategy		Action plan in place and compliant
		All actions implemented, embedded and sustainable		Action plan in place and compliant
	Implementation of 7 essential learning actions from the Ockendon first report	Fetal Surveillance midwife appointed as a minimum 0.4 WTE		0.6 wte
		Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 PAs		Only has 1 PA
		Plan in place for implementation and roll out of A-EQUIP		Compliant
	A-EQUIP implemented	Clear plan for model of delivery for A-EQUIP and working in collaboration with the maternity governance team		Needs development
		Training plan for transition courses and succession plan for new professional midwifery advocate (PMA) A-EQUIP model in place and being delivered		Trainees currently undertaking course
		Service provision and guidance aligned to national bereavement pathway and standards		
	Maternity bereavement services and support available	Bereavement midwife in post		
		Information and support available 24/7		24/7 care from mainstream midwifery
		Environment available to women consistent with recommendations and guidance from bereavement support groups and charities		
		Quality improvement leads in place		This would be the Bereavement midwife and SBL champion

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Quality improvement structure applied	Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation		Needs to be developed,
		Recognised and approved quality improvement tools and frameworks widely used to support services		Currently involved with Mat-NeoSip QI programme.. Project is risk assessment
		Established quality improvement hub, virtual or otherwise		Not Sure?
		Listening into action or similar concept implemented across the trust		Not Currently
		Continue to build on the work of the MatNeoSip culture survey outputs/findings.		This was never progressed but Maternity taking part in the culture and respect pilot
	MatNeoSip embedded in service delivery	MTP and the maternity safety strategy well defined in the local maternity system and quality improvement plan		LMS sighted on MTP via the regional steering group
	Maternity transformation programme (MTP) in place	Dynamic maternity safety plan in place and in date (in line with spotlight on maternity and national maternity safety strategy)		Need to develop a MTP action plan outlining what has been developed and on-going actions/ action plans are individual to projects or recommendations
Positive safety culture across the directorate and trust	**Maternity safety improvement plan in place**	Standing agenda item on key directorate meetings and trust committees		Needs further development. safety dashboard and safety notice boards are in place with safety walkabouts. Safety Champions bimonthly - meetings Action plan to be developed
		FTSU guardian in post, with time dedicated to the role		Trust Wide
	Freedom to Speak Up (FTSU) guardians in post	Human factors training lead in post		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Human factors training available	Human factors training part of trust essential training requirements		Training being rolled out across the Trust.
		Human factors training a key component of clinical skills drills		This is included in maternity mandatory training
		Human factors a key area of focus in clinical investigations and formal complaint responses		
		Multiprofessional handover in place as a minimum to include Board handover with representation from every professional group: • Consultant obstetrician • ST7 or equivalent • ST2/3 or equivalent • Senior clinical lead midwife • Anaesthetist And consider appropriate attendance of the following: • Senior clinical neonatal nurse • Paediatrician/neonatologist? • Relevant leads form other clinical areas eg, antenatal/postnatal ward/triage.		IN PLACE
	Robust and embedded clinical handovers in all key clinical areas at every change of staff shift	Clinical face to face review with relevant lead clinicians for all high-risk women and those of concern		Twice daily consultant ward rounds in place
		A minimum of two safety huddles daily in all acute clinical areas to include all members of the MDT working across and in maternity services as well as the opportunity to convene an urgent huddle as part of escalation process's		Twice daily huddles in place

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Safety huddles	Guideline or standard operating procedure describing process and frequency in place and in date		No SOP aligned to Trust SOP
		Audit of compliance against above		Audits not undertaken as embedded in normal practice x 2 daily
		Annual schedule for Swartz rounds in place		In place across the Trust but not Maternity or NNU specific
	Trust wide Swartz rounds	Multiprofessional attendance recorded and supported as part of working time		
		Broad range of specialties leading sessions		
		Trust-wide weekly patient safety summit led by medical director or executive chief nurse		If this is executive Safety Group
	Trust-wide safety and learning events	Robust process for reporting back to divisions from safety summit		Governance and service Leads attend these meetings.
		Annual or biannual trust-wide learning to improve events or patient safety conference forum		Where in place quarterly prior to pandemic
		Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes		Patient stories on Trust Board Cycle of Business bi Monthly
		In date business plan in place	??	
Comprehension of business/	**Business plan in place for 12 months prospectively**	Meets annual planning guidance	??	
		Business plan supports and drives quality improvement and safety as key priority	??	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
contingency plans impact on quality. **(ie Maternity Transformation plan, Neonatal Review, Maternity Safety plan and Local Maternity System plan)**		Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups		
		Consultant job plans in place and meet service needs in relation to capacity and demand		
		All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans		
		Business plans ensures all developments and improvements meet national standards and guidance		
		Business plan is aligned to NHS 10-year plan, specific national initiatives and agendas.		
		Business plans include dedicated time for clinicians leading on innovation, QI and Research		
		That service plans and operational delivery meets the maternity objectives of the Long-Term Plan in reducing health inequalities and unwarranted variation in care. Note the Maternity and Neonatal Plans on Pages 12 & 13.		
Meeting the requirements of Equality and Inequality & Diversity Legislation and Guidance.	**That Employment Policies and Clinical Guidance meet the publication requirements of Equity and Diversity Legislation.**	Assess service ambitions against the Midwifery 2020: Delivering expectations helpfully set out clear expectations in relation to reducing health inequalities, parts 3.1, 4.1 and 4.3 of the documents.		
		Refer to the guidance from the Royal College of Midwives (RCM) Stepping Up to Public Health, (2017). Utilise the Stepping up to Public Health Model, Table 10 as a template.		

Key lines of enquiry	Kirkup recommendation number
Leadership and development	2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 17, 18
Governance: Covers all pillars of Good governance	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Quality Improvement: application of methodology and tools	5, 6, 9, 12, 13, 15, 16, 17, 18
National standards and Guidance: service delivery	2, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Safety Culture: no blame, proactive, open and honest approach, Psychological safety	2, 3, 4, 5, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Patient Voice: Service user involvement and engagement through co-production and co-design. MVP and wider	6, 9, 11, 12, 13, 15, 17, 18
Staff Engagement: Harvard System two leadership approach, feedback and good communication tools	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Business Planning: aligned with LMNS plans and the National Maternity Transformation agenda, Maternity safety strategy and the Long term plan	8, 9, 10, 14, 15, 16, 17, 18

Key supporting documents and reading list

1. NHS England National Maternity review: Better Births. February 2016; https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

2. Royal College of Obstetricians and Gynaecologists Maternity Standards 2016; https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/maternitystandards.pdf

3. NHS England NHS Long Term Plan: January 2019; https://www.longtermplan.nhs.uk/

4. Report of the Investigation into Morecambe Bay March 2015; https://www.gov.uk/government/publications/morecambe-bay-investigation-report

5. Royal College of Midwives. Birth-rate plus tools; https://www.rcm.org.uk/media/2375/working-with-birthrate-plus.pdf

6. Royal College of Midwives State of Maternity Services 2018; https://www.rcm.org.uk/media/2373/state-of-maternity-services-report-2018-england.pdf

7. NHS England. Spotlight on Maternity: Safer Maternity care. 2016; https://www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/11/spotlight-on-maternity-guide.pdf

8. Department of Health Safer Maternity care. The National Ambition. November 2017; https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/560491/Safer_Maternity_Care_action_plan.pdf

9. NHS Resolution. Maternity Incentivisation Scheme 2019/20; https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

10. NHS staff survey. (2018); https://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2018-Results/

11. Maternity Picker Survey. 2019; https://www.picker.org/wp-content/uploads/2014/10/Maternity-4-pager-for-website-ARe-V2-18122018.pdf

12. National Maternity Perinatal Audit. (NMPA) report; https://www.hqip.org.uk/resource/national-maternity-and-perinatal-audit-nmpa-clinical-report-2019/#.XdUiX2pLFPY

13. Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. (MBRACE) report; https://www.npeu.ox.ac.uk/mbrrace-uk

14. Organisations Monthly Maternity Dashboards; https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/maternity-services-dashboard

15. Organisational Maternity and Neonatal Cultural Score Survey; https://improvement.nhs.uk/documents/5039/Measuring_safety_culture_in_matneo_services_qi_1apr.pdf

16. NHS England Saving babies lives Care bundle. V2 March 2019; https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

17. 7 Features of safety in maternity services framework; https://for-us-framework.carrd.co/

18. Ockendon Report: investigation into maternity services at Shrewsbury and |Telford NHS hospitals 2020; https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

19. Perinatal Surveillance Model; https://www.england.nhs.uk/wp-content/uploads/2020/12/implementing-a-revised-perinatal-quality-surveillance-model.pdf

20. Maternity Incentive Scheme; https://resolution.nhs.uk/wp-content/uploads/2021/03/Maternity-Incentive-Scheme-year-3-March-2021-FINAL.pdf

To: NHS Trust and Foundation Trust Chief Executives

cc. Trust Chairs and Directors of Nursing
ICS, CCG, LMS Leaders,
Regional Directors,
Regional Chief Nurses,
Regional Chief Midwives,
and Regional Obstetricians

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

25 January 2022

Dear colleagues,

Ockenden review of maternity services – one year on

Thank you for all your efforts in response to the Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust published in December 2020, and for your continued focus on the Immediate and Essential Actions (IEAs) despite the sustained pressure on your services throughout the pandemic. As well as ensuring progress continues, we need to prepare for the publication of further reports into maternity services during 2022.

The national response to the Ockenden report included a £95.6M investment into maternity services across England including funding for:

- 1200 additional midwifery roles,
- 100 wte equivalent consultant obstetricians,
- backfill for MDT training
- International recruitment programme for midwives
- Support to the recruitment and retention of maternity support workers

In our letter of 14 December 2020, we asked you to use the Assurance Assessment Tool, which includes the recommendations from the Morecambe Bay investigation report and the Ockenden report, to support a discussion at your trust public Board. One year on, we are asking that you again discuss progress at your public Board before the end of March 2022.

We expect the discussion to cover:

- Progress with implementation of the 7 IEAs outlined in the Ockenden report and the plan to ensure full compliance,
- Maternity services workforce plans,

Ensuring local system oversight of maternity services was a key element in the Ockenden review and therefore you should ensure progress is shared and discussed with your LMS and ICS. Progress must also be reported to your regional maternity team by 15 April 2022.

As you will no doubt agree, women and families using our maternity services deserve the best of NHS care. We recognise the huge efforts being made across the system and thank you for your continued commitment and support in driving the improvements required.

Yours faithfully

Sir David Sloman
Chief Operating Officer
NHS England and NHS Improvement

Ruth May
Chief Nursing Officer, England
NHS England and NHS Improvement

Completion Guidance:

1.Overview tab – please complete in full
2.Ockenden return tab – this mirrors earlier returns and requires updating on progress to 31/12/2021
3.Kirkup return tab – please note some recommendations have been greyed out – these do not require completion as they are superseded by information in the Ockenden recommendations. (There is a 4th tab which details the Kirkup recommendations as a helpful reminder – this doesn't require any completion)

Internal trust governance

	Confirmation of / or planned Public Trust Board update on progress against the Ockenden action plan	Date of Public Board update	Executive sign off of this return		
	Yes/No	please insert date	Date	Name	Role
Insert Trust Name					
Insert Trust Name					
Insert Trust Name					
Insert Trust Name					

LMNS sign off of the combined trust returns

LMNS Name	Executive sign off		
	Date	Name	Role
Name of LMNS			

Ockenden Inital report reccomendations

				GMEC	GMEC
IEA	**Question**	**Action**	**Evidence Required**	**August 2021 Submission - WRIGHTINGTON, WIGAN AND LEIGH**	**Current Submission - WRIGHTINGTON, WIGAN AND LEIGH**
IEA1	**Q1**	Maternity Dashboard to LMS every 3 months	Dashboard to be shared as evidence.	100%	100%
			Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken.	100%	100%
			SOP required which demonstrates how the trust reports this both internally and externally through the LMS.	100%	100%
			Submission of minutes and organogram, that shows how this takes place.	100%	100%
		Maternity Dashboard to LMS every 3 months Total		**100%**	**100%**
	Q2	External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death	Audit to demonstrate this takes place.	0%	100%
			Policy or SOP which is in place for involving external clinical specialists in reviews.	100%	100%
		External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death Total		**50%**	**50%**
	Q3	Maternity SI's to Trust Board & LMS every 3 months	Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion	100%	100%
			Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed	100%	100%
			Submit SOP	100%	100%
		Maternity SI's to Trust Board & LMS every 3 months Total		**100%**	**100%**
	Q4	Using the National Perinatal Mortality Review Tool to review perinatal deaths	Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.	100%	100%
			Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance.	100%	100%
		Using the National Perinatal Mortality Review Tool to review perinatal deaths Total		**100%**	**100%**
	Q5	Submitting data to the Maternity Services Dataset to the required standard	Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.	100%	100%
		Submitting data to the Maternity Services Dataset to the required standard Total		**100%**	**100%**
		Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme	Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.	100%	100%

	Q6	**Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme Total**		**100%**	**100%**
	Q7	Plan to implement the Perinatal Clinical Quality Surveillance Model	Full evidence of full implementation of the perinatal surveillance framework by June 2021.	100%	100%
			LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.	100%	100%
			Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure.	100%	100%
		Plan to implement the Perinatal Clinical Quality Surveillance Model Total		**100%**	**100%**
IEA1 Total				**94%**	
IEA2	Q11	Non-executive director who has oversight of maternity services	Evidence of how all voices are represented:	0%	100%
			Evidence of link in to MVP; any other mechanisms	100%	100%
			Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed	100%	100%
			Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions	0%	100%
			Name of NED and date of appointment	100%	100%
			NED JD	100%	100%
		Non-executive director who has oversight of maternity services Total		**67%**	**100%**
	Q13	Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	100%
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%	100%
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%	100%
		Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services Total		**100%**	**100%**
	Q14	Trust safety champions meeting bimonthly with Board level champions	Action log and actions taken.	100%	100%
			Log of attendees and core membership.	100%	100%
			Minutes of the meeting and minutes of the LMS meeting where this is discussed.	100%	100%
			SOP that includes role descriptors for all key members who attend by-monthly safety meetings.	100%	100%
		Trust safety champions meeting bimonthly with Board level champions Total		**100%**	**100%**
		Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	100%

	Q15	**Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. Total**		**100%**	**100%**
	Q16	Non-executive director support the Board maternity safety champion	Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken	0%	100%
			Name of ED and date of appointment	0%	100%
			Role descriptors	100%	100%
		Non-executive director support the Board maternity safety champion Total		**33%**	**100%**
IEA2 Total				**76%**	
IEA3	Q17	Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	0%	100%
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.	100%	100%
			Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.	100%	100%
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%	100%
			Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	0%	100%
		Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year. Total		**60%**	**100%**
	Q18	Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.	Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP)	100%	100%
			SOP created for consultant led ward rounds.	100%	100%
		Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. Total		**100%**	**100%**
	Q19	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Confirmation from Directors of Finance	0%	100%
			Evidence from Budget statements.	100%	100%
			Evidence of funding received and spent.	100%	100%
			Evidence that additional external funding has been spent on funding including staff can attend training in work time.	100%	100%
			MTP spend reports to LMS	0%	0%
		External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only Total		**60%**	**80%**
		90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	0%	100%
			Attendance records - summarised	100%	100%

0

	Q21		LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	100%	100%
		90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session Total		**67%**	**100%**
	Q22	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP)	100%	100%
		Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. Total		**100%**	**100%**
	Q23	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	100%
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data.	100%	100%
		The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place Total		**100%**	**100%**
IEA3 Total				**72%**	
	Q24	Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre	Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians	100%	100%
			SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway.	100%	100%
		Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre Total		**100%**	**100%**
	Q25	Women with complex pregnancies must have a named consultant lead	Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.	100%	100%
			SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead.	100%	100%
		Women with complex pregnancies must have a named consultant lead Total		**100%**	**100%**
	Q26	Complex pregnancies have early specialist involvement and management plans agreed	Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.	100%	100%
			SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams.	100%	100%
		Complex pregnancies have early specialist involvement and management plans agreed Total		**100%**	**100%**
IEA4		Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	Audits for each element.	100%	100%

	Q27		Guidelines with evidence for each pathway	100%	100%
			SOP's	100%	100%
		Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 Total		**100%**	**100%**
	Q28	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	SOP that states women with complex pregnancies must have a named consultant lead.	100%	100%
			Submission of an audit plan to regularly audit compliance	100%	100%
		All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. Total		**100%**	**100%**
	Q29	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Agreed pathways	100%	100%
			Criteria for referrals to MMC	100%	100%
			The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.	100%	100%
		Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres Total		**100%**	**100%**
IEA4 Total				**100%**	**100%**
IEA5	Q30	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	How this is achieved within the organisation.	100%	100%
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	100%	100%
			Review and discussed and documented intended place of birth at every visit.	100%	100%
			SOP that includes definition of antenatal risk assessment as per NICE guidance.	100%	100%
			What is being risk assessed.	100%	100%
		All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Total		**100%**	**100%**
	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Evidence of referral to birth options clinics	100%	100%
			Out with guidance pathway.	100%	100%
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	100%	100%
			SOP that includes review of intended place of birth.	100%	100%
		Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. Total		**100%**	**100%**

	Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)	100%	100%
			How this is achieved in the organisation	0%	100%
			Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.	100%	100%
			Review and discussed and documented intended place of birth at every visit.	100%	100%
			SOP to describe risk assessment being undertaken at every contact.	0%	50%
			What is being risk assessed.	100%	100%
		A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. Total		**67%**	**100%**
IEA5 Total				**87%**	
	Q34	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring	Copies of rotas / off duties to demonstrate they are given dedicated time.	100%	100%
			Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs.	0%	100%
			Incident investigations and reviews	100%	100%
			Name of dedicated Lead Midwife and Lead Obstetrician	100%	100%
		Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring Total		**75%**	**100%**
	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Consolidating existing knowledge of monitoring fetal wellbeing	0%	100%
			Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision	100%	100%
			Improving the practice & raising the profile of fetal wellbeing monitoring	100%	100%
			Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	100%	100%
			Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post	100%	100%
			Keeping abreast of developments in the field	0%	100%
			Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	100%	100%
			Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training.	0%	100%
IEA6		**The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health Total**		**63%**	**100%**

	Q36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Audits for each element	100%	100%
			Guidelines with evidence for each pathway	100%	100%
			SOP's	100%	100%
		Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? Total		**100%**	**100%**
	Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	100%
			Attendance records - summarised	100%	100%
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%	100%
		Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? Total		**100%**	**100%**
IEA6 Total				**78%**	
	Q39	Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	Information on maternal choice including choice for caesarean delivery.	100%	100%
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%	100%
		Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery Total		**100%**	**100%**
	Q41	Women must be enabled to participate equally in all decision-making processes	An audit of 1% of notes demonstrating compliance.	100%	100%
			CQC survey and associated action plans	100%	100%
			SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded.	100%	100%
		Women must be enabled to participate equally in all decision-making processes Total		**100%**	**100%**
	Q42	Women's choices following a shared and informed decision-making process must be respected	An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.	100%	100%
			SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded.	100%	100%

IEA7		**Women's choices following a shared and informed decision-making process must be respected Total**		**100%**	**100%**
	Q43	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	100%
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%	100%
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%	100%
		Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Total		**100%**	**100%**
	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Co-produced action plan to address gaps identified	100%	100%
			Gap analysis of website against Chelsea & Westminster conducted by the MVP	100%	100%
			Information on maternal choice including choice for caesarean delivery.	0%	100%
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%	100%
		Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. Total		**75%**	**100%**
IEA7 Total				**93%**	**100%**
	Q45	Demonstrate an effective system of clinical workforce planning to the required standard	Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	100%	100%
			Evidence of reviews 6 monthly for all staff groups and evidence considered at board level.	0%	100%
			Most recent BR+ report and board minutes agreeing to fund.	100%	100%
		Demonstrate an effective system of clinical workforce planning to the required standard Total		**67%**	**100%**
	Q46	Demonstrate an effective system of midwifery workforce planning to the required standard?	Most recent BR+ report and board minutes agreeing to fund.	100%	100%
		Demonstrate an effective system of midwifery workforce planning to the required standard? Total		**100%**	**100%**
	Q47	Director/Head of Midwifery is responsible and accountable to an executive director	HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director	100%	100%
		Director/Head of Midwifery is responsible and accountable to an executive director Total		**100%**	**100%**

WF	**Q48**	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:	Action plan where manifesto is not met	0%	50%
			Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care	100%	100%
		Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: Total		**50%**	**50%**
	Q49	Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.	Audit to demonstrate all guidelines are in date.	100%	100%
			Evidence of risk assessment where guidance is not implemented.	100%	100%
			SOP in place for all guidelines with a demonstrable process for ongoing review.	100%	100%
		Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Total		**100%**	**100%**
WF Total				**80%**	

Kirkup report recommendations
Regional Update

Those that are greyed out are superseded by Ockenden and do not need completing on this tab.

				GMEC
Kirkup Action no.	**Relating to Kirkup Recommendation (see Kirkup Recommendations tab for further information)**	**Action**	**Suggested documents that may support Trust assurance.**	**WRIGHTINGTON, WIGAN AND LEIGH**
1	**R1, R13, R24**	Ensure that an open and honest approach is taken to any incident	Critical friend is allocated for every level 4/ 5 incident (SI's)	
			Women and their families are kept informed of the progress of the	
			Women and their families are invited to contribute to the investigation	
			Offering an apology	
			Ensure that all nurses and midwives are aware of their responsibilities in	
2	**R1, R13**	Review the current processes for obtaining feedback from the public to increase the information received	Offering women and their families the opportunity to make suggestions	
			Ensuring that national/ local awareness opportunities are utilised	
			Continue to support the LSA in the feedback mechanism to staff from	
			Share patient stories	
3	**R2**	Review the current skills and drills programme across the directorate to ensure that a wide range of scenarios are included across all clinical settings, including bespoke skills drills for different clinical areas	Ensure a high quality training scheme is delivered	
4		Foster a culture of shared learning between clinical departments that supports effective communication and practice development	Minutes of meetings showing MDT working	
5	**R2**	Review the current preceptorship programme	Midwives/ Nurses are allocated a buddy in each clinical area and that this is supported by the clinical team.	Green
			The buddy midwife is allocated time to support the preceptee	Green
			Midwives are supported throughout the programme, progress is monitored and there is a clear plan developed for any midwife that is struggling to	Green
			Midwives are confident and competent to go through the gateway within the agreed timeframe	Green
6	**R2**	Obtain feedback from midwives and nurses who have recently completed a preceptorship programme to identify any improvements that can be made to the programme	Utilise PMA feedback	Amber
7	**R2, R3**	Review the skills of Band 6 midwives to identify and address any training needs to ensure a competent and motivated workforce	Develop a robust support package for new band 6 midwives	Amber
			Completion of the Mentoring module	Green
			Suturing competency	Green
			IV therapy competency	Green
			Care of women choosing epidural anaesthesia.	Green
8		Review the current induction and orientation process for midwives and nurses joining the organisation at Band 6 to ensure they are competent and confident to provide care	Practice educator reports and feedback	Amber
9	**R2**	Review the current induction programme for locum doctors	Locum policies	Amber
10		Review the current provision of education and training for locum doctors with the aim of introducing streamlined bespoke training for this group.		Amber

11	**R2**	Review the provision of maternal AIMS courses and ensure that all places are allocated appropriately and staff attend the session.	Practice educator meeting notes, discussion with DoMS/HoMs	Green
12	**R2**	Review the educational opportunities available for staff working in postnatal areas to increase their understanding of the compromised neonate, including consideration of bespoke educational sessions and HEI courses e.g. Care of the compromised baby module at University of Salford	Practice educator reports and feedback	Amber
13	**R2**	Improve staff knowledge, response time and escalation processes in relation to a woman's deteriorating condition	Incident review and feedback, related lessons learnt, training opportunities	Green
14	**R2**	Implement a process for cascading learning points generated from incidents or risk management in each clinical area e.g. email to staff, noticeboard, themed week / message of the week, core huddles, NICU news		Green
15	**R3**	Review the current process for staff rotation to ensure that a competent workforce is maintained in all clinical areas.		Green
16	**R2, R3, R4**	Review and update the Education Strategy		
17	**R3**	Review the support provided when staff are allocated to a new clinical area and what supernumerary actually means in order to manage staff expectations		Green
18	**R3**	Offer opportunities to other heads of service for staff from other trusts to broaden their experience by secondment or supernumerary status		
19	**R5**	Develop a list of current MDT meetings and events and share with staff across the directorate		
20	**R8**	Develop and implement a recruitment and retention strategy specifically for the obstetric directorate		Amber
21		Review the current midwifery staffing establishment to ensure appropriate staffing levels in all clinical areas		
22		Ensure that all staff who leave are offered an exit interview with a senior member of staff and use the information gained from these interviews to inform changes aimed at improving retention		Green
23		Provide Staff Forum meetings where staff are encouraged to attend and discuss concerns		Green
24	**Only applicable to multi-site trusts.**	Improve working relationships between the different sites located geographically apart but under the same organization.		
25	**R9**	Reiterate to all staff via email and team meetings the roles and responsibilities of the consultant obstetrician carrying the hot week bleep.		
26	**R11, R12**	Ensure that staff receive education during their induction regarding the incident reporting process including the process for reporting incidents, the incidents that should be reported and the rationale for learning from incidents.		Green
27	**R11, R12**	Including a review of the processes for disseminating and learning from incidents		
28		Ensure that staff undertaking incident investigations have received appropriate education and training to undertake this effectively	All consultants to have completed RCA training	Amber
			Identified midwives to have completed RCA training	Green
			Staff who have completed RCA training undertake an investigation within 1 year and regularly thereafter in order to maintain their skills	Green
			Staff who have completed RCA training undertake an investigation within 1 year and regularly thereafter in order to maintain their skills	Green

29	**R12**	Ensure that the details regarding staff debriefing and support are completed on the Trust incident reporting system for all level 4 and 5 incidents		
30	**R12**	Ensure that all Serious Incidents (SI's)are fedback to the staff		
31	**R12**	Identify ways of improving attendance of midwives at SI's feedback sessions		
32	**R13**	Maternity Services Liaison Committee involvement in complaints	Collation of complaints reports	
33	**R14**	Review the current obstetric clinical lead structure		
34	**R15**	Review past SI's and map common themes	Thematic reviews	
35	**R23**	Ensure that maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths are reported, reviewed and an investigation undertaken where appropriate	Maternal deaths, stillbirths and early neonatal deaths reports	
36	**R26**	Ensure that all staff are aware of how to raise concerns	Whistle blowing staff policy	Green
37	**R31**	Provide evidence of how we deal with complaints		Green
38	**R31**	Educate staff regarding the process for local resolution and support staff to undertake this process in their clinical area	Identifying situations where local resolution is required	Green
39	**R32**	Develop a plan to maintain a supervision system beyond the decommissioning of the LSAs once national recommendations have been agreed.	Implementation of the A-AQUIP model	
40	**R38**	Ensure that all perinatal deaths are recorded appropriately	Sending the completed form to the Deputy Director of Nursing/ Head of Midwifery and the Divisional Clinical Effectiveness Manager	
41	**R39**	Ensure that Confidential Enquiry reports are reviewed following publication and that an action plan is developed and monitored to ensure that high standards of care are maintained	MBRRACE action plan	Green

Recommendations from the published Kirkup report

1	The University Hospitals of Morecambe Bay NHS Foundation Trust should formally admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected, not only for the avoidable damage caused but also for the length of time it has taken to bring them to light and the previous failures to act. This should begin immediately with the response to this Report.
2	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies. This review will be completed by June 2015, and identify requirements for additional training, development and, where necessary, a period of experience elsewhere if applicable
3	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up plans to deliver the training and development of staff identified as a result of the review of maternity, neonatal and other staff, and should identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice. These should be in place in time for June 2015.
4	Following completion of additional training or experience where necessary, the University Hospitals of Morecambe Bay NHS Foundation Trust should identify requirements for continuing professional development of staff and link this explicitly with professional requirements including revalidation. This should be completed by September 2015.
5	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and develop measures that will promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities. Attendance at designated events must be compulsory within terms of employment. These measures should be identified by April 2015 and begun by June 2015.
6	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up a protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of delivery at Furness General Hospital and who should not; who will carry out this assessment against which criteria; and how this will be discussed with pregnant women and families. The protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region. The Trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all Trust staff are aware that they should not vary decisions without a documented risk assessment. This should be completed by June 2015.
7	The University Hospitals of Morecambe Bay NHS Foundation Trust should audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups. This should be in place by September 2015.
8	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience. This should include, but not be limited to, seeking links with one or more other centre(s) to encourage development of specialist and/or academic practice whilst offering opportunities in generalist practice in the Trust; in addition, opportunities for flexible working to maximise the advantages of close proximity to South Lakeland should be sought. Development of the strategy should be completed by January 2016.
9	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify an approach to developing better joint working between its main hospital sites, including the development and operation of common policies, systems and standards. Whilst we do not believe that the introduction of extensive split-site responsibilities for clinical staff will do much other than lead to time wasted in travelling, we do consider that, as part of this approach, flexibility should be built into working responsibilities to provide temporary solutions to short-term staffing problems. This approach should be begun by September 2015.
10	The University Hospitals of Morecambe Bay NHS Foundation Trust should seek to forge links with a partner Trust, so that both can benefit from opportunities for learning, mentoring, secondment, staff development and sharing approaches to problems. This arrangement is promoted and sometimes facilitated by Monitor as 'buddying' and we endorse the approach under these circumstances. This could involve the same centre identified as part of the recruitment and retention strategy. If a suitable partner is forthcoming, this arrangement should be begun by September 2015.
11	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and implement a programme to raise awareness of incident reporting, including requirements, benefits and processes. The Trust should also review its policy of openness and honesty in line with the duty of candour of professional staff, and incorporate into the programme compliance with the refreshed policy.
12	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, identifying any residual conflicts of interest and requirements for additional training. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review should include the provision of appropriate arrangements for staff debriefing and support following a serious incident. This should be begun with maternity units by April 2015 and rolled out across the Trust by April 2016.
13	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in responding to complaints, and introduce measures to promote the use of complaints as a source of improvement and reduce defensive 'closed' responses to complainants. The Trust should increase public and patient involvement in resolving complaints, in the case of maternity services through the Maternity Services Liaison Committee. This should be completed, and the improvements demonstrated at an open Board meeting, by December 2015.
14	The University Hospitals of Morecambe Bay NHS Foundation Trust should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. The Trust has implemented change at executive level, but this needs to be carried through to the levels below. All staff with defined responsibilities for clinical leadership should show evidence of attendance at appropriate training and development events. This review should be commenced by April 2015.
15	The University Hospitals of Morecambe Bay NHS Foundation Trust should continue to prioritise the work commenced in response to the review of governance systems already carried out, including clinical governance, so that the Board has adequate assurance of the quality of care provided by the Trust's services. This work is already underway with the facilitation of Monitor, and we would not seek to vary or add to it, which would serve only to detract from implementation. We do, however, recommend that a full audit of implementation be undertaken before this is signed off as completed.
16	As part of the governance systems work, we consider that the University Hospitals of Morecambe Bay NHS Foundation Trust should ensure that middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and it should provide appropriate guidance and where necessary training. This should be completed by December 2015.
17 & 18	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify options, with a view to implementation as soon as practicable, to improve the physical environment of the delivery suite at Furness General Hospital, including particularly access to operating theatres, an improved ability to observe and respond to all women in labour and en suite facilities; arrangements for post-operative care of women also need to be reviewed. Plans should be in place by December 2015 and completed by December 2017. 18. All of the previous recommendations should be implemented with the involvement of Clinical Commissioning Groups, and where necessary, the Care Quality Commission and Monitor. In the particular circumstances surrounding the University Hospitals of Morecambe Bay NHS Foundation Trust, NHS England should oversee the process, provide the necessary support, and ensure that all parties remain committed to the outcome, through an agreed plan with the Care Quality Commission, Monitor and the Clinical Commissioning Groups.
Recommendations for the wider NHS	
19	In light of the evidence we have heard during the Investigation, we consider that the professional regulatory bodies should review the findings of this Report in detail with a view to investigating further the conduct of registrants involved in the care of patients during the time period of this Investigation. Action: the General Medical Council, the Nursing and Midwifery Council.
20	There should be a national review of the provision of maternity care and paediatrics in challenging circumstances, including areas that are rural, difficult to recruit to, or isolated. This should identify the requirements to sustain safe services under these conditions. In conjunction, a national protocol should be drawn up that defines the types of unit required in different settings and the levels of care that it is appropriate to offer in them. Action: NHS England, the Care Quality Commission, the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Royal College of Paediatrics and Child Health, the National Institute for Health and Care Excellence.
21	The challenge of providing healthcare in areas that are rural, difficult to recruit to or isolated is not restricted to maternity care and paediatrics. We recommend that NHS England consider the wisdom of extending the review of requirements to sustain safe provision to other services. This is an area lacking in good-quality research yet it affects many regions of England, Wales and Scotland. This should be seen as providing an opportunity to develop and promote a positive way of working in remote and rural environments. Action: NHS England.
22	We believe that the educational opportunities afforded by smaller units, particularly in delivering a broad range of care with a high personal level of responsibility, have been insufficiently recognised and exploited. We recommend that a review be carried out of the opportunities and challenges to assist such units in promoting services and the benefits to larger units of linking with them. Action: Health Education England, the Royal College of Obstetricians and Gynaecologists, the Royal College of Paediatrics and Child Health, the Royal College of Midwives.
23	Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. We believe that there is a strong case to include a requirement that investigation of these incidents be subject to a standardised process, which includes input from and feedback to families, and independent, multidisciplinary peer review, and should certainly be framed to exclude conflicts of interest between staff. We recommend that this build on national work already begun on how such a process would
24	We commend the introduction of the duty of candour for all NHS professionals. This should be extended to include the involvement of patients and relatives in the investigation of serious incidents, both to provide evidence that may otherwise be lacking and to receive personal feedback on the results. Action: the Care Quality Commission, NHS England.
25	We recommend that a duty should be placed on all NHS Boards to report openly the findings of any external investigation into clinical services, governance or other aspects of the operation of the Trust, including prompt notification of relevant external bodies such as the Care Quality Commission and Monitor. The Care Quality Commission should develop a system to disseminate learning from investigations to other Trusts. Action: the Department of Health, the Care Quality Commission
26	We commend the introduction of a clear national policy on whistleblowing. As well as protecting the interests of whistleblowers, we recommend that this is implemented in a way that ensures that a systematic and proportionate response is made by Trusts to concerns identified. Action: the Department of Health.
27	Professional regulatory bodies should clarify and reinforce the duty of professional staff to report concerns about clinical services, particularly where these relate to patient safety, and the mechanism to do so. Failure to report concerns should be regarded as a lapse from professional standards. Action: the General Medical Council, the Nursing and Midwifery Council, the Professional Standards Authority for Health and Social Care.
28	Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels, including, but not limited to, clinical directors, clinical leads, heads of service, medical directors, nurse directors. Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, the General Medical Council, the Nursing and Midwifery Council, all Trusts.
29	Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, including executive directors, middle managers and non-executives. All Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, all Trusts.
30	A national protocol should be drawn up setting out the duties of all Trusts and their staff in relation to inquests. This should include, but not be limited to, the avoidance of attempts to 'fend off' inquests, a mandatory requirement not to coach staff or provide 'model answers', the need to avoid collusion between staff on lines to take, and the inappropriateness of relying on coronial processes or expert opinions provided to coroners to substitute for incident investigation. Action: NHS England, the Care Quality Commission.
31	The NHS complaints system in the University Hospitals of Morecambe Bay NHS Foundation Trust failed relatives at almost every turn. Although it was not within our remit to examine the operation of the NHS complaints system nationally, both the nature of the failures and persistent comment from elsewhere lead us to suppose that this is not unique to this Trust. We believe that a fundamental review of the NHS complaints system is required, with particular reference to strengthening local resolution and improving its timeliness, introducing external scrutiny of local resolution and reducing reliance on the Parliamentary and Health Service Ombudsman to intervene in unresolved complaints. Action: the Department of Health, NHS England, the Care Quality Commission, the Parliamentary and Health Service Ombudsman.
32	The Local Supervising Authority system for midwives was ineffectual at detecting manifest problems at the University Hospitals of Morecambe Bay NHS Foundation Trust, not only in individual failures of care but also with the systems to investigate them. As with complaints, our remit was not to examine the operation of the system nationally; however, the nature of the failures and the recent King's Fund review (*Midwifery regulation in the United Kingdom*) lead us to suppose that this is not unique to this Trust, although there were specific problems there that exacerbated the more systematic concern. We believe that an urgent response is required to the King's Fund findings, with effective reform of the system. Action: the Department of Health, NHS England, the Nursing and Midwifery Council.

33	We considered carefully the effectiveness of separating organisationally the regulation of quality by the Care Quality Commission from the regulation of finance and performance by Monitor, given the close inter-relationship between Trust decisions in each area. However, we were persuaded that there is more to be gained than lost by keeping regulation separated in this way, not least that decisions on safety are not perceived to be biased by their financial implications. The close links, however, require a carefully coordinated approach, and we recommend that the organisations draw up a memorandum of understanding specifying roles, relationships and communication. Action: Monitor, the Care Quality Commission, the Department of Health.
34	The relationship between the investigation of individual complaints and the investigation of the systemic problems that they exemplify gave us cause for concern, in particular the breakdown in communication between the Care Quality Commission and the Parliamentary and Health Service Ombudsman over necessary action and follow-up. We recommend that a memorandum of understanding be drawn up clearly specifying roles, responsibilities, communication and follow-up, including explicitly agreed actions where issues overlap. Action: the Care Quality Commission, the Parliamentary and Health Service Ombudsman.
35	The division of responsibilities between the Care Quality Commission and other parts of the NHS for oversight of service quality and the implementation of measures to correct patient safety failures was not clear, and we are concerned that potential ambiguity persists. We recommend that NHS England draw up a protocol that clearly sets out the responsibilities for all parts of the oversight system, including itself, in conjunction with the other relevant bodies; the starting point should be that one body, the Care Quality Commission, takes prime responsibility. Action: the Care Quality Commission, NHS England, Monitor, the Department of Health.
36	The cumulative impact of new policies and processes, particularly the perceived pressure to achieve Foundation Trust status, together with organisational reconfiguration, placed significant pressure on the management capacity of the University Hospitals of Morecambe Bay NHS Foundation Trust to deliver against changing requirements whilst maintaining day-to-day needs, including safeguarding patient safety. Whilst we do not absolve Trusts from responsibility for prioritising limited capability safely and effectively, we recommend that the Department of Health should review how it carries out impact assessments of new policies to identify the risks as well as the resources and time required. Action: the Department of Health.
37	Organisational change that alters or transfers responsibilities and accountability carries significant risk, which can be mitigated only if well managed. We recommend that an explicit protocol be drawn up setting out how such processes will be managed in future. This must include systems to secure retention of both electronic and paper documents against future need, as well as ensuring a clearly defined transition of responsibilities and accountability. Action: the Department of Health.
38	Mortality recording of perinatal deaths is not sufficiently systematic, with failures to record properly at individual unit level and to account routinely for neonatal deaths of transferred babies by place of birth. This is of added significance when maternity units rely inappropriately on headline mortality figures to reassure others that all is well. We recommend that recording systems are reviewed and plans brought forward to improve systematic recording and tracking of perinatal deaths. This should build on the work of national audits such as MBRRACE-UK, and include the provision of comparative information to Trusts. Action: NHS England.
39	There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is in our view no less applicable to maternal and perinatal deaths, and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay. Action: the Department of Health.
40	Given that the systematic review of deaths by medical examiners should be in place, as above, we recommend that this system be extended to stillbirths as well as neonatal deaths, thereby ensuring that appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths following neonatal transfer. Action: the Department of Health
41	We were concerned by the ad hoc nature and variable quality of the numerous external reviews of services that were carried out at the University Hospitals of Morecambe Bay NHS Foundation Trust. We recommend that systematic guidance be drawn up setting out an appropriate framework for external reviews and professional responsibilities in undertaking them. Action: the Academy of Medical Royal Colleges, the Royal College of Nursing, the Royal College of Midwives.
42	We further recommend that all external reviews of suspected service failures be registered with the Care Quality Commission and Monitor, and that the Care Quality Commission develops a system to collate learning from reviews and disseminate it to other Trusts. Action: the Care Quality Commission, Monitor.
43	We strongly endorse the emphasis placed on the quality of NHS services that began with the Darzi review, *High Quality Care for All* , and gathered importance with the response to the events at the Mid Staffordshire NHS Foundation Trust. Our findings confirm that this was necessary and must not be lost. We are concerned that the scale of recent NHS reconfiguration could result in new organisations and post-holders losing the focus on this priority. We recommend that the importance of putting quality first is re-emphasised and local arrangements reviewed to identify any need for personal or organisational development, including amongst clinical leadership in commissioning organisations. Action: NHS England, the Department of Health.
44	This Investigation was hampered at the outset by the lack of an established framework covering such matters as access to documents, the duty of staff and former staff to cooperate, and the legal basis for handling evidence. These obstacles were overcome, but the need to do this from scratch each time an investigation of this format is set up is unnecessarily time-consuming. We believe that this is an effective investigation format that is capable of getting to the bottom of significant service and organisational problems without the need for a much more expensive, time-consuming and disruptive public inquiry. This being so, we believe that there is considerable merit in establishing a proper framework, if necessary statutory, on which future investigations could be promptly established. This would include setting out the arrangements necessary to maintain independence and work effectively and efficiently, as well as clarifying responsibilities of current

Agenda item: [23]

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	New Version v1.8. IPC Board Assurance Framework update
Presented to:	WWL Board
On:	06 April 2022
Presented by:	[Rabina Tindale, Chief Nurse, Director IPC]
Prepared by:	[Julie O'Malley, Deputy Director IPC]
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Executive summary

Summary

This report provides an update on progress with the IPC BAF. Ongoing gaps in assurance are also listed below before the main table.

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

- **Microbiology provision within the Trust:** Two Microbiologists have left permanent posts during Q4. Two locum Microbiologist's are currently providing a specific/ limited remit, via virtual/ remote service arrangement in the interim period. The recruitment of permanent Microbiologist's is under consideration.
- **The IPC Audit Programme** was modified in response to the Omicron wave noted during November to January. The currently presenting increase in positive COVID-19 cases within the Trust suggests a return to increasing demand on bed capacity and will impact the response required by the IPC Team. The IPC audit programme may require a further pause.
- **The demand on the IPC workforce** has increased on the background of depleted team capacity, the continuing COVID-19 Pandemic, and the impact of the emerging Omicron variant. A full Business case is being developed with an aim to secure resource and investment for the IPC Service within the Trust.
- **The current unknown impact and uncertainty of the path the COVID-19 Pandemic** requires services to prepare for additional impact on capacity and demand of rising COVID-19 cases. IPC measures, and management resources, guidance and SOPs remain in place to support staff and patient care.

The WWL Way

- Due to the number of patients with COVID 19 during the Omicron wave, the Trust was not always able to separate pathways. Amber site status has been adopted during the Omicron wave in response to capacity and demand and local application of pathways in line with UKHSA/ NHSE Guidance.
- **Within the Trust there is limited side room capacity** to consistently enable isolation as required, for patients with confirmed or suspected infections, including COVID-19. A risk assessment on the lack of side rooms has been completed. The IPC Team attend daily bed meetings and support bed managers with decision making on a 24/7 basis. A Datix is completed if unable to isolate a patient and mitigating IPC actions and measures are implemented to maintain safety whilst bed management colleagues continuing to secure isolation capacity.
- **The Trust has a heavy reliance on natural ventilation**, particularly at the RAEI site. Most areas have been identified as being adequately mechanically ventilated, or natural ventilation has been improved. Some limited small areas may still have poor ventilation.
- **Lateral Flow Device (LFD) testing:** The Trust is awaiting notification of the LFD supply arrangement from the National Team. Arrangements for Pre-attendance LFD testing of patients and routine, twice weekly staff asymptomatic testing and the ability to end COVID-19 isolation early for positive and contact staff will be dependent upon a supply of LFD testing kits to enable testing.
- **The capacity of Test and Trace assessment provision** is limited within the Trust and is unable to meet the current demand, requiring additional support.
- **Compliance with the staff LFD reporting process.** The data is not accurate for the number of staff carrying out twice weekly lateral flow tests.
- **Face fit testing** continues but the central register of staff tested indicates that not all staff are tested to a model that is currently in stock. Fit test sessions continue to be advertised. Divisions have been provided with a list of compliant staff to review
- **Fit testing training records** are not fully complete for staff who wear air purifying respirators (PAPR) (mechanical respirators with hood). Health and Safety are working with Divisions to identify staff who rely on or choose to wear PAPR to ensure they have all been fully trained.
- **Specific options and arrangements for mask exempt staff** are being investigated and reviewed in collaboration with Occupational Health, Human Resources and Infection Prevention and Control Services to secured working arrangement for mask exempt staff to return to workplace whilst maintaining the safety of the individual, patients, staff colleagues and visitors.
- **The use of face masks in non-clinical areas** is not currently audited. All staff within NHS premises are required to wear face masks in line with current UKHSA Guidance. The guidance remains unchanged and was last updated on 15.3.2022
- **Currently the Trust are not monitoring cleaning standards in non-clinical areas**. The Trust board has approved a 2nd wave of recruitment to undertake the cleaning and monitoring of non-clinical areas within the Trust during 2022/2023.
- **A reduction in compliance with the Mandatory IPC and COVID-19 e-learning modules** was noted to in Quarter 3. Compliance with Mandatory training was reported at the January 2022 IPC Committee with a request for each Division to provide a timeline and action plan to address and improve compliance at the next meeting in March 2022.
- **Hand hygiene and PPE compliance** is below expected standard in ward areas. A refocus on IPC Compliance with “Back to Basics” approach will be adopted to support improved compliance and ownership.
- **No recent data of in-patient compliance of wearing masks**. Ward and Department staff continue to encourage in-patient mask wearing, unless medically exempt. Plan to re audit Mask wearing by patients.

Link to strategy

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

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

Financial implications
Some actions will require significant financial resource to implement fully e.g., 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 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.

Recommendation(s)
Please acknowledge the key points in this paper and continue to support the implementation of actions required to enable compliance with national guidance and reduce hospital onset COVID-19 infection.
IPC BAF Framework (last updated 21 March 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**
Systems and processes are in place to ensure: A respiratory season/winter plan is in place: ▪ that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe	▪ Pandemic Plan in place. ▪ POCT in Emergency Care Centre (ECC). ▪ All patients attending ECC are screened for COVID-19 on registration with a risk assessment completed. Symptomatic and	None	N/A

management according to local needs, prevalence, and care services • to enable appropriate segregation of cases depending on the pathogen. ▪ plan for and manage increasing case numbers where they occur. ▪ a multidisciplinary team approach is adopted with hospital leadership, estates and facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan.	asymptomatic patients are segregated at this point. ▪ All patients requiring admission undergo a LAMP test as well as PCR. ▪ Patients who are admitted straight to wards are tested on admission. ▪ Triaging to COVID-19 status: Positive/ Negative. ▪ **March 2022:** Local application of care pathways in line with UKHSA COVID-19 Guidance: *Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022*. Updated 15.3.2022. ▪ Amber site status in operation during Omicron wave in response to capacity and demand. ▪ Segregation of patients enabled through care pathways: Blue: Positive. Amber status, Contact and Post 14 days isolation/ COVID-19 recovered. ▪ Flowchart for respiratory pathways ▪ **January 2022:** Additional bed capacity created during January 2022 at Leigh site: Jean Heyes, Community Assessment Unit (ECC pressures/ flow), Wrightington Ward A, and Designated setting: Alexandra Court/ Intermediate care. ▪ **January 2022:** Alexandra Court SOP developed and updated as care pathways changed in response to demand. Collaboration between CCG, Trust and Local Authority colleagues.		

	▪ Collaboration: IPC Team supports Bed Managers at Bed Meetings. ▪ Regular communications three per day ▪ Discussions re patient placement: IPC/ Microbiology/ Operations Team ▪ Outbreak Meetings attended by: IPC/ Microbiology, Ward Sisters/ Matrons/ Nursing staff/ Domestic Services/ Bed/ Ops Managers. ▪ **February 2022:** UKHSA Guidance: *Management of staff and exposed patients or residents in health and social care settings.* ▪ **February 2022: Flowchart and checklist** developed and enabled early isolation for COVID-19 positive patients remaining in hospital. ▪ **15 March 2022: UKHSA updated:** *COVID-19 Guidance: Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022.*		
Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	▪ Estates and Facilities support secure workplace requirements, room capacity limits with signage. This continues and remains in place, supported by the IPC Team. ▪ The IPC Audit programme includes COVID-19 safe measures as a standard/ criterion. ▪ Home working arrangements continue within the Trust as aligned with agreed working arrangements.	**January 2022:** The IPC Audit Programme was modified in response to the Omicron wave which resulted in increasing demand on capacity of the IPC Team in response to increasing COVID-19 cases within a background of staffing vacancies within the Team.	Resource and investment within the Trust IPC Service. A full Business case is being developed with an aim to secure resource and investment for the IPC Service. **March 2022:** Recruitment to Band 7 IPC Lead Nurse: Post advertised.

		March 2022: The currently presenting increase in positive COVID-19 cases within the Trust suggests a return to increasing demand on bed capacity and will impact the response required by the IPC Team. The audit programme may require a further pause.	Band 8a Acting-up role continues, until funding secured to full time, permanent arrangement. CCG Seconded role continues.
Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: ▪ based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area. ▪ applied in order and include elimination; substitution, engineering, administration and PPE/RPE. ▪ communicated to staff.	▪ Risk manager has reviewed and advised on risk assessments with respect of IPC risks. ▪ Risks are reviewed at Trust Risk Management Group. ▪ **December 21:** Estates have completed a review of ventilation at all sites with the exception of a small area at the Leigh site. The report has highlighted there is a heavy reliance on natural ventilation particularly at the RAEI site. ▪ **December 21:** Window opening capacity has been increased at the Wigan site within safety limitations. ▪ Measures consistent with the hierarchy of control measures are consistently reviewed in line with current UKHSA	Secured working arrangement for mask exempt staff to return to workplace whilst maintaining the safety of the individual, patients, staff colleagues and visitors.	**March 2022:** Specific options and arrangements for mask exempt staff are being investigated and reviewed in collaboration with OH, HR and IPC.

	Guidance, with regards to ventilation as indicated above and in **Section 2.** ▪ Management of staff and exposed patients or residents in health and social care settings: Staff isolation, management of outbreaks in line with UKHSA guidance and Trust Policies and SOPs. ▪ PPE/ RPE requirements in line with Trust Policies and SOPs. ▪ During Outbreak and Bay closures additional recommendations for the use of FFP3 masks by staff in the areas (not just during aerosol generating procedures and in high-risk areas). ▪ If staff are not fit tested for FFP3 masks, a fit test can be requested directly with the Fit Test trainers for immediate action. ▪ Collaboration between Health and Safety and IPC Team: Review of PPR/ RPE training and compliance. ▪ Collaboration between Occupational Health (OH), Human Resources (HR) and IPC with regards to mask exempt staff and safe working arrangements. ▪ DDIPC is on circulation list for updates from UKHSA and attends GM and NW IPC meetings and relevant webinars. ▪ All new guidance is acted upon in a timely manner. Where necessary SOPs are updated. ▪ Changes are communicated through the IPC team, newsletters and Divisional leads and meetings. ▪ **January to March 2022:** Gold and Silver Command meetings		

	▪ **March 2022:** Meetings/ discussion with OH, HR and IPC are reviewing specific options and arrangements for mask exempt staff to return to workplace whilst maintaining the safety of the individual, patients, staff colleagues and visitors. ▪ Review of current National guidance, surveillance and audit activity by the Trust IPC Team including Microbiologist in respect of infection prevalence and new variants of concern. ▪ Regular communications to staff. ▪ 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. ▪ Regular global communications shared with all staff.		
Safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	▪ Trust Risk Assessment tools approved through Trust Governance process ▪ 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.	None	N/A

	▪ DIPC presents to the Board through the performance report or specific agenda items. ▪ IPC Committee and Quality and Safety committee review quarterly IPC reports. ▪		
If the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems.	▪ **December 2022:** Amber status approach adopted by the Organisation from 29.12.2021 continues to date. ▪ **January 2022:** UKHSA Guidance: *Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022.* The removal of the 3 COVID-19 specific care pathways (high, medium, and low) in response to stakeholder feedback to facilitated local application of the guidance by organisations/employers. Care pathways defined locally: Amber status. ▪ **January 2022:** GM NHSE/ NHSI Guidance (v3 1.2022): *Decision making support tool for managing COVID-19 contacts and closed wards/ bays during times of extreme bed pressure.* ▪ **March 2022:** Trust process continues with specific pathways from point of entry segregation and testing: On identification of positive result, patients transferred to a positive ward. ▪ Contact patients are identified, and isolation period maintained in line with current UKHSA guidance. ▪ Outbreaks are identified and declared in line with guidance definition and managed	None	N/A

	in line with national guidance, Trust Policies and SOPs. ▪ Bay closures in operation with criteria as above for positive and contact patients. ▪ Routine swabbing to identify COVID-19 status and support appropriate patient management.		
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 respiratory infectious agents.	▪ Trust Risk Assessment tools approved through Trust Governance process. ▪ Risk assessments completed by Ward Leaders/ Managers. ▪ Support available: IPC Team, Health and Safety, Occupational Health, Risk Managers, Governance Team, Senior Team.	None	N/A
If an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	▪ FFP3 face masks worn in COVID-19 Positive areas, High risk areas, areas experiencing Outbreaks and where AGP procedures are undertaken. ▪ Programme of FFP3 mask fit training in operation within the Trust.	None	N/A
Ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.	▪ This is adopted whenever possible and practicable in conjunction with IPC, Bed Management and Operations Teams. ▪ Microbiology results are obtained and documented in HIS before patients are moved to designated COVID negative or positive wards. ▪ The process to limit movement of the patient contacts of a positive case, during the isolation period continues to operate. ▪ An IPC Team member attends the daily bed meetings to support appropriate patient placement.	None	N/A

The Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases	▪ The IPC Team review and validate data for all reported hospital onset COVID-19 infections (HOCI) cases in collaboration with Business Intelligence and electronic systems: HIS. Data is received by Senior Team/ DIPC/CN/ MD. ▪ **March 2022:** Case of Influenza A reported to Senior Team/ Medical Team.	None	N/A
There are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.	▪ **February and March 2022:** 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 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.	None	N/A
Resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	▪ IPC Audit Programme for all aspects of IPC Practice, standard IPC precautions, COVID-19 safe measures. ▪ Audit visits include all staff working within area at time of audit. inclusive of permanent, agency and external contractors. ▪ **January 2022:** The IPC Team targeted audit activity due to the impact of the Omicron variant and the presenting outbreaks and bay closures. ▪ Action plans are developed, and supportive learning opportunities provided	The demand on the IPC workforce has increased on the background of depleted team capacity and the continuing COVID-19 Pandemic, and the impact of the emerging Omicron variant.	Resource and investment within the Trust IPC Service

	in collaboration with the ward leaders and the IPC Team. ▪ **March 2022:** Routine COVID-19 Swabbing audit undertaken by all ward areas with reported Outbreaks and Bay closures. Audits completed by ward staff. Plan to extend swabbing audit to all ward areas.		
The application of IPC practices within this guidance is monitored, e.g., ▪ Hand hygiene ▪ PPE donning and doffing training ▪ Cleaning and decontamination	▪ IPC Audit Programme includes hand hygiene, PPE practice and cleanliness of equipment and the environment. ▪ The audit findings and action plans are reviewed at the IPC Committee bi-monthly. ▪ Divisional, service and ward ownership is expected and supported and reinforced through the IPC Committee. ▪ Opportunistic and reactive audits are completed with outbreak or bay closure areas. ▪ **March 2022:** Review of hand hygiene and PPE audit tools with plan to pilot on specific ward areas. ▪ Cleaning Audits are also completed by Estates and Facilities in line with the National Cleaning Standards: **See Section 2** ▪ **March 2022:** Audits of Trust medical equipment including Mattresses, pillows and beds.	None	N/A
The IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.	▪ The IPC BAF has been reviewed consistently to date, last reporting period to December 2021. ▪ Reviewed with opportunity for discussion at Executive/ Board Meetings. ▪ Report presented by DIPC.	None	N/A

The Trust Board has oversight of ongoing outbreaks and 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. ▪ 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.	None	N/A
The Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	▪ 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.	None	N/A
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: ▪ The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness (NSHC) 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/rooms	All clinical rooms have been designated as meeting the revised changes to the standards of Health care cleanliness. The Bed Management Team communicate and identify functionality of areas and patient 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 in all clinical areas.	Currently the Trust are not monitoring non-clinical areas	The Trust board has approved a 2nd wave of recruitment to undertake the cleaning and monitoring of non-clinical areas in 2022/23
Increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.	All clinical areas have been revised within the cleaning frequencies incorporating the increased standard of cleanliness	None	N/A
Where patients with respiratory infections are cared for: cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance.	All clinical areas are cleaned with 1000 ppm chlorine-based product (SoChlor), this is in line with current UKHSA/ NHSE guidance.	None	N/A
If an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.	Whilst there is no deviation from cleaning with chlorine the domestic service and IPC have a strong partnership and work together with the implementation of new products and chemicals through the cleaning services forum.	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
A minimum of twice daily cleaning of: ▪ Patient isolation rooms ▪ Cohort areas ▪ Donning & doffing areas ▪ 'Frequently touched' surfaces (FTS) e.g., door/toilet handles, patient call bells, over bed tables and bed rails ▪ Where there may be higher environmental contamination rates, including, toilets/	The Trust has a 2nd clean process for all wards and clinical areas incorporating Frequently Touched Surfaces (FTS and toilets in addition to the standard daily clean.	None	N/A

commodes particularly if patients have diarrhoea.			
A terminal/deep clean of inpatient rooms is carried out: ▪ Following resolutions of symptoms and removal of precautions. ▪ When vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens). ▪ Following an AGP if room 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 infectious patient areas. ▪ Disposable curtains where applicable are replaced as part of this process. ▪ Hydrogen Peroxide Vapour (HPV) Decontamination Cleaning (Bioquell) process is also undertaken when applicable.	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 by nursing 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: FR1 – Weekly. FR2 – Monthly. FR3/FR4 – Monthly	None	N/A
As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult inpatient facilities	▪ The NHS does not routinely undertake any annual verification exercises on general ventilation systems. ▪ The HTM 03-01 DH refers to the requirement for annual verification for specialised ventilation systems such as Operating Theatres etc only.	As previously identified, large parts of RAEI clinical areas are not mechanically ventilated. This includes the following patient ward areas; Astley, Standish, Swinley, and Langtree	Across most of the patient areas at RAEI, the window openings have been increased from 100mm to 200mm in order to increase natural ventilation.

	▪ However, Estates and Facilities at WWL have evaluated ventilation across the Trust and especially RAEI.	and Maternity area. Additionally, parts of Orrell and Winstanley are NOT mechanically ventilated.	*NHS mandatory window opening restriction is 100mm – this rule restricts natural ventilation in buildings that are designed to be naturally ventilated?
The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer.	▪ **December 21:** Estates and Facilities Team completed a review of ventilation at all sites, with the exception of, a small area at the Leigh site. ▪ A report, written by the Head of Operational Estates highlighted a heavy reliance on natural ventilation, particularly at the RAEI site. ▪ **March 2022:** The report has been submitted to the Ventilation and Water Group (VWG) and the IPC Committee.	Most areas have been identified as being adequately mechanically ventilated, or natural ventilation has been improved. Some limited small areas may still have poor ventilation.	N/A
A systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	▪ Respiratory care area pathways are usually via the Emergency Floor into Covid wards, escalating to Winstanley/ Ince with further escalation to ICU/ HDU. Some patient areas including parts of Winstanley Ward (Respiratory - CPAP/ BiPAP) are NOT mechanically ventilated.	The VWG is not aware of any ventilation consideration when determining respiratory pathways.	The VWG could be asked to provide as assessment of ventilation when determining patient pathways.
Where possible air is diluted by natural ventilation by opening windows and doors where appropriate	▪ Across the majority of the patient areas at RAEI (both mechanically ventilated and naturally ventilated), the window openings have been increased from 100mm to 200mm in order to increase natural ventilation. ▪ December 21: Window opening capacity was increased at the Wigan site within safety limitations. ▪ Where mechanical ventilation is not	Some limited small areas may still have poor ventilation.	Window open capacity has been increased at the Wigan site within safety limitations.

	available, managers have been advised to encourage the dilution of air by opening windows.		
Where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.	RAEI and Leigh Endoscopy utilise Filtex AC-1500 HEPA and UV filtration "air scrubbers". SunWeb S-400 smaller "air scrubbers" were trialled on Winstanley Ward but the trial was stopped at the request of local staff.	Widely recognised standards have not been developed. A variety of products are available. CIBSE recommend either HEPA or UV but not both.	N/A
When considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	Estates within Estates and Facilities manages requests for partitions, with the majority of screens/ partitions erected much earlier in the Pandemic. Once installed the Estates and Facilities Domestic Teams clean the screens in line with current cleaning schedules in line with NSHC.	None	N/A
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: ▪ Arrangements for antimicrobial stewardship are maintained	▪ Remote antimicrobial ward rounds were performed by the Clinical Pharmacist from January 2022. ▪ Antimicrobial ward rounds performed within Critical Care by Clinical Pharmacist from January 2022. ▪ Data collected on each intervention and feedback given. ▪ Antimicrobial Pharmacist continues to review prescribing and new guidance as appropriate. ▪ Antimicrobial audit programme. ▪ Antibiotic audits completed on wards following each reported CDT case in line with Saving lives guidance and repeated if	**January 2022:** Microbiologist/ IPC Doctor left the Trust and not permanently replaced at time of reporting. **March 2022:** Second Microbiologist has left the Trust and not permanently replaced at time of reporting.	Two locum Microbiologist's are currently providing a specific/ limited remit, via virtual/ remote service arrangement in the interim period. Recruitment of new/ Microbiologist discussed at Senior Meeting (Risk Management Group).

	<95% scored. ▪ **January 2022:** Microbiologist/ IPC Doctor has left the Trust ▪ **March 2022:** Second Microbiologist has left the Trust ▪ **March 2022:** Two Locum Microbiologists recruited, providing remote/ virtual support 5 days per week with a specific/ limited remit.		
Previous antimicrobial history is considered	▪ Data available via HIS ▪ Clinical Pharmacist in post to support reviews	None	N/A
The use of antimicrobials is managed and monitored: ▪ To reduce inappropriate prescribing. ▪ To ensure patients with infections are treated promptly with correct antibiotic.	▪ Data available via HIS ▪ Clinical Pharmacist and two locum Microbiologist's in post to support review ▪ **March 2022:** Two Locum Microbiologists recruited, providing remote/ virtual support 5 days per week with a specific/ limited remit. ▪ Programme of Antibiotic Point Prevalence Audits by Medicines Management Team	**January 2022:** Microbiologist/ IPC Doctor left the Trust and not permanently replaced at time of reporting. **March 2022:** Second Microbiologist has left the Trust and not permanently replaced at time of reporting.	Two locum Microbiologist's are currently providing a specific/ limited remit, via virtual/ remote service arrangement in the interim period. Recruitment of new/ Microbiologist discussed at Senior Meeting (Risk Management Group)
Mandatory reporting requirements are adhered to, and boards continue to maintain oversight	▪ Mandatory reporting through the Board performance report. ▪ Mandatory reporting through the quarterly IPC paper to Quality and Safety Committee. ▪ Monthly reporting through Divisional Quality Assurance Groups.	None	N/A
Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	▪ Microbiology support supported risk assessment until left the Trust. Limited support available at time of report: March	**January 2022:** Microbiologist/ IPC Doctor has left the	Two locum Microbiologist's are currently providing a

	2022. ▪ Clinical Pharmacist in post to support reviews	Trust and not replaced at time of reporting. **March 2022:** Second Microbiologist has left the Trust and not replaced at time of reporting.	specific/ limited remit, via virtual/ remote service arrangement in the interim period. Recruitment of new/ Microbiologist discussed at Senior Meeting (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: ▪ 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	▪ Visiting suspended during December 2021. ▪ Specific visiting continued during the visiting pause and included: End of Life, Paediatrics and Maternity. ▪ Visiting recommenced in **February 2022**, enabling one visitor. ▪ Trust Visiting SOP and information leaflet. ▪ **March 2022:** Review of NHS Guidance: *Visiting healthcare inpatient settings while COVID-19 is in general circulation: principles.* ***8 March 2022**. Version 4.* ▪ Communications of process to staff, patients, and visitors.	None	N/A
National guidance on visiting patients in a care setting is implemented.	▪ Visiting in operation: **February 2022**. ▪ Trust Visiting SOP and information leaflet.	None	N/A
Restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	▪ Visiting is suspended during a declared outbreak and/ or bay closure, with exceptions of End of Life, Paediatrics and Maternity. ▪ Risk assessment may enable consideration to other visiting arrangements in specific/	None	N/A

	individual circumstances. ▪ Visiting suspended during December 2021. ▪ Visiting recommenced in **February 2022** enabling one visitor.		
There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing.	▪ Information and signage present and visible throughout Trust site areas. ▪ Trust Visiting SOP and Visitor information leaflet available.	None	N/A
If visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.	▪ Local Trust SOP/ Policy aligned with National UKHSA/ NHSE guidance. ▪ All changes communicated through Divisional Teams and via COVID-19 communications. ▪ Visitor disclaimer, Decision tree and IPC requirements available within SOP. ▪ December 21: Patient visiting was suspended for 14 days due to Outbreak and Bay closures. Reviewed and the decision taken to pause visiting with the exception of End of Life, Paediatrics and Maternity. ▪ Visitor information provided by ward and clinical staff. ▪ Visiting recommenced in **February 2022** enabling one visitor.	None	N/A
Visitors with respiratory symptoms should not be permitted to enter a care area. However, if 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 wherever possible.	▪ Processes in place adopting UKHSA/ NHSE Guidance. Mitigation includes pre-booked visits. Triage questions/ safe measures, excluding symptomatic visitors. ▪ Trust Visiting SOP and information leaflet aligned with the current UKHSA/ NHSE guidance. ▪ Entry to wards is via swipe which restricts unauthorised access. ▪ Visible signage at entry points.	None	N/A

	▪ Individual consideration and risk assessment by care area staff/ clinician		
Visitors are not 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 considered C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	▪ Review of all resources by IPC and Comms. ▪ Several items have been used in internal and external comms. ▪ Toolkit also shared with HR staff.	None	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: ▪ Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	▪ Dedicated COVID-19 tab on landing page of Trust Intranet with divided sections including PPE and IPC. ▪ External website has clear information and advice. ▪ Signage is available at all entry points. ▪ Triage on entry. ▪ Entry to wards is via swipe which restricts unauthorised access. ▪ Entry signage in place for all wards, departments. ▪ Signage includes key instructions, e.g., PPE required, hand hygiene and physical distancing. ▪ Information is displayed at each entrance to prompt patients, visitors, and staff to comply with hands, face, space. ▪ Alcohol hand gel/ mask stations are available at entrances. ▪ Patient leaflets includes information on masks, hand hygiene and physical	None	N/A

	distancing. ▪ Clear signage in EEC indicating triage on entry.		
Infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred.	▪ Infection status is communicated verbally before the patient is transferred and then in writing via a transfer form when the patient is moved. ▪ Discharge to assess process works to rapidly discharge patients to the most appropriate setting with a philosophy of home wherever possible reducing contact with others. ▪ Patients are swabbed 48 hours before discharge to nursing or care home.	None	N/A
Staff are aware of agreed template for screening questions to ask.	▪ Screening questions are available for ward, service, and division staff in line with current UKHSA/ NHSE guidance. ▪ Screening questions in line with UKHSA/ NHSE guidance are included within Visitor SOP and Information leaflet. ▪ HIS core assessment questions are included in the COVID-19 checklist. ▪ Staff encouraged to adopt proactive approach to self-screen/ triage before attending for duty.	None	N/A
Screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment.	▪ Pre attendance screening for elective pathways/ Maternity pathways. ▪ Dedicated COVID-19 tab on landing page of Trust Intranet with divided sections including PPE and IPC. ▪ External website has clear information and advice. ▪ Telephone screening is in place for all elective patients; they are swabbed 3 days prior to admission and asked to self-isolate	Arrangements for Pre-attendance LFD testing of patients will be dependent upon a supply of LFD testing kits to enable testing.	Discussions in progress. Awaiting notification of swabbing process/ LFD supply arrangement from National Team.

	prior to coming in. ▪ SOPs are in place to support guidance. ▪ **March 2022:** Review of updated guidance in progress: *NHSE/ NHSI: UK infection prevention and control (IPC) guidance for elective services.* 11 February 2022.		
Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance.	▪ All patients attending EEC (and other entry sites i.e., Walk-in-Centre) are screened for COVID-19 symptoms on entry. ▪ Patients are assessed at triage (EEC) and COVID-19 tested and subsequently segregated appropriate to pathway and designated ward area. ▪ Fluid Resistant Surgical Masks (FRSM) are available in all clinical areas and at all entrances; staff and visitors continue to be requested to wear masks as they enter the hospital setting. ▪ **December 2021:** Patient flow pathways developed by the Microbiologist and shared within Divisions/ Clinical colleagues, remain in place. ▪ **March 2022:** Updated UKHSA/ NHSE Guidance: *Infection Prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for Winter 2021 to 2022'.* Reviewed and Trust guidance updated.	None	N/A
Triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	▪ Staff within EEC have received specific training in relation to COVID-19 clinical case definition. ▪ Triage questions and COVID-19 checklist assessment within HIS further supports staff in clinical care definition and patient allocation.	None	N/A

	▪ Pathways of care are defined within the Trust Policy/ SOP. ▪ **March 2022:** Updated UKHSA/ NHSE Guidance: *Infection Prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for Winter 2021 to 2022'.* Reviewed and Trust guidance updated. ▪ Patient flow pathways developed by the Microbiologist and shared within Divisions/ Clinical colleagues.		
There is evidence of compliance with routine patient testing protocols in line with Trust approved hierarchies of control risk assessment and approved.	▪ Patients are swabbed on day of admission (day 1) (PCR and LAMP tests), day 4, day 6 and then weekly thereafter. ▪ Reminders on HIS tracking board to alert staff when swabs are due. ▪ Appropriate management and action is taken on receipt of results. ▪ Surveillance of results by IPC Team. ▪ An App is available to report compliance with swabbing and the data reported to IPCC and included in quarterly IPC reports. ▪ **March 2022:** Routine COVID-19 Swabbing audit undertaken by all ward areas with reported Outbreaks and Bay closures. Audits completed by ward staff. Plan to extend swabbing audit to all ward areas.	None	N/A
Patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated.	▪ Patients are asked to wear a mask unless clinically impossible or medically exempt. ▪ Patient mask wearing is encouraged with all patients. ▪ Patients requested to wear a face mask during transportation around the hospital site. ▪ Patient mask wearing is reinforced if	No recent data of in-patient compliance of wearing masks.	Ward and Department staff continue to encourage in-patient mask wearing. Unless medically exempt. Plan to re audit Mask wearing by patients.

	increased incidence/ during outbreak or bay closures. ▪ Department and ward staff advise and encourage patients, unless medically exempt. ▪ There is an information leaflet for patients on masks wearing approved at the IPC Committee. ▪ Compliance was audited in 2021.		
Patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result.	▪ 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. ▪ There is an information leaflet for patients on masks approved at IPC Committee.	**See Criteria 7.** Lack of isolation capacity is a challenge within the Trust with competing priorities for isolation.	**See Criteria 7: Provide Secure adequate isolation facilities.**
Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing.	▪ 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 24/7 (including on-call) to support patient placement decisions.	**See Criteria 7.** Lack of isolation capacity is a challenge within the Trust with competing priorities for isolation.	
Patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered.	▪ 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 24/7 (including on-call) to support patient placement decisions.	**See Criteria 7.** Lack of isolation capacity is a challenge within the Trust with competing priorities for isolation.	

Where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	▪ Clinical assessment to inform decision making. ▪ Virtual consultation option to be considered.	None	N/A
Face masks/coverings are worn by staff and patients in all health and care facilities.	▪ **March 2022:** FRSM are required by all staff, to be worn Universally within all Trust settings in line with current UKHSA guidance. ▪ RPE/ FFP3 masks are required in high-risk areas/ whilst undertaking AGPs and if indicated during COVID-19 outbreaks/ bay closures. ▪ Audit of compliance, reported to and monitored by IPCC. ▪ FRSMs are available in all clinical areas and at all entrances. ▪ Visitors are requested to wear masks as they enter hospital. ▪ Outpatients and visitors are requested to wear at all times, unless exempt. ▪ IPC SOPs includes information on mask wearing.	No recent data of in-patient compliance of wearing masks.	Ward and Department staff continue to encourage in-patient mask wearing. Unless medically exempt. Plan to re audit Mask wearing by patients.
Where infectious respiratory patients are cared for physical distancing remains at 2 metres distance.	▪ Physical distancing has been maintained at 2 metres within the Trust in all settings, with the exception of direct care. ▪ March 2022: Trust SOPs in line with current UKHSA/ NHSE guidance	None	N/A
Patients, visitors, and staff can maintain 1 metre or greater social and physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g., to protect reception staff.	▪ Physical distancing has been maintained at 2 metres within the Trust in all settings, with the exception, of direct care. ▪ Seating rearranged or areas blocked off to ensure segregation. ▪ Floor markings where required. ▪ Trust SOP in line with current UKHSA/ NHSE guidance.	None	N/A

	▪ Staff are not utilising patient entrances in order to reduce footfall. ▪ Screens are in-situ within reception areas. ▪ **March 2022:** Consideration to reducing to 1 metre distancing in low-risk areas/ specific situations i.e., elective programme under consideration in line with NHS/ DH guidance.		
Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly.	▪ Symptomatic patients are re-swabbed and transferred to a symptomatic ward (or isolated dependent upon capacity/ side room availability), whilst awaiting swab result and are transferred depending on results. ▪ Review of contacts are completed. ▪ Patient incident forms completed for all HOCI >8days that includes test and trace requirements. ▪ IPC Team undertake daily tracking to monitor patient transfers and bed moves. ▪ IPC Lead Nurse attends the bed manager meetings every day. ▪ Bay closure spreadsheet is maintained by the IPC Team. ▪ **March 2022:** COVID-19 Routine swabbing audits in progress on wards and actively requested in Outbreak/ Bay closure areas.	None	N/A
Isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative.	▪ Symptomatic patients are re-swabbed and transferred to a symptomatic ward (or isolated dependent upon capacity/ side room availability), whilst awaiting swab result and are transferred depending on results. ▪ Review of contact are completed. ▪ Patient incident forms completed for all	None	N/A

	HOCI >8days that includes test and trace requirements. ▪ IPC Team undertake daily tracking to monitor patient transfers and bed moves. ▪ IPC Lead Nurse attends the bed manager meetings every day. ▪ Bay closure spreadsheet is maintained by the IPC Team.		
Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	▪ Patients are managed in line with UKHSA guidance for symptomatic individuals, swabbed and advised to isolate at home and follow UKHSA guidance until result received. To follow UKHSA guidance in line with result. ▪ Clinical review in line with presenting symptoms/ differential diagnosis. ▪ In line with departmental SOPs, a risk assessment must be undertaken if a symptomatic patient attends a routine appointment. ▪ All COVID departmental SOPs are signed off by IPC.	None	N/A
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: ▪ Appropriate infection prevention education is provided for staff, patients, and visitors.	▪ Mandatory e-learning for all staff. ▪ Environmental risk assessments have been completed at ward and department level. ▪ Where concerns are raised additional bespoke training is undertaken by the relevant individual to ensure staff comply. ▪ COVID-19 safe information available in all clinical areas and at all entrances. ▪ Patients are supported with IPC measures	**January 2022:** A reduction in compliance with Mandatory IPC/ COVID-19 e-learning modules was noted to in Quarter 3.	**January 2022:** Compliance with Mandatory training was reported at the January 2022 IPC Committee with a request for each Division to provide a timeline and action plan to address and

	during hospital attendance/ admission, i.e., hand hygiene, face masks and distancing. ▪ Information leaflet for patients on COVID-19 Safe measures masks approved at IPC Committee.		improve compliance at the next meeting in March 2022.
Training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely.	▪ Mandatory e-learning for all staff. ▪ All mandatory training is recorded through personal passports and electronically through the Trust mandatory training system. ▪ Environmental risk assessments have been completed at ward and department level. ▪ Where concerns are raised additional bespoke training is undertaken by the relevant individual to ensure staff comply. ▪ Mask fit training available for Trust staff as applicable to working environment and risk assessment. ▪ FFP3 mask fit training is organised and managed by the Health and Safety Team. Records held centrally and shared with Divisions. ▪ Information provided to all staff at time of Mask fit test advising fit check on each episode of wearing an FFP3 mask and correct donning and doffing procedure applicable to mask type. ▪ Audit of compliance with PPE practice by ward and IPC Team.	**January 2022:** A reduction in compliance with Mandatory IPC/ COVID-19 e-learning modules was noted to in Quarter 3.	**January 2022:** Compliance with Mandatory training was reported at the January 2022 IPC Committee with a request for each Division to provide a timeline and action plan to address and improve compliance at the next meeting in **March 2022**.
All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it.	▪ Don and doff posters are displayed in all wards and departments. ▪ IPC check posters are present on ward visits.	None	N/A

	▪ IPC advice is available 24/7. ▪ The Professional Practice Team support IPC to carry out classroom training on donning and doffing. ▪ Don and doff guidance is included in the PPE e-learning module. ▪ Specific Mask fit testing and training for individual staff members dependent upon role, work environment and risk assessment.		
Adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	▪ 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. ▪ All key wards PPE compliance is audited at least every 2 months. Results feedback to ward leaders and staff members. ▪ PPE audit results are reported to IPCC, reviewed with action plans as indicated. ▪ Audit results are included within quarterly report to Quality and Safety Committee. ▪ **January 2022:** The compliance with PPE was reiterated to the IPCC group. members for cascade within all Divisions. ▪ Ownership of PPE compliance reinforced and encouraged through IPC Committee and ward level IPC support. ▪ **March 2022:** PPE Compliance reported through IPC Committee. ▪ **March 2022:** Compliance reviewed during Senior Leader Ward visits/ Accreditation	PPE compliance is below expected standard in ward areas.	A refocus on IPC Compliance with “Back to Basics” approach will be adopted to support improved compliance and ownership.

	visits.		
Gloves 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.	▪ Compliance with correct glove use is reviewed, observed, and audited during IPC Team 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 episodes. ▪ IPC support with doffing and donning technique. ▪ Education included within Mandatory e-learning. ▪ **March 2022:** Compliance reviewed during Senior Leader Ward visits/ Accreditation visits.	None	N/A
The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance	▪ There are no hand dryers in any clinical areas at WWL. Where hand dryers were available for the public these have been deactivated and replaced with paper towels. ▪ Hand hygiene training is mandatory. ▪ Monthly hand hygiene audits are completed in all clinical areas and the results are monitored by IPCC. ▪ There is an annual programme of CQC Spot audits for clinical areas monitoring the environment and practice.	None	N/A
Staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	▪ Physical distancing has been maintained at 2 metres within the Trust in all settings, with the exception, of direct care in line with current UKHSA guidance. ▪ **March 2022:** Compliance reviewed during Senior Leader Ward visits/ Accreditation visits.	None	N/A

Staff understand the requirements for uniform laundering where this is not provided for onsite.	▪ Trust Uniform Policy in line with National guidance ▪ **January 2022:** Global communication: Compliance with Uniform Policy reinforced.	None	N/A
All staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance	▪ Regular Trust communications reinforcing UKHSA guidance and Trust Policy/ SOP. ▪ Testing drive through facility for staff testing at Leigh and Wrightington. ▪ Flowchart: Early isolation early following COVID-19 positive result. ▪ Flowchart: Exemption from isolation following COVID-19 Contact. ▪ Staff responsibility for own supply of lateral flow kits for twice weekly testing. ▪ IPC advice and support is available 24/7. ▪ **February 2022:** UKHSA guidance updated: *COVID-19 Management of staff and exposed patients or residents in health and social care settings.* ▪ **March 2022:** Updated UKHSA/ NHSE Guidance: *Infection Prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for Winter 2021 to 2022'.* Reviewed and Trust guidance updated. ▪ **March 2022:** UKHSA guidance: *Living with COVID-19*	**March 2022:** Awaiting National guidance regarding staff LFD swabbing/ testing arrangement and the process for provision and availability of LFD swab supplies (No response as at: 21 March 2022. To note: From **1 April 2022** the government will no longer provide free universal testing for the general public.	**March 2022:** Trust colleagues are linking with Regional/ GM colleagues and groups to source further information. **March 2022:** Internal Trust discussions regarding LFD swab/ process/ supplies arrangements.
To monitor compliance and reporting for asymptomatic staff testing	▪ Organisational process for twice weekly LFD Testing and local system reporting. ▪ Track and Trace reviews by dedicated COVID-19 Test and Trace Team, risk assessments completed and shared with IPC Team. ▪ IPC Team and Test and Trace Team	**January 2022:** Reduced capacity to undertake all Test and Trace assessments with volume of positive results and capacity of Team.	**March 2022:** To consider sources of support for Test and Trace Team.

	worked collaboratively to support the system ▪ Regular communications encouraging. staff engagement. ▪ **January 2022:** All staff are advised and encouraged to LFD testing twice weekly in line with current guidance during Omicron wave. ▪ **March 2022:** Noted small increase in staff COVID-19 positive results. ▪ **March 2022:** Noted decrease in the number of completed Test and Trace assessments for COVID-19 positive staff.	**March 2022:** Awaiting National guidance regarding staff LFD swabbing/ testing arrangement and the process for provision and availability of LFD swab supplies (No response as at: 21 March 2022. **To note: From 1 April 2022 the government will no longer provide free universal testing for the general public.** **March 2022:** Noted small increase in staff reported COVID-19 Positive staff results with no Test and Trace risk assessment completed. **March 2022:** The capacity of Test and Trace provision within the Trust is limited and currently unable to meet the current demand. Compliance with the LFD staff reporting process. The data is	**March 2022:** Trust colleagues are linking with Regional/ GM colleagues and groups to source further information. **March 2022:** Internal Trust discussions regarding LFD swab/ process/ supplies arrangements. Global communications to encourage staff compliance with reporting LFD test results.

		not accurate for the number of staff carrying out twice weekly lateral flow tests.	
There is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	▪ The IPC Team undertake daily surveillance of all reported results, including COVID-19 results from local and PHE/ UKHSA reporting systems. ▪ An electronic laboratory reporting process (Queue) provides the IPCT with timely COVID results. ▪ Surveillance data for patients and staff. ▪ Hospital onset COVID-19 cases (HOCI) are reported via the daily nosocomial sitrep. ▪ Active surveillance for any increased incidence to specific areas/ staff/ patient groups. ▪ An in-house COVID-19 App has been developed that supports the collation, evaluation, and summary of COVID cases. ▪ Wards/ Departments/ Bed Managers and Operations Team to be vigilant for increased patient or staff incidence and encouraged to report staff positive result notifications. ▪ Local UKHSA information on population transmission is circulated to IPC.	None	N/A
Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	▪ Active surveillance by the IPC Team. ▪ Active surveillance for any increased incidence to specific areas/ staff/ patient groups. ▪ Patient investigation templates are completed for patients who test positive for COVID-19 from 8 or more days after	None	N/A

	admission. ▪ Wards/ Departments/ Bed Managers and Operations Team to be vigilant for increased patient or staff incidence and encouraged to report staff positive result notifications. ▪ Local outbreak email cascades sharing information. ▪ If the Outbreak criteria is met, an outbreak is declared and management in line with Trust Policy and SOPs and current UKHSA guidance. ▪ Outbreaks are reported in line with Trust/ Regional Policy, SOPs and process and reported to DIPC and NHSE/ NHSI via App. ▪ Bay closures are reported internally and managed in line with Trust Policies and SOPs. ▪ Daily outbreak meetings are held when necessary and minutes recorded. ▪ StEIS Concise Investigations completed for all reported Outbreaks. ▪ StEIS Concise Investigation reports are reviewed through Trust Governance and Safety Systems with additional external scrutiny.		
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 monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing	▪ Advice and guidance is provided to in-patients within the Trust with mask wearing, providing they can be tolerated and not detrimental to their (physical or mental) care needs.	No current audit data available for patient mask wearing compliance.	Staff monitor compliance at ward level

it can be tolerated and is not detrimental to their (physical or mental) care needs.	▪ IPC measures to continue within all Trust health and care settings including face masks/ coverings for all patients/visitors, Physical distancing, and increased ventilation. ▪ National UKHSA guidance followed. ▪ Trust COVID-19 SOP aligned with National UKHSA guidance.		
Separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients.	▪ Patient pathways according to risk stratification have been defined and included within the Trust COVID-19 SOP which has been disseminated to all clinical teams. ▪ Environmental risk assessments have been completed by wards and departments to establish safe flow of patients and staff. ▪ **December 21:** UKHSA/ NHSE Guidance: Infection Prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for Winter 2021 to 2022'. Reviewed and Trust guidance updated. ▪ Patient flow pathways developed by the Microbiologist and shared within Divisions/ Clinical colleagues.	None	N/A
Patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.	▪ **December 21:** Updated UKHSA/ NHSE Guidance: Infection Prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for Winter 2021 to 2022'. Reviewed and Trust guidance updated. ▪ Patient flow pathways developed by the Microbiologist and shared within Divisions/ Clinical colleagues.	None	N/A

Patients are appropriately placed i.e., infectious patients in isolation or cohorts.	▪ 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. If a confirmed Contact, isolated in side room or bay closure. ▪ Outbreak confirmed and management if meet definition. ▪ 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.	Due to the number of patients with COVID 19 during the Omicron wave, the Trust was not always able to separate pathways. Within the Trust there is limited side room capacity to consistently enable isolation as required.	Amber site status adopted during Omicron wave in response to capacity and demand. Local application of pathways in line with UKHSA/ NHSE Guidance. There is a risk assessment on lack of side rooms. IPC attend bed meetings and support bed managers with decision making and are available 24/7 if required. A Datix is completed if unable to isolate a patient and mitigating IPC actions and measures are implemented to maintain safety. Action to secure isolation continues by Bed management colleagues.
Ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).	▪ All bed spaces have been reviewed by Estates and Facilities. ▪ Physical distancing continues within Office spaces to ensure distancing in line with National guidance for healthcare services is maintained. ▪ Home working arrangements continue	Due to the number of patients with COVID 19 during the Omicron wave, the Trust was not always able to separate pathways.	Amber site status adopted during Omicron wave in response to capacity and demand.

	within services. ▪ Additional review of areas as additional capacity brought on-line within the Trust estate. ▪ All community premises have been reviewed for social distancing and a number of work areas have been designated as no longer in use. ▪ Areas will be reviewed in line with any change to National guidance. ▪ Ward staff are requested to use privacy curtains between beds to minimise close contact where safe to do so. ▪ IPC guidance is available on all ward areas, supported by the IPC Team and reinforced through staff global communications, newsletter, and meetings. ▪ IPC advice continues to support national guidance within healthcare services, Wards, include minimum numbers at staff handovers and meetings, safe break arrangements, advice re car sharing. ▪ Amber site status adopted during Omicron wave in response to capacity and demand. ▪ Collaboration between IPC Team, Operations Team, Bed Managers, and ward staff to inform patient placement. ▪ IPC Lead Nurse attends Bed Management meetings to support decision making. ▪ Outbreak meetings arranged and held during Outbreaks and Bay closures. ▪ IPC environmental checklists completed with every confirmed outbreak.		
Standard infection control precautions (SIPC's) are used at point of care for patients who have been	▪ SICP and COVID-19 safe measures are adopted across the Trust in line with	None	N/A

screened, triaged, and tested and have a negative result	current National UKHSA/ NHSE guidance and aligned with Trust Policy and SOPs.		
The principles of SICPs and TBPs continued to be applied when caring for the deceased	▪ National UKHSA guidance followed. ▪ Trust SOP aligned with National UKHSA guidance.	None	N/A
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: ▪ Testing is undertaken by competent and trained individuals;	▪ The Laboratories used are UKAS accredited.	None	N/A
Patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance;	▪ 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. ▪ The HIS tracking board highlights when patients need re-swabbing in line with National guidance. ▪ System established for antibody testing in line with UKHSA Guidance: *Coronavirus (COVID-19): antibody testing. Last updated 4 November 2021* ▪ System established for carrying out additional testing on vaccinated patients and for identifying patients who may have new variants. ▪ December 21: Identification of the new variant of concern Omicron notified via Regional UKHSA. ▪ **February 2022:** UKHSA guidance updated: *COVID-19 Management of staff and exposed patients or residents in health and*	Current unknown impact and uncertainty of the path the COVID-19 Pandemic will take.	Services to prepare for additional impact on capacity and demand of rising COVID-19 cases. IPC measures, and management resources, guidance and SOPs remain in place to support staff and patient care.

	social care settings. ▪ **March 2022:** Current increase in COVID-19 cases noted impacting on services and capacity. ▪ **23 February 2022:** UKHSA guidance: *Living with COVID-19* ▪ **15 March 2022:** Updated UKHSA/ NHSE Guidance: *Infection Prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for Winter 2021 to 2022'*. Reviewed and Trust guidance updated.		
Staff testing protocols are in place	▪ Local testing systems in place, including rapid testing where indicated. ▪ Testing via National systems also in operation via UKHSA/ gov portal.	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;	▪ App shows turnaround times. ▪ HIS alert if time interval is greater than 24 hours.	None	N/A
There is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data);	▪ National policy is followed. ▪ Patient incident reviews are carried out on all probable and definite hospital onset COVID-19 patients.	None	N/A
Screening for other potential infections takes place;	▪ National policy is followed. ▪ Alert organisms are reported as required on national database and at IPCC and investigated according to National guidance.	None	N/A
That all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission;	▪ All patients tested on admission via LAMP and PCR.	None	N/A
That those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise;	▪ Management in line with Trust COVID-19 SOP. ▪ Patients re-swabbed if symptoms present in line with National guidance and moved	None	N/A

	to a symptomatic ward and to positive ward on confirmation of positive result.		
That emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission	▪ National policy is followed. ▪ An App is in place to monitor compliance. ▪ There are electronic reminders on the HIS tracking board to highlight when swabs are due. ▪ Q3 Audit demonstrated compliance with inpatient COVID-19 swabbing at 89%. ▪ **March 2022:** Routine COVID-19 Swabbing audit undertaken by all ward areas with reported Outbreaks and Bay closures. Audits completed by ward staff. Plan to extend swabbing audit to all ward areas.	None	N/A
That sites with high nosocomial rates should consider testing COVID negative patients daily;	▪ IPC Team consider and review if nosocomial rates high. Swabbing of all patients 3 times per week in an outbreak. ▪ There will be a discussion with Microbiology for any deviation from guidance.	None	N/A
That those being discharged to a care home are tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge;	▪ National UKHSA guidance followed. ▪ Trust COVID-19 SOP aligned with National UKHSA guidance. ▪ **January and February 2022:** Trust DDIPC provided assistance to WBCCG and Wigan Council to develop and review an SOP for use by local Designated care setting in line with UKHSA guidance.	None	N/A
That patients being discharged to a care facility within their 14 day isolation period are discharged to a designated care setting, where they should complete their remaining isolation; as per national guidance	▪ National UKHSA guidance followed. ▪ Trust COVID-19 SOP aligned with National UKHSA guidance. ▪ **January and February 2022:** Trust DDIPC provided assistance to WBCCG and Wigan Council to develop and review an SOP for	None	N/A

	use by local Designated care setting in line with UKHSA guidance. ▪ **February 2022:** UKHSA guidance updated: *COVID-19 Management of staff and residents in health and social care settings.*		
There is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.	▪ National UKHSA guidance followed. ▪ Trust SOPs aligned with National UKHSA guidance. ▪ **March 2022:** Arrangements for elective programme currently under review in line with UKHSA guidance.	None	N/A
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: ▪ The application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	▪ IPC Policies and SOPs are approved at IPCC and are available via the Trust Intranet. ▪ A review process is in operation for the review, update and ratification/ approval of all Policies and SOPs ▪ IPC and microbiology advice is available 24/7 for all Trust staff. ▪ IPC level 1 and 2 e-learning is mandatory in line with national guidance with engagement and completion monitored. ▪ **March 2022:** Review of Policies and SOPs is currently limited due to gap in Microbiology/ IPC Doctor role to support. This applies to all the points below in criteria/ section 9.	**January 2022:** Noted decrease in compliance with COVID-19 and IPC level 2 training during Quarter 3 with the modules scores below the Trust target of 95% during Quarter 3. **January 2022:** Microbiologist/ IPC Doctor left the Trust and not permanently replaced at time of reporting. **March 2022:** Second Microbiologist has left the Trust and not	**January 2022:** This was raised as an Agenda item at the IPC Committee in Jan 2022, with a request for all Divisions to provide a trajectory with a timescale to improve compliance at the next IPCC in March 2022. Two locum Microbiologist's are currently providing a specific/ limited remit, via virtual/ remote service arrangement in the interim period. Recruitment of new/ Microbiologist discussed

		permanently replaced at time of reporting. **March 2022:** Microbiology input required to review Policies and SOPs robustly, specifically with reference to treatment and clinical management of infections.	at Senior Meeting (Risk Management Group)
Staff are supported in adhering to all IPC policies, including those for other alert organisms.	▪ IPC Policies and SOPs are approved at IPCC and are available via the Trust Intranet. ▪ A review process is in operation for the review, update and ratification/ approval of all Policies and SOPs. ▪ IPC and microbiology advice is available 24/7 for all Trust staff. ▪ IPC level 1 and 2, COVID-19 Module e-learning is mandatory in line with national guidance and engagement/ completion monitored.	Operational pressures and increased COVID-19 staff absence/ sickness relating to the Omicron variant have impacted upon compliance with COVID-19 and IPC level 2 training during Quarter 3 with the modules scores below the Trust target of 95% during Quarter 3.	**January 2022:** This was raised as an Agenda item at the IPC Committee in Jan 2022, with a request for all Divisions to provide a trajectory with a timescale to improve compliance.
Safe spaces for staff break areas/changing facilities are provided.	▪ Areas are provided within ward and Service areas. ▪ IPC audits monitor compliance. ▪ Educational messages and organisational communications are cascaded to staff.	None	N/A
Robust 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.	None	N/A

	▪ 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. Theses are reviewed through Trust review and CCG systems/ National reporting systems.		
All clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored, and managed in accordance with current national guidance.	▪ Trust adheres to national guidance and Waste Legislation. This is evidenced within the Trust's Waste Management Policy and Procedures under Category waste. Community staff also follow the Trust's Policies including the national guidance regarding the disposal of COVID-19 PPE within a patient's home environment. ▪ The Clinical Waste Management Module is mandatory for all staff.	None	N/A
PPE stock is appropriately stored and accessible to staff who require it.	▪ PPE is distributed to the wards on a daily basis. The main PPE store is on the RAEI site and is accessible 24/7. Opening times are highlighted in Trust communications. ▪ PPE stores also at Leigh and Wrightington. ▪ In Community settings, PPE store is well stocked and accessible to all teams. ▪ **February 2022:** Transparent Face masks now available to order by the Trust. Communications shared to encourage wards/ services to provide supplies. ▪ **March 2022:** No issues with PPE supplies across the Trust.	None	N/A
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Appropriate systems and processes are in place to ensure: ▪ Staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.	▪ 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 email/ inbox for staff to contact OH Services. ▪ A system of access and response available to all staff, operated by the OH staff team. ▪ 24 hours access to IPC and Microbiology advice and support available to all staff. ▪ A system of access and response available to all staff, operated by the IPC staff team. ▪ Dedicated email/ inbox for staff to contact the IPC Team. ▪ Comprehensive SOPs and Policies available for staff. ▪ Pre-employment/ Recruitment on-boarding 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.	None	N/A
Bank, agency, and locum staff follow the same deployment advice as permanent staff.	▪ The systems and processes as above at point 1 are available to all Bank, Agency, and Locum staff.	None	N/A

Staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance)	▪ **Flowchart: *Ending Isolation Early for COVID-19 Contacts*** available to support staff identified as a COVID-19 Contact to enable ending isolation early to return to work. All local/ internal guidance in line with current UKHSA Guidance. The guidance reviewed and updated in line with any new or update guidance. ▪ Regular internal communications are emailed to all staff (minimum weekly, with increased frequency if indicated). ▪ Support available from IPC and OH Teams. ▪ UKHSA Guidance, Flowcharts, SOPs Policies available via Trust intranet. ▪ Process of review for SOPs and Policies in place within the Trust, updated by IPC Team, Microbiologist's, and IPC Committee.	None	N/A
Staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.	▪ COVID-19 Mandatory training via e-learning, ▪ Education programme delivered by IPC Team, face to face sessions. ▪ Practical education session in donning and doffing PPE (with the exception of RPE/ FFP3) is delivered by the Professional Practice Team. ▪ Opportunistic learning and training during ward/ service area visits ▪ Formal mask fit training programme for Mask fit trainers/ assessors. ▪ Mask fit testing programme in place across the Trust site. ▪ Audit of practice and compliance	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. ▪ Facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce ▪ Lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 ▪ Encourage staff vaccine uptake.	▪ COVID-19 Test and Trace (T+T): National and Local process. Local dedicated T+T Team, with support from IPC and OH Teams. ▪ Staff sickness/ COVID-19 absence monitoring within the Trust, Ward Leaders, Human Resources (HR). Data reported through Trust systems/ E-roster. Results via T+T Teams, IPC Systems and GM reporting systems. ▪ Data systems: Diagnostic codes, statistics, and analysis support reporting (HR and Business intelligence). ▪ Staff sickness/ absence data and impact reported via Silver and Gold Command/ Trust Senior Teams. Outbreak reporting/ IPC Teams. ▪ Access to antiviral treatment 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 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.	None	N/A

	▪ 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 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 national guidance.	▪ 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 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 and severe illness from COVID-19.	▪ 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	None	NA

▪ 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.	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.		
Vaccination and testing policies are in place as advised by occupational health/public health.	▪ Trust Vaccination Policy in line with national guidance. Available to all Trust staff. ▪ Dedicated Trust Vaccination Team. ▪ Dedicated T+T Policy in line with national guidance. Available to all Trust staff. ▪ Dedicated T+T Team. ▪ OH, and IPC Teams had greater input with Vaccination and T+T in earlier stages of the Pandemic but as progressed dedicated Vaccination and T+T Teams were developed and continue to date.	None	N/A
Staff required to wear FFP3 reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally/ 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. ▪ All mask fit testers have been trained in line with National legislation. ▪ 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	**March 2022:** Fit testing training records are not fully complete for staff who wear air purifying respirators (PAPR) (mechanical respirators with hood).	**March 2022:** Health and Safety are working with Divisions to identify staff who rely on or choose to wear PAPR to ensure they have all been fully trained.

	and issued to Wards and Departments with instructions for use. ▪ **March 2022:** A list of registered users of Powered air purifying respirators (PARP) is being developed and made available to Divisions for regular review so new starters can be captured. ▪ **March 2022:** Divisions have been provided with a list of compliant staff to review. ▪ **March 2022:** Some Divisions have also undertaken Fit testing of staff to improve local compliance.		
Staff who carry out fit test training are trained and competent to do so;	▪ Fit test training is managed by the Trust Health and Safety (H+S) Team and conducted by staff who have been trained in line with National legislation and are competent to do so. ▪ **March 22:** External contractor provides accredited Fit to Fit tester training to the Trust Face fit testers who then fit test WWLFT employees. ▪ **March 22:** Database of Face Fit Testers maintained by H+S Team. ▪ **March 22:** Refresher training required every 2 years. ▪ **21 March 22:** There are currently **90** trained local mask Fit Testers in key clinical areas across the Trust. 10 of the Fit Testers will require re-training by the end of April 2022.	None	N/A
All staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used;	▪ **March 2022:** 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.	Face fit testing continues but the Central Register of staff tested indicates that not all staff are	Fit test sessions continue to be advertised. Divisions have been provided with a list of compliant staff to review

		tested to a model that is currently in stock.	
A record of the fit test and result is given to and kept by the trainee and centrally within the organisation;	▪ A record of the fit test and the result is given to the staff member and mask fit trainer records on a central database managed by the Health and Safety Team and uploaded onto ESR.	None	N/A
Those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods;	▪ 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.	None	N/A
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.	▪ **March 2022:** 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;	▪ 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	None	NA

	team who oversee staff skill mix, knowledge, and experience.		
A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health;	▪ Documented records of discussions with staff member, Line manager, Occupational Health and HR are held centrally in line with Trust policies.	None	NA
Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board;	▪ Trust Respiratory Protective Equipment Policy in place. ▪ A centrally held mask fit database is maintained by the Health and Safety Team and is available. ▪ **March 2022:** A quarterly compliance report is produced for the Occupational Safety and Health Group, chaired by a member of the Trust Board.	None	N/A
Consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance;	▪ Healthroster system used for nurses which includes Staff risk status. ▪ Medical rotas for medical staff. ▪ Where safe and practicable staff are allocated to segregated areas in response to acuity and dependency of patients and COVID-19 status. ▪ Where safe and practicable staff are allocated to segregated areas during outbreaks of infection/ bay closures. ▪ Staff have been redeployed during the Pandemic in response to care/ service requirements/ to need for escalation of services. ▪ **March 22:** Consideration and planning for the return to the elective programme of care, enabling safe changes to services, in line with a local assessment of risk.	Head of Estates and Facilities has reviewed non-clinical staff allocation, but it was not possible to achieve everywhere.	Some staff do have to move between different areas on a daily basis. This includes circulating staff such as porters and phlebotomists.
Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any	▪ Space planning exercise undertaken at the start of the pandemic.	None	NA

workplace risk(s) are mitigated maximally for everyone;	▪ Maximum staff allowance per room assessments completed and supportive guidance provided to Departmental managers remain in place. ▪ Environmental risk assessments completed. ▪ Compliance in own areas continues to be reinforced and supported by IPC. ▪ **March 22:** National guidance: Living with COVID-19 was published on 23 February 2022 and the UKHSA COVID-19 Guidance updated on 24 February 2022 reinforcing the measures for healthcare services remains unchanged due to the higher risk nature of health care settings. ▪ **March 2022:** Consideration is being given to the return to operational activity balanced against the uncertainty about the path of the Pandemic.		
Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing.	▪ Staff absence is recorded for payroll purposes through e-roster. ▪ Staff are required to report sickness absence to Line managers. ▪ Staff are requested to undertake LFD testing twice weekly and report the results via the Trust reporting system. ▪ Staff continue to have access to COVID-19 swab tests via a Trust drive through facility and home testing. ▪ Expectation that staff source their own supplies of LFD testing kit supplies via the National government portal. **See note**. ▪ COVID-19 Flowcharts are available via the Trust intranet and are frequently communicated to staff.	**March 2022:** Awaiting National guidance regarding staff LFD swabbing/ testing arrangement and the process for provision and availability of LFD swab supplies (No response as at: 21 March 2022. **To note: From 1 April 2022 the government will no longer provide free universal testing for the general public.**	**March 2022:** Trust colleagues are linking with Regional/ GM colleagues and groups to source further information. **March 2022:** Internal Trust discussions regarding LFD swab/ process/ supplies arrangements.

	▪ **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. ▪ Well-being offers remain available to staff members, with pro-active holistic well-being provision through our Steps 4 Wellness and occupational health services. Psychological support programmes remain in place including access to well-being apps, EAP, SOS rooms with trained facilitators, critical incident debriefing and departmental support programmes. ▪ The Trust continues to actively manage and support staff through attendance management procedures. The Strategic HR lead completes a monthly review of all long-term sickness absence cases with HR Business Partners. ▪ The Central Unplanned Absence Team continues to contact staff on first day of absence and support managers through the attendance management process.	**March 2022:** Noted increase in staff reported COVID-19 Positive staff results with no Test and Trace risk assessment completed. **March 2022:** The capacity of Test and Trace provision within the Trust is limited and currently unable to meet the current demand.	
Staff who test positive have adequate information and support to aid their recovery and return to work.	▪ Flow charts based on national guidance outline the processes and time periods to follow and are on intranet. Staff are supported via managers during absence in accordance with all sickness absence. ▪ **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	**March 2022:** Ending isolation early for COVID-19 positive and contact staff will require availability of LFD testing kit supplies. The confirmation of government arrangements from 1 April 2022 are awaited: **See above**.	Staff will have supplies as in place to 31.3.2022. Regional and local discussions taking place, whilst decision awaited.

	have questions around returning to work or being absent due to COVID-19.		

Title of report:	National Staff Survey 2021
Presented to:	Trust Board
On:	06.04.2022
Presented by:	Alison Balson, Director of Workforce
Prepared by:	Dr Angelique Hartwig, Senior Organisational Psychologist; Andy Hayward, OD Practitioner; Martin Ball, OD Facilitator
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Executive summary

This paper outlines the key results of the 2021 National Staff Survey. It compares results with sector organisations along with the WWL's Your Voice report and identifies significant changes and trends over time. The Board are asked to review the findings and support the recommendations.

This year the National Staff Survey has undergone major changes to the reporting structure to yield better alignment of the survey questions to the seven NHS People Promises.

WWL achieved a 29.5% response rate (1,973 respondents) in the survey, one of the lowest in the country. The results from the National Staff Survey revealed that the majority of the People Promise scores are broadly in line with the sector scores for similar Acute and Acute & Community Trusts. The highest scoring People Promise is 'We are compassionate and inclusive' (7.30) and the lowest 'We are always learning' (4.93), with the latter being the only significantly worse People Promise score compared to the sector. Two People Promise scores are significantly better than the sector - 'We are safe and healthy' (6.17) and 'We work flexibly' (6.20). Staff Engagement (7.01) is also in line with scores for similar organisations, ranking 14th out of 68, whilst staff 'Morale' (6.12) is significantly better than in other Trusts and ranks 3rd out of 68 organisations. However, both scores have slightly declined since 2020.

The WWL Way

Divisional breakdowns reveal that two divisions' scores are in line or above organisational average for all themes (Corporate and Specialist services). Divisions scoring below organisational average on all themes include Medicine and Surgery divisions.

At question level, two-thirds of all scores are in the intermediate-60% range of organisations. 46 scores are significantly better than the sector, with five being significantly worse. The lower scores are mainly related to discrimination and appraisals. Where comparable to 2020, the majority of question-level scores have remained broadly static, although there have been nine significant declines including - 'advocacy', 'enough staff to do my job properly', and 'staff coming into work despite not feeling well enough'. There have been significant improvements since 2020 in line management and harassment, bullying and abuse (HBA).

Based on the results, we identified different areas of focus for future improvements. Areas of strength are Staff Engagement and People Promise 6 & 7 including flexible working, teamwork, and line management. Areas of continuous improvement include People Promises 1-4 and Morale with focus on compassionate culture, inclusion, burnout, raising concerns, staff resources, recommendation as a place of work/care, and recognition. People Promise 5 'We are always learning' was identified as an area of concern, including quality of appraisal and development opportunities.

The results have been shared and reviewed by the Staff Engagement Overview Group, Executive Team Meeting, and People Committee. They were also shared with Leaders' Forum, including an interactive session regarding suggestions for improving key areas of focus.

Link to strategy
Linked to the priority themes as part of Our Family, Our Future, Our Focus. The results from the National Staff Survey will inform different work streams, including our Just & Learning Culture work, Wellbeing, and the newly added Learning and Capability Development stream.

Risks associated with this report and proposed mitigations
N/A

Financial implications
N/A

Legal implications
N/A

People implications
The insight gained from the survey will help to support improvements in staff engagement, well-being and organisational culture. There may be broader implications for staff absence, recruitment and retention relating to the success of initiatives undertaken from the survey results.

Wider implications
Organisational culture and staff engagement have further implications on retention of staff, performance, operational delivery and outcomes for patients and the community.

Recommendation(s)

The report has identified a number of recommendations as a result of the survey findings for each area of focus. We will draw on our quarterly Your Voice survey results from April & July 2022 as well as the NSS 2022 to review progress regularly. Divisional action plans will be developed by divisional leads with the support from Staff Engagement team and updated quarterly. Our Family, Our Future, Our Focus remains supported as a key programme of work, with the addition of a fifth pillar regarding learning and development. Finally, feedback regarding response rate will also be acted upon to improve this for future surveys.

For detailed dissemination plan see Page 6.

	Recommendation	Timeline
Staff Engagement We work flexibly We are a team	• Continue with culture and engagement programmes for teams that need bespoke support (i.e., Go Engage, culture programme, stress management programme, leadership development) • Promote offered service and encourage leaders to identify teams who would benefit from team development (requests for team development triaged by SE&OD to appropriate programme – i.e., culture, go engage, leadership development) • Ensure that patient experience data is regularly shared with staff via comms workstream (e.g., all staff team briefs, leaders' forums) to highlight areas which are positive as well as areas to target improvement. Ensure that staff at all levels are involved in improvement work where appropriate.	In place Q1 April Q1
We are compassionate and inclusive	**Equality, diversity, and inclusion** Explore the experiences of discrimination within the trust in collaboration with ED&I lead to unpick issues related to perceived fairness vs formal discrimination on the grounds of protective characteristics; this aligns with the launch of new staff networks in Q1 which will provide opportunity to learn and gain feedback in this space	Q1 and Q2
We are recognised and rewarded	**Recognition** Review and improve current recognition scheme to provide more structured, meaningful recognition for staff via various formal and informal routes (including SEA network in improvement work)	Q1 May
We each have a voice that counts	**Psychological safety and civility** Continue Just and Learning Culture to promote speak-up culture and civility and compassion among colleagues (also available as bitesize modules as part of our leadership development launching in April)	In place
We are safe and healthy	**Wellbeing** Continue offer of wellbeing and psychological support services for staff during recovery (i.e., wellbeing support, psychological support, stress management, In-Reach work, Support Circles etc.)	In place
Morale	**Staff resources and retention** Triangulate NSS data with HR exit interview data to understand reasons for turnover and feed into trust-wide strategy to improve talent attraction and retention	Q1
We are always learning	**Personal development and appraisal** • Develop as fifth pillar of Our Family, Our Future, Our Focus • Review appraisal process, promote Route Plan Appraisal strategy (temporarily paused due to COVID) & provide appraisal training • Review Learning Needs Analysis to facilitate development	Q1 & Q2

Appendices

Appendix A Full Report

The results of the National Staff Survey (NSS) 2021 highlights key areas for WWL to focus on creating improvement strategies, ensuring we can support the needs of our staff better in addition to showcasing areas we can celebrate. The survey reveals a mixture of positive trends and areas which require our attention. It is important to note that although we may score well compared to previous years, or to the sector or YV scores, there is always room for continuous improvement.

The survey ran from 30th September – 26th November 2021. From 6,695 invited staff members, 1,973 completed the questionnaire. WWL achieved a 29.5% response rate in the survey, well below the median response rate for our benchmarking group Acute & Acute Community Trusts (46%). Therefore, it is important to consider that the survey results discussed below may not provide a good representation of the whole workforce as a large proportion of the workforce have not provided their views in the survey. It also suggests that there is more engagement work to be done to encourage survey participation and to make the results of our survey work meaningful for our staff.

This year, the NSS has undergone major changes to the questions and reporting structure. The questions have been aligned with the 7 People Promise themes and two additional engagement factors, Staff Engagement and Morale (see Appendix 1). This report will highlight WWL's scores for these themes for 2021 and additional areas of improvement and interest. The WWL's scores have been benchmarked against our NHS trust sector, including 68 other Acute and Acute & Community Trusts. For ease, the key results from the NSS have been structured using a RAG (red, amber, green) rating to indicate how well WWL are performing against each theme and to highlight areas for improvement.

As WWL routinely carries out our own Your Voice Staff Survey each quarter, we can dovetail a great deal of local feedback with the snapshot taken during the NSS 2021. The NSS results are compared to previous Your Voice (YV) Survey results where appropriate. However, it is important to note that a direct comparison of scores is not possible due to differences in question format, rating scales, and samples strategy.

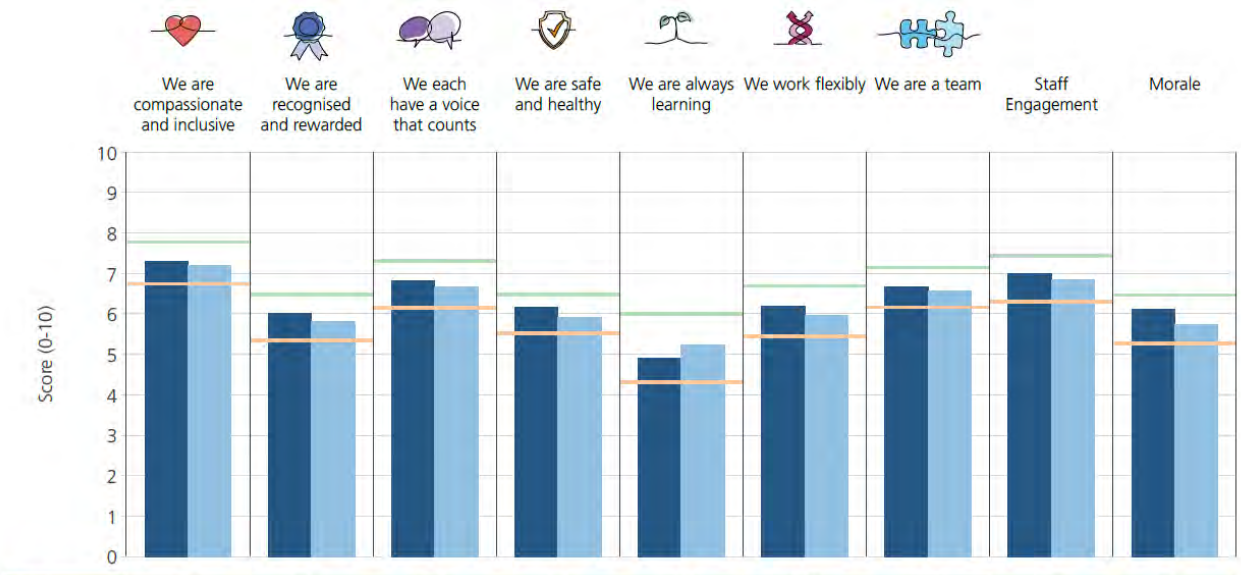
Key People Promises results

The results from the NSS revealed that the majority of the People Promise scores are above national average of the benchmarking group of Acute and Acute & Community trusts and broadly in line with the sector scores for similar organisations.[1] The highest scoring People Promise is 'We are compassionate and inclusive' (7.30)[2] and the lowest 'We are always learning' (4.93), with the latter being the only significantly worse People Promise score compared to the sector. The two People Promises scoring significantly better than the sector, namely 'We are safe and healthy' (6.17) and 'We work flexibly' (6.20) are in the mid-range. Staff Engagement (7.01) is in line with scores for similar organisations (14th out of 68 organisations) and staff 'Morale' (6.12) has yielded the 3rd highest score and is significantly better than in other Trusts in the sector (see Appendix 2 and 3 for overview of comparison with sector and subscore level ranking).

[1] Sector comparison done with Quality Health Acute and Acute & Community sector average = 68 organisations

[2] Scores fall between 0 and 10 on a summary scale

Figure 1. People Promises and Staff Engagement Themes against benchmarking group in 2021 (126 organisations).



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.3	6.0	6.8	6.2	4.9	6.2	6.7	7.0	6.1
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	1,964	1,950	1,948	1,952	1,854	1,935	1,954	1,965	1,966

Directorate level results

The report provides comparisons between the organisational average on each People Promise and six Directorates, including Community, Corporate, Estates & Facilities, Medicine, Specialist Services, and Surgery (see Appendix 4 for charts). Two divisions' scores are mainly in line or higher than organisational average (Corporate and Specialist Services). Conversely, two divisions' scores are below organisational average on all People Promises (Surgery and Medicine). The highest divisional group score is 'We are compassionate and inclusive' at 7.5 in Specialist Services, whilst the lowest divisional group score is 'We are always learning' at 4.2 in Estates & Facilities. In comparison to WWL's Your Voice survey we can see that both Surgery and Medicine continue to score lower than the organisation. Specialist Services scored significantly lower in 4 areas (see Appendix 5 for tables) in the most recent YV survey, the results from the NSS indicate they have improved and score above average on 6/7 areas. Corporate remains one of the top scoring divisions on both surveys. Community and Estates & Facilities scores from the national are broadly in line with scores from YV, with certain factors continuing to score lower for the latter division such as working flexibly. Divisional leads will be asked to review their action plans from the previous YV survey August 2021. Staff engagement team will meet with divisional leads to discuss and support them with the action plans for their divisions.

Key Question-level Results

At question level, two-thirds of all scores are in the intermediate-60% range of organisations. There are 46 scores which are significantly better than the sector, and four scores which are significantly

worse. The lower scores are mainly related to discrimination and appraisals. The Top 10 organisational scores include questions related to experiences of physical violence, discrimination, and harassment, bullying and abuse. However, we would expect reports of these experiences often to be in the lower range (< 10%) compared to many other questions score. Thus, they do not give a good indication of the ranking of questions related to other People Promises. The Bottom 10 scores include mainly questions on quality of appraisals and burnout.

Trends over time

Due to the changes in this year's report, the results only allow us to identify trends over time for specific subscores or questions. Where comparable to 2020, none of the previous subscores have significantly changed and the majority of question-level scores have remained broadly static. Nor Staff Engagement scores or Morale have changed significantly since 2020 and have stayed same or above national average since 2017. There have been significant improvements since 2020 in five questions related to feedback from line management, and harassment, bullying and abuse (HBA). However, there have been nine significant declines including - 'advocacy', 'enough staff to do my job properly', and 'staff coming into work despite not feeling well enough'.

Dissemination and action plans

There are several steps that the Staff Engagement team will take to disseminate the results and to develop local action plans.

- Sharing NSS results report with People Committee (23rd March) and Trust Board (6th April)
- Dissemination NSS headline results in newsletter and Your Voice/ NSS page on the Intranet
- Dissemination of divisional NSS results to divisional leads
- Discussion of NSS results as part of the Leader's Forum in March 2022
- Divisional leads to be asked to review and update local action plans in accordance with results from Your Voice and NSS; Staff engagement team to support them with feeding back results and discussion of action plans
- Share with Staff Engagement Associates, with a focus on what offer and support is available for individuals and teams to access in relation to WWL improvement areas.
- Divisional leads to report back to ETM on updates on their action plans from YV Aug 2021

Areas of focus

For more detailed results, the report identifies key areas of focus using a Red, Amber, and Green (RAG) ranking for more clarity.

Areas of Strength

Staff Engagement

Our overall score for staff engagement is higher than the sector but not significantly (7.01 compared to 6.81). The staff engagement scores are based on sub-scores for "motivation", "involvement" and "advocacy". We highlight the significantly better scoring subscores of this theme below.

Motivation

WWL scored overall significantly better than the sector (7.14 to 6.92). All three questions for this subscore are significantly higher than the sector and in the Top 20% of organisations within the sector:

- I look forward to going to work. 56% to 51%
- I am enthusiastic about my job. 69% to 66%
- Time passes quickly when I am working 76% to 72%. WWL were also significantly higher in this area in 2020 too.

For the first two questions under Motivation had declined from 2019-2020 but were in line with sector. The scores haven't significantly improved locally but are significantly better than the sector this time.

Involvement

WWL scored significantly better in involvement compared to sector (6.91 to 6.71). We scored significantly higher than sector on two of three questions below:

- I am able to make suggestions to improve the work of my team / department 72% to 70%
- I am able to make improvements happen in my area of work 56% to 53% (although the score is better than sector, we aim to further improve in this area)

'We work flexibly' – People Promise 6

For this people promise, WWL scored significantly higher than the sector, 6.20 to 5.95.
There are 2 questions that score significantly better than the sector:

- My organisation is committed to helping me balance my work and home life 48% to 43%
- I achieve a good balance between my work life and my home life 57% and 51%

'We are a team' – People Promise 7

Team working

WWL scored in line with sector scores for the above People Promise measure and

- My team has enough freedom in how to do its work (WWL 61% is significantly better than sector at 57%)
- The team I work in often meets to discuss the teams' effectiveness (not significantly different from sector in 2021, however 3.6% increase since 2020 when WWL had significantly declined from 2019-20 as well as had been lower than sector, this highlights improvements in WWL over the past year)
- 80% of staff report enjoying working in their team

Line management

This sub score of 6.69 is not significant compared to sector at 6.58 however there are some key questions which have scored significantly better than last year:

- Manager asks for opinion before making decisions (this is also significantly better than sector)

- My immediate manager gives me clear feedback on my work (this is now in line with sector as in 2020 we were below)

These improvements over time provide support for the leadership development work that the staff engagement team has been doing to. It is important to note that 21% staff have said they feel pressured by managers to come to work however our score is 4% sig. better than the sector.

Recommendations:

- ❖ Staff engagement team continues to offer a set of culture and engagement programmes for teams that need bespoke support (i.e., Go Engage, culture programme, stress management programme, leadership development)
- ❖ Plans to promote the service and encourage leaders to identify teams who would benefit from team development and team stress support (i.e., via SEA network); requests for team development will be triaged by SE&OD to route through to appropriate programme – i.e.**,** culture, go engage, leadership development**)**
- ❖ Ensure that patient experience data is regularly shared with staff via the comms workstream (e.g., all staff team briefs, leaders forums) to highlight areas which are positive (and should be celebrated) as well as areas to target improvement. Ensure that staff at all levels are involved in improvement work where appropriate.

Areas of Continuous Improvement

'We are compassionate and inclusive' – People Promise 1

WWL's score for People Promise 1 (7.3) is in line with the sector (7.17) and all subscores are similar or sign. better than the sector which include Compassionate Culture (7.22), Diversity and Equality (8.23, sig. better), and Inclusion (6.84). However, there are some subscore trends which require more attention and further improvement.

Compassionate culture

There are some areas of interest within the subscore, with all questions below having significantly declined since 2020.

- Staff who feel their role makes a difference to patients / service users (3.02% decline since 2020)
- Care of patients/ service users is my organisations top priority (3.83% decline since 2020)
- If a friend or relative needed treatment, I would be happy with standard of care provided by organisation (4.32% decline since 2020, 9% since 2019)

Important to note: *For the Friends and Family test question, WWL scored significantly worse than the sector in 2020 and it has been declining in the YV survey for the previous 3 years, from 78% in 2019 to 69% 2021.*

Diversity & Equality, Inclusion

WWL (8.23) scores significantly higher than the sector (8.05) with regards to 'Diversity and Equality' which has remained unchanged since 2020 (see Appendix 7/8 for WRES/WDES data). The 'Inclusion' score is in line with the sector. Some key areas of interest within this measure are as follows:

- Three questions score significantly higher than the sector, including 'my organisation acts fairly with regards to career progression / promotion regardless of protected characteristics' (WWL is 57% compared to the sector at 55%) BUT there is still 43% of staff who do not believe WWL acts fairly in relation to the above question.

- Two questions scores related to discrimination on the ground of 'sexual orientation' and 'anything else' are in the Bottom 20% of organisations in the sector with the latter question scoring significantly worse than the sector (38% compared to 24% of the sector[3]; see Appendix 6 for further breakdown of discrimination trends over past 3 years)

The results on discrimination may indicate that many people feel treated unfairly on the grounds other than protected characteristics which links to perceived fairness in our YV. Whilst there is no direct comparison with this theme to the YV survey, it is important to consider our 'Perceived fairness' scores which have consistently been one of our lowest scoring enablers and is currently 3.11, declined from 3.51 in 2019. People's understanding and experience of formal discrimination and perceived fairness may be ambiguous based on these responses. Further exploration of the issue around discrimination and perceived fairness at our trust is needed.

'We are recognised and rewarded' – People Promise 2

WWL score is in line with the sector for this theme and three questions were significantly better than the sector

- I am satisfied with the recognition I get for good work, 54% to 51%
- I am satisfied with the extent to which my organisation values my work, 44% to 41%
- I am satisfied with my level of pay, 38% to 32%

Even though the scores were significantly better than the sector, the results suggest that approx. half of surveyed staff are not satisfied with the recognition they receive at the trust and feel not valued.

'We each have a voice that counts' – People Promise 3

(links to Staff Engagement, Morale, advocacy)

Overall, WWL score insignificantly better than the sector in this People Promise, scoring 6.83 compared to 6.66.

There are a number of areas that score significantly better than the sector in relation to involvement and autonomy at work:

- I am able to make suggestions to improve the work of my team / department (72% to 73%)
- I am involved in deciding on changes introduced that affect my work area / team / department 52% to 49%
- I am able to make improvements happen in my area of work 56% to 53%
- I am able to make improvements happen in my area of work 57% to 52%. This area also scored significantly higher than our sector in 2022

[3] Percentage based on number of people who reported having experienced discrimination (n = 201 at WWL)

- My organisation acts on concerns raised by patients / service users 73% to 71%
- I am confident that my organisation would address my concern 62% to 58%
- If I spoke up about something that concerned me, I am confident my organisation would address my concern 51% to 48%

An area WWL are scoring lower (insignificantly) compared to sector is 'feeling safe to speak up about concerns in the organisations', this scores 60% compared to sector 61%. Importantly, this has been a significant decline (3.88%) locally compared to our score on the same question for 2020, as well as a declining area in our Your Voice measure "Psychological Safety". Comments in the previous YV Survey contradict the sig. better than sector scores around confidence in concerns being addressed by the organisation, in that staff wouldn't feel confident concerns would be addressed.

'We are safe and healthy' – People Promise 4

WWL (6.17) scored significantly better than the sector (5.88) for People Promise 4 which provides support for the benefits of the investment in health and wellbeing initiatives at our trust. Sub-scores 'Burnout' (5.12) and 'Health and safety climate' (5.63) both also scored significantly higher than the sector, which was 4.81 and 5.21 respectively.

Burnout

Burnout is a new metric for the NSS in 2021, therefore we cannot compare the results to previous data. However, it is important to note that five of WWL's lowest overall scores are related to Burnout, some questions within this measure are as follows:

- I often/ always feel worn out at the end of my working day/shift – 40%
- I often /always find my work emotionally exhausting – 33%
- I often/ always feel burnt out because of my work – 31%

The above figures are however significantly better than the sector. This could be as a result of the investment into health and wellbeing services at WWL, but it is still a high number of staff who are seriously unwell due to the nature of the work and pandemic-related pressures. This also has links to the question regarding 'Presenteeism' and how many staff come to work despite not feeling well enough, where WWL score 56% which is significantly higher than in 2020 (48%). Staff who work additional unpaid hours above contracted hours is significantly lower than the sector for 2021 and 2020 but still indicates that 52% of staff are spending longer at work than contracted. As the survey results are a snapshot in time (November 2021) and we would expect burnout levels to take considerable time for recovery, this will need to be kept under review for the next YV survey.

In relation to the YV survey, our most recent Wellbeing score was 3.22 which had significantly declined from the previous quarter. Two determinants of this measure are 'burnout' and 'energy' which have both been in constant decline and is in line with what staff have said in the NSS.

Health and safety climate

WWL scored significantly better than the sector in four areas under this subscore, this was also the case in 2020.

- I am able to meet all conflicting demands on my time at work (WWL scored 50% compared to sector 43%)
- I have unrealistic time pressures (never/rarely) (WWL scored 29% compared to sector 23%)

- I have adequate materials, supplies and equipment to do my work (WWL scored 62% compared to 55%)
- There are enough staff at this organisation for me to do my job properly (WWL scored 36% compared to sector 26% - however has sig. declined by 6% from WWL 2020 results)

Also, the NSS scores contrast somewhat with previous YV survey results. These show that number of staff who feel they have the adequate materials/ supplies /equipment has declined, albeit insignificantly, and is therefore an area to watch. Similarly, having enough staff to do my job properly has also declined and is currently 2.95 which is a low score. This is also in line with increases in sickness absence levels due to COVID 19 in the year.

One question from this subscore relating to feeling safe to report physical violence scored in the Bottom 20% of organisations (41% did not report it vs 34% of the sector). The same question shows non-significant decline of 7% since 2020 and is 6.7% lower than sector (not sig.). This links to a significant decline in staff feeling safe to speak up since 2020 (see below People Promise 3).

Morale

WWL score is ranking 3rd best and is significantly higher than the sector here, 6.12 to 5.74. The Morale theme score is based on the sub-scores for 'Thinking about leaving', 'Work pressure' and 'Stressors'. It should be noted this contradicts out YV Survey's recent data where morale has declined in the last quarter. To further understand this we can look at staff's intention to leave and work pressure.

Work Pressure

WWL score significantly better than the sector here, 5.6 compared to 5.0. All three questions for this subscore score significantly better than the sector in 2021.

- I am able to meet all the conflicting demands on my time at work 50% to 43%
- I have adequate materials, supplies and equipment to do my work 62% to 55%
- There are enough staff at this organisation for me to do my job properly 36% to 26%

It is important to highlight even though WWL score significantly higher than the sector in feedback for there being enough staff to do my job properly – this is a significant 6% decline of our score from 2020. Equally, our latest YVS feedback/ scores for 'Resources' is low at 2.95. In addition to having enough staff, YVS also asks staff for feedback on having adequate materials and supplies to do their job properly – which scores mid-range at 3.47

An additional area (not linked to any People Promises) to highlight is:

My employer has made adequate adjustment(s) to enable me to carry out my work. This isn't scoring significantly lower to sector (68% to 71%) but has significantly declined by 8.43% compared to WWL's response in 2020 after this question significantly improved by 18% in 2020 from 2019. It may highlight the impact of temporary measures to protect staff from COVID (e.g., staff returning from redeployment or from shielding).

Thinking about leaving

Overall WWL does score better than the sector for this area 6.34 compared to 5.97.

The three questions in this area are all significantly higher than sector, but show no significant changes from our scores in 2020. However, it is important to note all 3 areas had previously sig. declined from 2019 to 2020 and are an area to look out for.

- I often think about leaving this organisation 27% to 32%
- I will probably look for a job at a new organisation in the next 12 months 19% to 23%
- As soon as I can find another job, I will leave this organisation. 13% to 17%

The result suggests that, although WWL is scoring well compared to the sector on Staff Engagement, over a quarter of surveyed staff are often thinking about leaving the organisation, 25% of staff would consider moving to another job within WWL (12%) or another NHS trust (13%), and a further 13% are planning on retiring or taking a career break.

WWL score significantly better than the sector for recommending WWL as a place to work (63% to 59%). However, the WWL's score has **significantly decreased** by 4% since 2020. In addition to this, our YVS shows some non-sig. decline in recommending WWL as a place to work with many staff (33-36%) not recommending WWL as a place to work:

YVS 2021	63.6% would recommend WWL as a place to work
YVS 2020	67% would recommend WWL as a place to work
YVS 2019	66.5% would recommend WWL as a place to work

Recommendations

Equality, Diversity and inclusion

- ED&I lead is working towards supporting the cultural integration of our international nurses and the wider ED&I agenda for the trusts
- ED&I lead has launched FAME and LGBTQIA+ networks to provide staff networks for protected groups and plans for a network of people living with disabilities and long-term conditions are underway
- ED&I lead & OD team to consider exploring the experiences of discrimination within the trust (e.g., via staff networks) to unpick issues related to perceived fairness vs formal discrimination on the grounds of protective characteristics (e.g., listening events, junior doctor diversity and inclusion training etc.)

Wellbeing

- Staff Engagement team continues to offer and promote a range of services to support staff's wellbeing throughout their employee cycle (i.e., wellbeing support, psychological support, stress management, In-Reach work, Support Circles, Redeployment Passport)
- Plans for improving process of triaging teams to offer the most appropriate support to meet teams' needs

Psychological safety and civility:

- Staff engagement team will continue with the culture work to support staff engagement and raise awareness with regards psychological safety, civility and compassionate leadership. WWL's Just and Learning Culture new culture toolkit has been launched as part of the 'Our Family, Our Future, Our Focus' programme of work and signposts to some useful resources for staff and leaders on how to raise concerns, the routes of escalation available and support for leaders in adopting a just and learning approach.
- Launch of bitesize modules on psychological safety and civility as part of our leadership development in April

Recognition

- The current recognition scheme is under review and due to be changed. The aim is to provide a more structured recognition scheme which gives staff opportunities for meaningful recognition by the organisation and their colleagues via various formal and informal routes and to receive appropriate reward for their service.
- Staff Engagement Associate Network (SEA) will be stronger involved in improvement work to provide feedback from and cascade information to staff

Staff resources and retention

- Trust-wide strategy to improve talent attraction and retention by making WWL employer of choice
- Staff Engagement team in collaboration with HR to consider triangulating NSS data with feedback from exit interviews to gain better understanding of staff experience and reasons for leaving

Areas of Concern

'We are always learning' – People Promise 5

WWL scores significantly worse than the sector compared to (4.93 vs. 5.23) for People Promise 5, 'We are always learning'. The subscores that make up the overall measure include Appraisals (3.63, sig. worse) and Development (6.2, not sig.).

The report highlighted that 75% of staff have had an appraisal in the last 12 months, this is significantly lower than the sector (83%) and in the Bottom 20% of the organisations (see for comparison Appendix 10 appraisal compliance data). For those staff who have had an appraisal:

- 18% said it helped to improve how to do their job
- 28% said it helped to agree clear objectives for their work
- 29% said it left them feeling that their work is valued by the organisation

The above questions all scored in the bottom 10 scores for WWL. From the results, it is not clear if the low scores relating to the quality of the appraisal can be attributed to the design of our current appraisal or the missing application.

50% staff feel there are opportunities to develop their career at WWL which is significantly lower than the sector (52%). There is also a significant difference in staff feeling they have opportunities to improve their knowledge and skills, scoring 63% compared to the sector at 66%. This question is also in the Bottom 20% of sector organisation scores (see Appendix 9 for appraisal trend charts). The NSS confirms the observed trend of our staff development scores in that there has been a significant decline in 'Personal development' scores on the Your Voice (YV) survey for the past three years, dropping from 3.62 in October 2019 to 3.46 in August 2021.

Recommendations

Personal development

The NSS has recognised development at WWL, in particular the quality of appraisals, as an underperforming area for some time. In 2019 a full root and branch review was conducted including engagement with colleagues and leaders to understand what would make a meaningful appraisal (Route Plan Conversation). Key feedback from our leaders was they did not have confidence to hold meaningful coaching conversations, resulting in the appraisal feeling transactional and process driven. An extensive package was put in place, however the launch of the Route Plan Appraisal Strategy had to be paused due to COVID-19 in late 2020. This included:

- Updated the appraisal paperwork, including the introduction of a mini-360 feedback tool, titled "tell me what you see" to ensure the conversation and feedback was strengths based and ensured staff felt valued.
- Route Plan Conversation had a big launch, showcasing the new documentation, colleague and leader support guides along with the divisional leads across the organisation to support staff in making the most of their appraisal.
- Divisional Appraisal Leads were identified and trained by Staff Engagement team to drive uptake/ quality of appraisal at a divisional level and to cascade the training to line managers in the division.
- Divisional Super Coaches were identified to support line managers in preparing for an appraisal (e.g., practice holding an appraisal if anxious).

A lot of work has already been completed to meet the feedback from colleagues about the poor quality of their appraisal and from our leaders who felt they lacked confidence to hold meaningful coaching conversations. All documentation and guides are available on the staff intranet and the appraisal workshops have since been incorporated to the Leadership Development Programmes and it is recommended:

1. Review approach if still valid, although may need some updates to the documentation and re-engagement with Divisions / Divisional Appraisal Leads and super coaches (refresher training).
2. Large scale promotion of the Route Plan Appraisal and introduction of an appraisal season (aligned with Comms strategy), highlighting it's purpose / importance to not only focus on development, but it being an opportunity to recognise staff, leave them feeling valued and heard. Promotion at exec level and grass root staff networks driven by staff voice (NSS). Consider accessibility and support for certain staff groups (incl. E&F)
3. Seek ongoing feedback on the effectiveness of appraisals
4. Balance time to complete appraisal with the current Trust Risk around Learning Needs Analysis and budget allocation.
5. Consider plans to digitalise appraisal process for ease and better data gathering across the trust
6. The interconnection between Our family, Our focus, Our Future – Culture Work and Compassionate Leadership development are vital when striving to make improvements in this area. Specifically having a focus on gaining a greater understanding of the importance of Psychological Safety will be key to the success of a successful appraisal strategy.

Appendix B - Report appendices

Appendix 1 – Overview of People Promise themes and subscores

People Promise element	Sub-scores
We are compassionate and inclusive	Compassionate culture Compassionate leadership Diversity and equality Inclusion
We are recognised and rewarded	[No sub-scores]
We each have a voice that counts	Autonomy and control Raising concerns
We are safe and healthy	Health and safety climate Burnout Negative experiences
We are always learning	Development Appraisals
We work flexibly	Support for work-life balance Flexible working
We are a team	Team working Line management
Theme	**Sub-scores**
Staff Engagement	Motivation Involvement Advocacy
Morale	Thinking about leaving Work pressure Stressors

Appendix 2 – Ranked People Promise Subscores

Ranked People Promise Subscores for your organisation

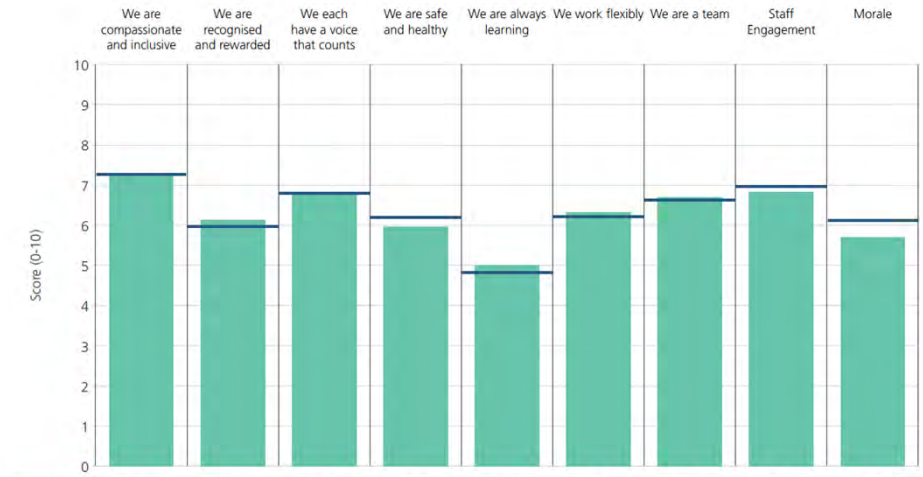
			Score
1	People Promise 1 Subscore 3	We are compassionate and inclusive Diversity and equality	8.23
2	People Promise 4 Subscore 3	We are safe and healthy Negative experiences	7.75
3	People Promise 1 Subscore 1	We are compassionate and inclusive Compassionate culture	7.22
4	People Promise 3 Subscore 1	We each have a voice that counts Autonomy and control	7.06
5	People Promise 1 Subscore 2	We are compassionate and inclusive Compassionate leadership	6.88
6	People Promise 1 Subscore 4	We are compassionate and inclusive Inclusion	6.84
7	People Promise 7 Subscore 2	We are a team Line management	6.69
8	People Promise 7 Subscore 1	We are a team Team working	6.64
9	People Promise 3 Subscore 2	We each have a voice that counts Raising concerns	6.59
10	People Promise 6 Subscore 1	We work flexibly Support for work-life balance	6.27
11	People Promise 5 Subscore 1	We are always learning Development	6.20
12	People Promise 6 Subscore 2	We work flexibly Flexible working	6.14
13	People Promise 4 Subscore 1	We are safe and healthy Health and safety climate	5.63
14	People Promise 4 Subscore 2	We are safe and healthy Burnout	5.12
15	People Promise 5 Subscore 2	We are always learning Appraisals	3.63

Appendix 3 – *People promise scores / themes*

People Promise or Theme	Significance comparison to sector
People Promise 1: We are compassionate and inclusive (not sign.)	1. Compassionate culture – not sign. 2. Compassionate Leadership – not sign., BUT **3/4 indicators sign. +** 3. Diversity and equality – **sign. +** 4. Inclusion (not sign.) – not sign.
People Promise 2: We are recognised and rewarded (not sign.)	1. Recognition for good work – **Sign +** 2. Organisation values work – **Sign +** 3. Satisfied with pay – **Sign +**
People Promise 3: We each have a voice that counts (not sign.)	1. Autonomy and control – not sign., BUT **4/7 indicators sign. +** 2. Raising concerns – not sign., BUT **2/4 indicators sign. +**
People Promise 4: We are safe and healthy **(sign. +)**	1. Health and safety climate – **sign. +** 2. Burnout – **sign. +** 3. Negative experiences – not sign.
People Promise 5: We are always learning **(sign. -)**	1. Development – not sign. & **2/5 indicators sign. -** 2. Appraisals – **sign. - ,** BUT all indicators not sign.
People Promise 6: We work flexibly **(sign. +)**	1. Support for work-life balance – **sign. +** 2. Flexible working – not sign. **BUT indicator sign. +**
People Promise 7: We are a team (not sign.)	1. Teamworking – not sign. **BUT 1/8 indicator sign. +** 2. Line management – not sign. **BUT 1/4 indicator sign. +**
Staff engagement (not sign.)	a. Motivation – **sign. +** b. Involvement – **sign. +** c. Advocacy – not sign. **BUT 1/3 indicator sign. +**
Morale – **sign. +**	a. Thinking about leaving – **sign. +** b. Work pressure – **sign. +** c. Stressors – not sign. **BUT 3/7 indicator sign. +**

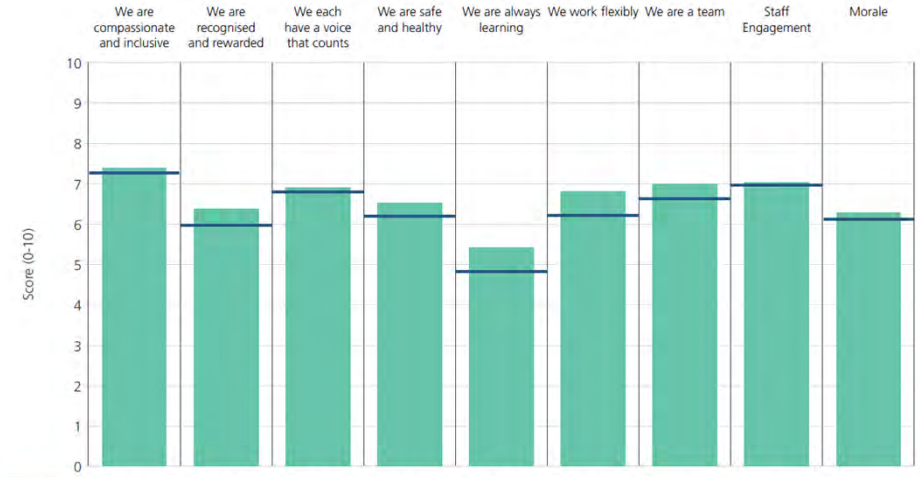
Appendix 4 – Directorate breakdown of People Promises scores

Community



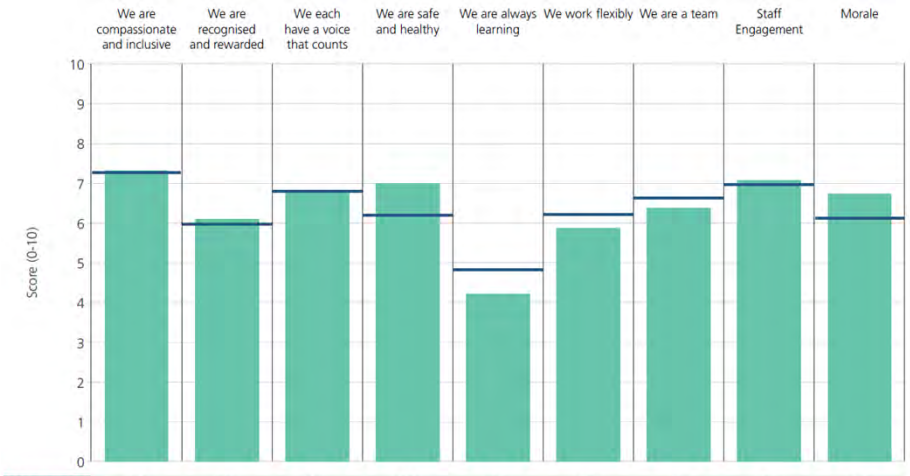
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Directorate	7.3	6.1	6.8	6.0	5.0	6.3	6.7	6.8	5.7
Your org	7.3	6.0	6.8	6.2	4.8	6.2	6.6	7.0	6.1
Responses	252	251	251	251	247	251	252	252	252

Corporate



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Directorate	7.4	6.4	6.9	6.5	5.4	6.8	7.0	7.0	6.3
Your org	7.3	6.0	6.8	6.2	4.8	6.2	6.6	7.0	6.1
Responses	314	312	314	315	306	310	315	315	315

Estates & Facilities

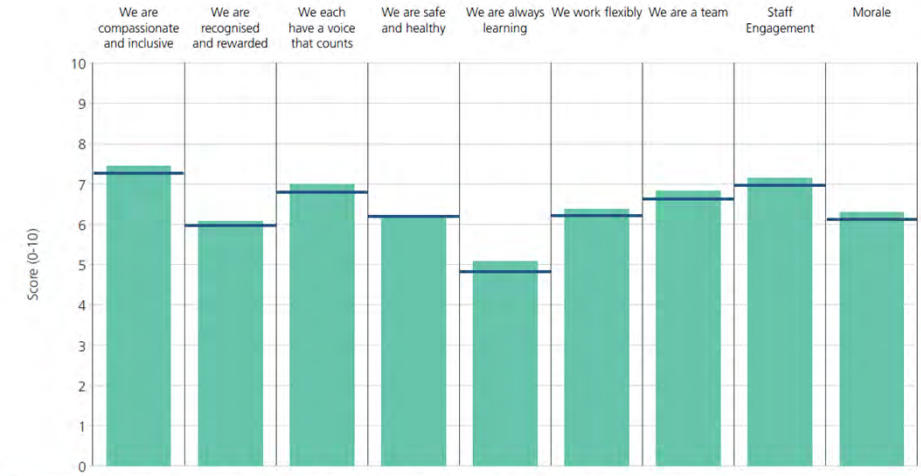


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Directorate	7.3	6.1	6.7	7.0	4.2	5.9	6.4	7.1	6.7
Your org	7.3	6.0	6.8	6.2	4.8	6.2	6.6	7.0	6.1
Responses	195	195	185	193	180	190	194	193	194

Medicine

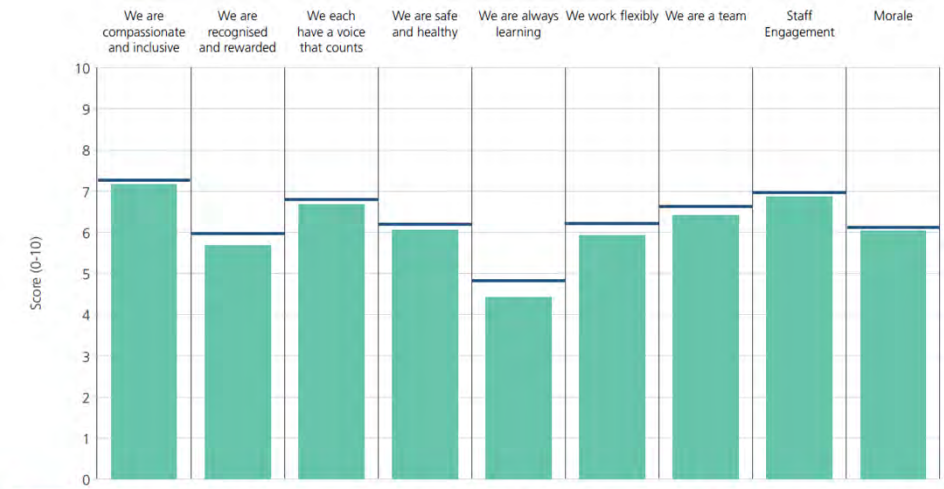
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Directorate	7.1	5.7	6.7	5.7	4.8	6.0	6.5	6.9	5.8
Your org	7.3	6.0	6.8	6.2	4.8	6.2	6.6	7.0	6.1
Responses	332	327	328	329	301	324	331	334	334

Specialist services



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Directorate	7.5	6.1	7.0	6.2	5.1	6.4	6.8	7.1	6.3
Your org	7.3	6.0	6.8	6.2	4.8	6.2	6.6	7.0	6.1
Responses	387	385	387	382	367	381	385	387	387

Surgery



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Directorate	7.2	5.7	6.7	6.1	4.4	5.9	6.4	6.9	6.0
Your org	7.3	6.0	6.8	6.2	4.8	6.2	6.6	7.0	6.1
Responses	484	480	483	482	453	479	477	484	484

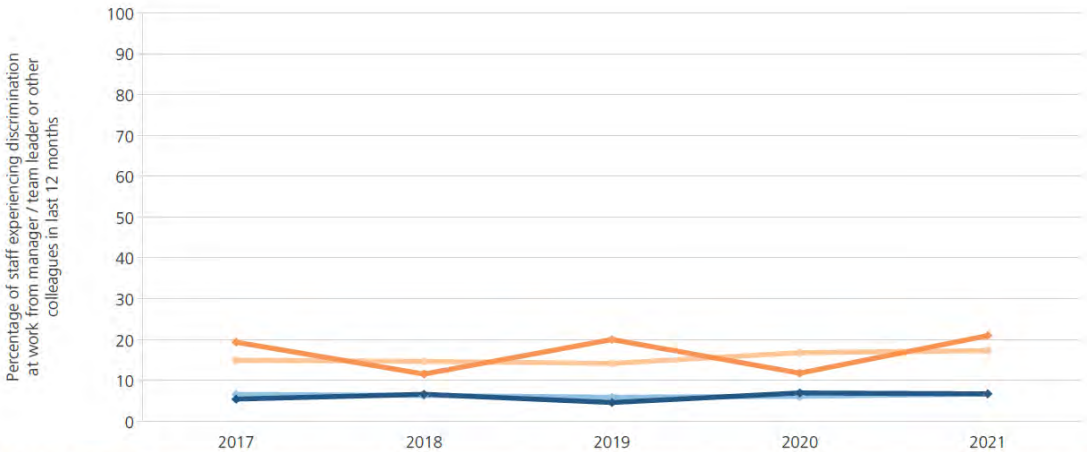
Appendix 5 – Divisional comparison trends

	NSS key data	YV Aug 21 key data
Medicine	Recognition scored 0.3 lower than Organisation score	Recognition was lowest scoring enabler
	'we are safe and healthy' scored 0.5 lower than Organisation	has links to resources, burnout and workload in YV – in line with org. scores for survey
	Morale scored 0.3 lower than Organisation score	overall wellbeing in YV was 3.14 compared to Org average of 3.22
	Flexible working scored 0.2 below Organisation average	Flexible working was significantly lower than Organisation average
Surgery	Scored lower than Organisation average in all areas	Scored significantly lower in recognition, org support, influence and flexible working
	Most notable difference was 0.4 'we are always learning'	Personal development scored 3.47 which was in line with Organisation scores
Specialist Services	Scored higher than Organisation in 6/7 people promise scores	Scored significantly worse in teamwork, resources, influence and overall engagement
	Staff Engagement / Morale score higher than Organisation average	Scored lowest for advocacy – recommend as place to work (60%) Comments of morale being low, linked to redeployment issues
Community	Lower than Organisation average for 'we are safe and healthy'	comparisons to burnout, workload, resources in YV – the latter 2 scoring as the lowest 2 enablers Overall wellbeing in YV was also lower than org average
	Scored slightly lower in 'Staff Engagement' measure	Scored slightly lower for overall Engagement albeit insignificantly
	Morale is lower than Organisation average	Overall wellbeing is lower than Organisation average but not significant
Estates and Facilities	Better by 0.8 compared to org. in 'we are safe and healthy'	YV 'resources' E&F staff scored 3.34 which was a sig decline on previous quarter and year 'Workload' was 3.54 but in line with Org
	'we are always learning' was 0.4 lower than Org. average	YV personal development had decreased to 3.47 and had sig declined from previous quarter
	Scored higher than average in Morale and Staff Engagement	YV Engagement was in line with Org
Corporate	Scored above Org in all NSS areas	Many enablers scored above average across all sub-divisions
	Biggest differences to Org in NSS are in ' we are always learning' and 'we work flexibly'	In YV flexible working is also higher than Org however Personal development is in line

Appendix 6 - Trends of discrimination reports 2019-2021

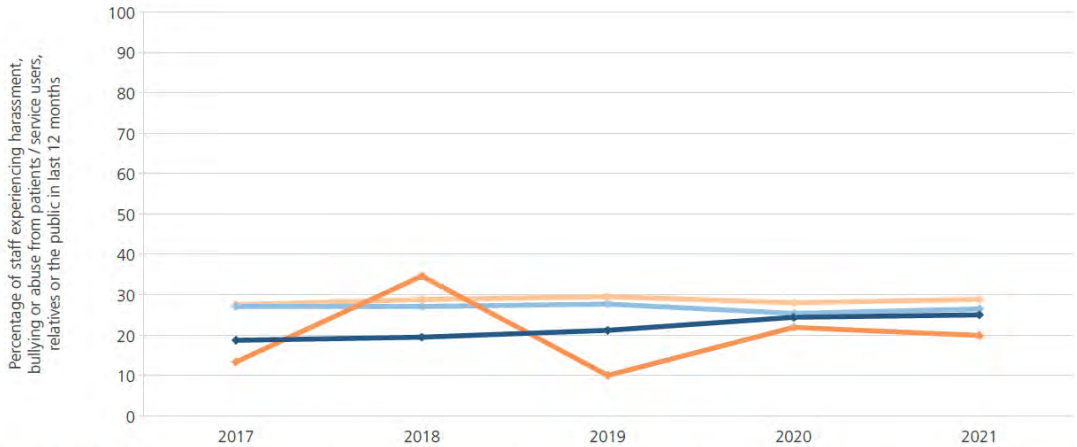
Staff have experienced discrimination based on:	2021		2020		2019	
	WWL	Sector	WWL	Sector	WWL	Sector
sexual orientation	5% (12 people)	4%	5% (8 people)	4%	0%	4%
ethnicity	27% (55 people)	48%	22% (39 people)	50%	21% (6 people)	42%
disabled	8% (16 people)	8%	10% (18 people)	7%	7% (2 people)	7%
anything else	40% (81 people)	24%	39% (68 people)	24%	32% 9 people	25%

Appendix 7 - Workforce Race Equality Standard (WRES)



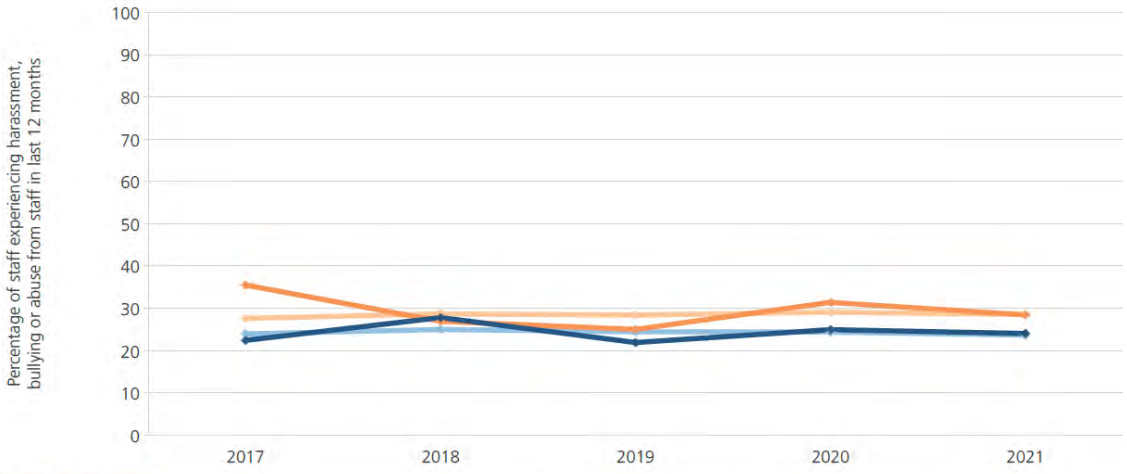
	2017	2018	2019	2020	2021
White: Your org	5.4%	6.6%	4.6%	6.9%	6.7%
BME: Your org	19.4%	11.5%	20.0%	11.8%	20.9%
White: Average	6.6%	6.3%	5.9%	6.1%	6.7%
BME: Average	14.9%	14.6%	14.1%	16.8%	17.3%
White: Responses	388	380	306	1,664	1,736
BME: Responses	31	26	20	136	191

Average calculated as the median for the benchmark group



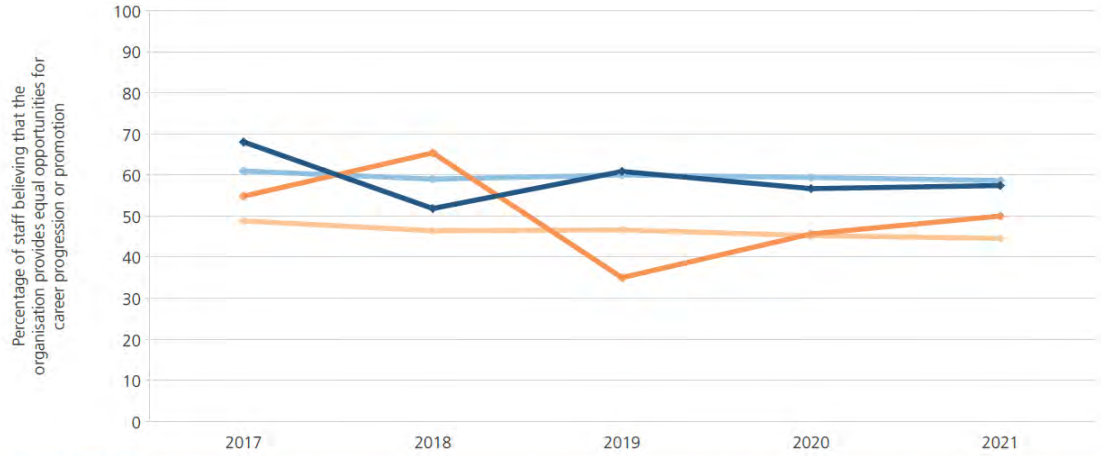
	2017	2018	2019	2020	2021
White: Your org	18.7%	19.5%	21.2%	24.4%	25.0%
BME: Your org	13.3%	34.6%	10.0%	21.9%	19.9%
White: Average	27.1%	27.1%	27.7%	25.4%	26.5%
BME: Average	27.5%	28.8%	29.5%	28.0%	28.8%
White: Responses	385	380	307	1,664	1,736
BME: Responses	30	26	20	137	191

Average calculated as the median for the benchmark group



	2017	2018	2019	2020	2021
White: Your org	22.4%	27.8%	21.9%	24.9%	24.0%
BME: Your org	35.5%	26.9%	25.0%	31.4%	28.4%
White: Average	23.9%	25.0%	24.4%	24.4%	23.6%
BME: Average	27.6%	28.7%	28.4%	29.1%	28.5%
White: Responses	388	385	306	1,668	1,736
BME: Responses	31	26	20	137	190

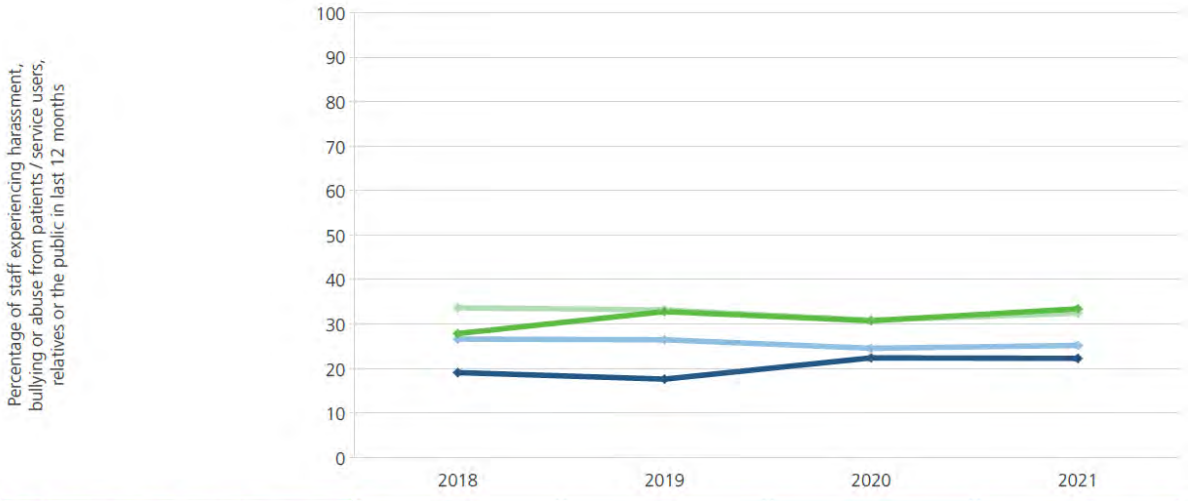
Average calculated as the median for the benchmark group



	2017	2018	2019	2020	2021
White: Your org	68.0%	51.8%	60.9%	56.7%	57.4%
BME: Your org	54.8%	65.4%	35.0%	45.7%	50.0%
White: Average	61.0%	59.0%	60.0%	59.4%	58.6%
BME: Average	48.8%	46.4%	46.6%	45.2%	44.6%
White: Responses	388	382	304	1,678	1,736
BME: Responses	31	26	20	138	190

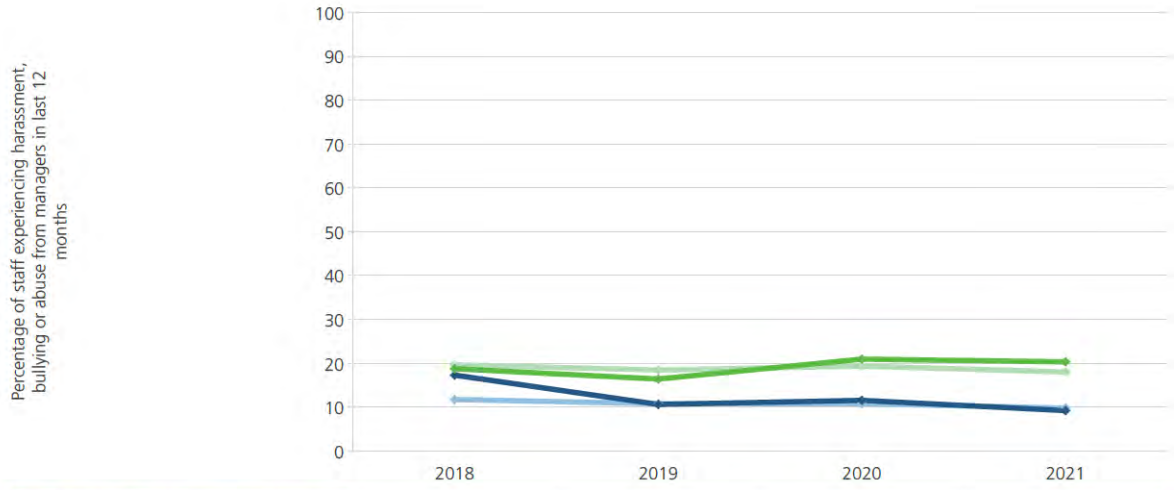
Average calculated as the median for the benchmark group

Appendix 8 - Workforce Disability Equality Standard (WDES)

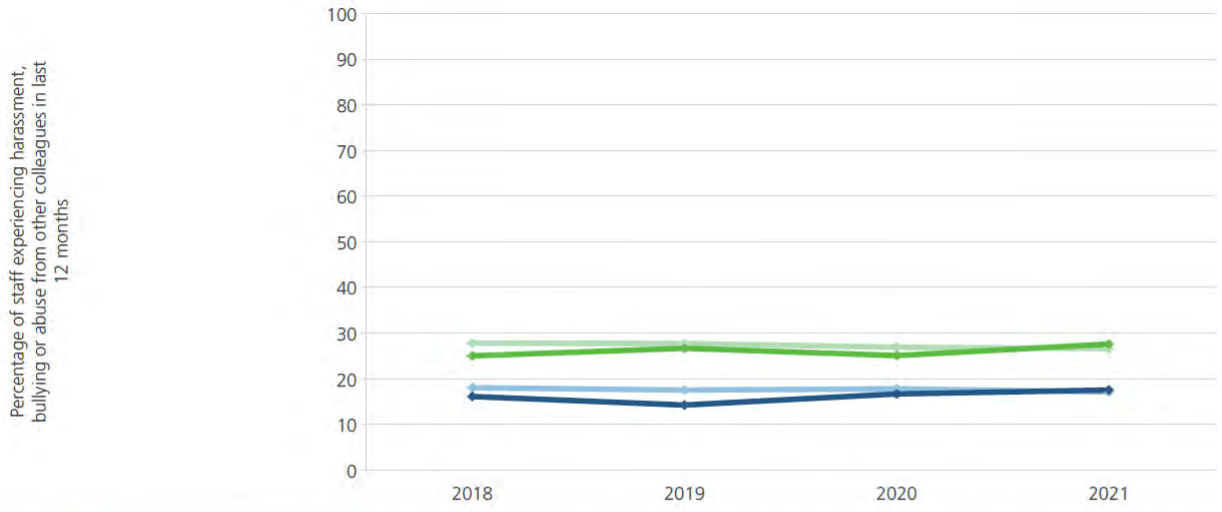


	2018	2019	2020	2021
Staff with a LTC or illness: Your org	27.8%	32.8%	30.7%	33.4%
Staff without a LTC or illness: Your org	19.1%	17.6%	22.4%	22.3%
Staff with a LTC or illness: Average	33.6%	33.2%	30.9%	32.4%
Staff without a LTC or illness: Average	26.6%	26.5%	24.5%	25.2%
Staff with a LTC or illness: Responses	79	61	410	440
Staff without a LTC or illness: Responses	325	267	1,394	1,482

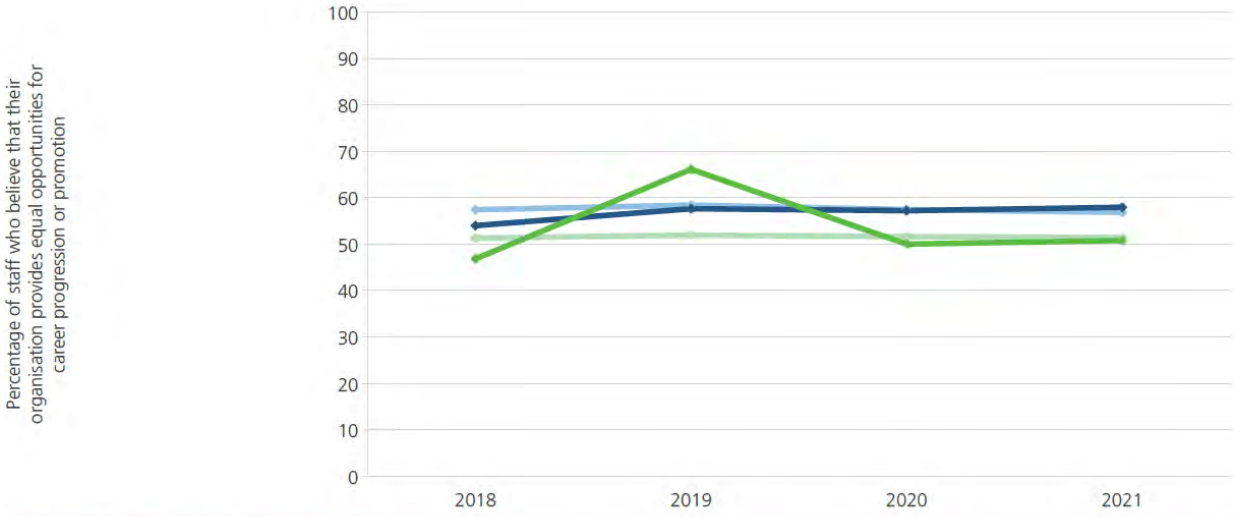
Average calculated as the median for the benchmark group



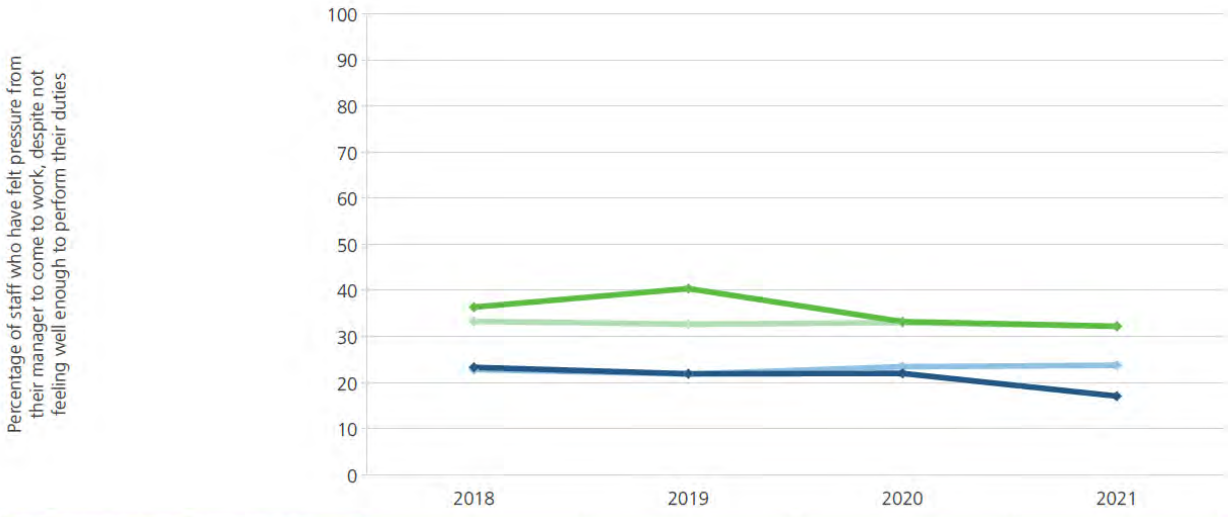
	2018	2019	2020	2021
Staff with a LTC or illness: Your org	18.8%	16.4%	20.9%	20.3%
Staff without a LTC or illness: Your org	17.3%	10.6%	11.5%	9.2%
Staff with a LTC or illness: Average	19.6%	18.4%	19.3%	18.0%
Staff without a LTC or illness: Average	11.7%	10.8%	10.8%	9.8%
Staff with a LTC or illness: Responses	80	61	406	438
Staff without a LTC or illness: Responses	324	264	1,388	1,467



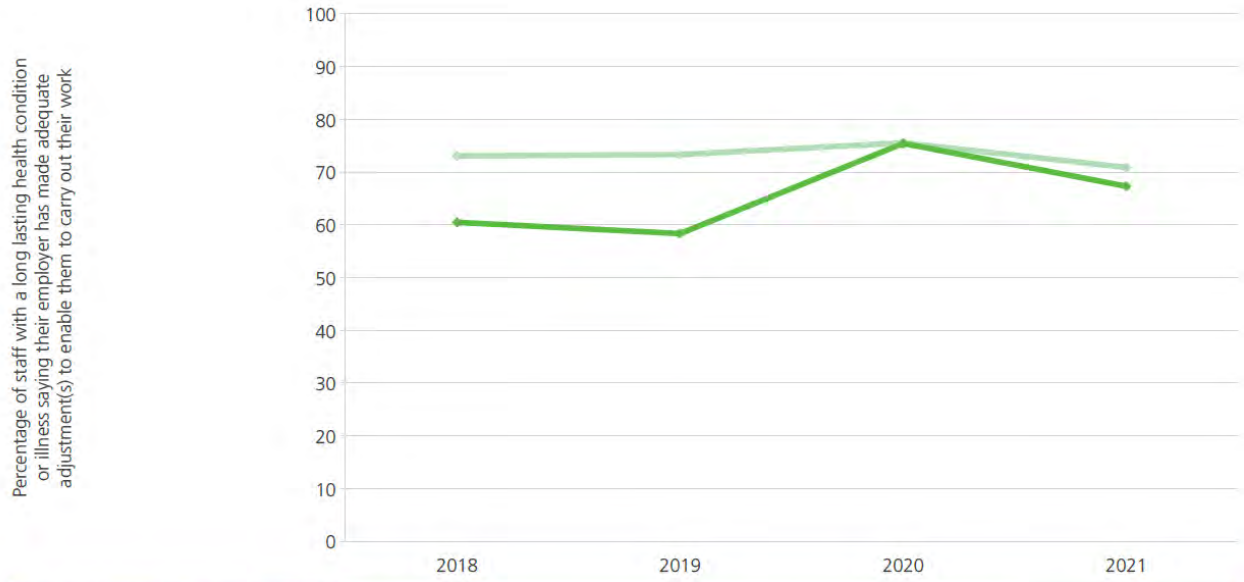
	2018	2019	2020	2021
Staff with a LTC or illness: Your org	25.0%	26.7%	25.1%	27.6%
Staff without a LTC or illness: Your org	16.1%	14.2%	16.7%	17.5%
Staff with a LTC or illness: Average	27.8%	27.7%	26.9%	26.6%
Staff without a LTC or illness: Average	18.0%	17.5%	17.8%	17.1%
Staff with a LTC or illness: Responses	80	60	403	435
Staff without a LTC or illness: Responses	323	260	1,380	1,461



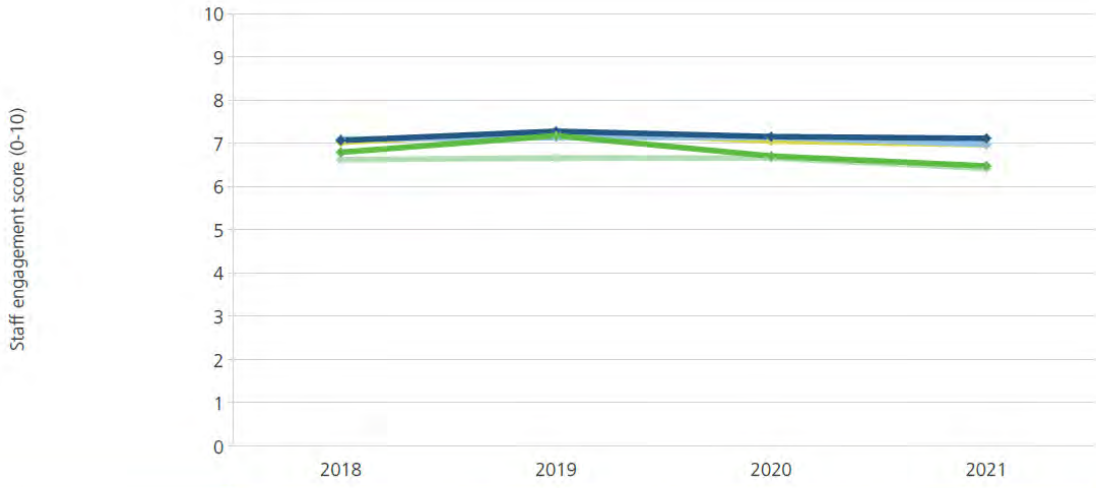
	2018	2019	2020	2021
Staff with a LTC or illness: Your org	46.8%	66.1%	50.0%	50.8%
Staff without a LTC or illness: Your org	54.0%	57.6%	57.2%	57.9%
Staff with a LTC or illness: Average	51.3%	51.9%	51.6%	51.4%
Staff without a LTC or illness: Average	57.4%	58.4%	57.4%	56.8%
Staff with a LTC or illness: Responses	79	62	412	441
Staff without a LTC or illness: Responses	326	262	1,407	1,481



	2018	2019	2020	2021
Staff with a LTC or illness: Your org	36.4%	40.4%	33.2%	32.2%
Staff without a LTC or illness: Your org	23.3%	21.9%	22.0%	17.1%
Staff with a LTC or illness: Average	33.3%	32.7%	33.0%	32.2%
Staff without a LTC or illness: Average	22.8%	21.8%	23.4%	23.7%
Staff with a LTC or illness: Responses	55	52	274	298
Staff without a LTC or illness: Responses	176	137	596	727



	2018	2019	2020	2021
Staff with a LTC or illness: Your org	60.5%	58.3%	75.4%	67.3%
Staff with a LTC or illness: Average	73.1%	73.3%	75.5%	70.9%
Staff with a LTC or illness: Responses	43	36	232	260

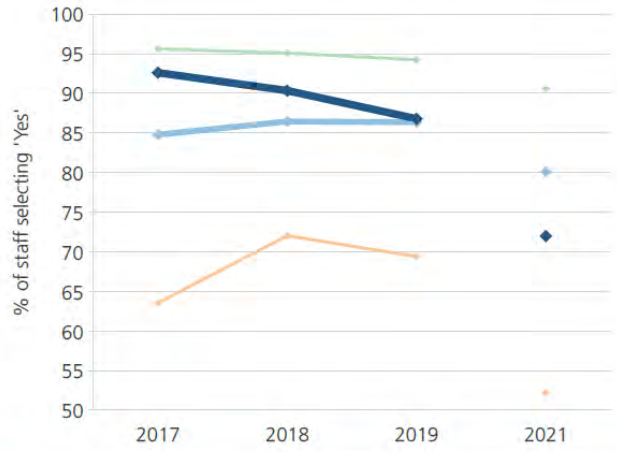


	2018	2019	2020	2021
Organisation average	7.0	7.3	7.0	7.0
Staff with a LTC or illness: Your org	6.8	7.2	6.7	6.5
Staff without a LTC or illness: Your org	7.1	7.3	7.2	7.1
Staff with a LTC or illness: Average	6.6	6.7	6.7	6.4
Staff without a LTC or illness: Average	7.1	7.1	7.1	7.0
Organisation Responses	425	339	1,844	1,965
Staff with a LTC or illness: Responses	79	63	412	442
Staff without a LTC or illness: Responses	331	266	1,413	1,489

Appendix 9 – Appraisal subscores questions against benchmarking group

Q19a
In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?

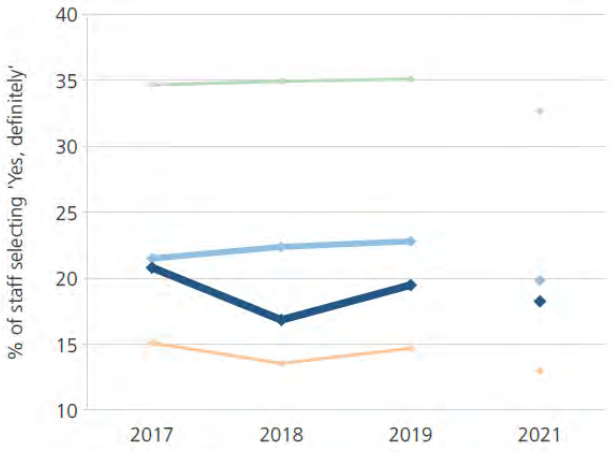
Note that Q19a-d were not asked in 2020. In interpreting these results, consideration should be given to the gap in the data series and evidence of changes to the response profiles over time.



	2017	2018	2019	2021
Highest	95.6%	95.1%	94.2%	90.6%
Your org	92.6%	90.3%	86.8%	72.0%
Average	84.8%	86.4%	86.3%	80.1%
Lowest	63.5%	72.0%	69.4%	52.2%
Responses	417	416	332	1,954

Q19b
It helped me to improve how I do my job

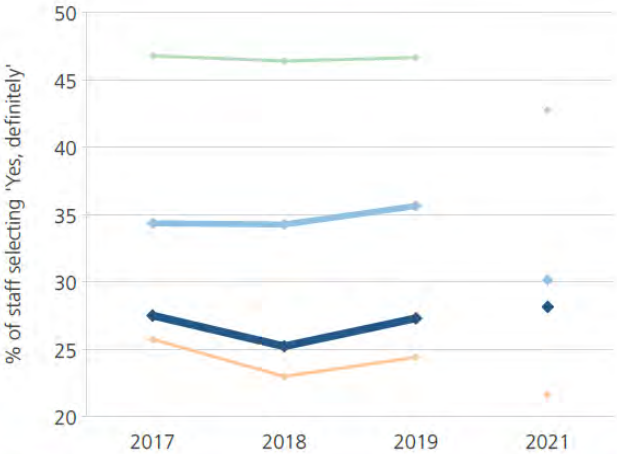
Note that Q19a-d were not asked in 2020. In interpreting these results, consideration should be given to the gap in the data series and evidence of changes to the response profiles over time.



	2017	2018	2019	2021
Best	34.6%	34.9%	35.1%	32.7%
Your org	20.8%	16.8%	19.5%	18.2%
Average	21.5%	22.4%	22.8%	19.8%
Worst	15.1%	13.6%	14.7%	13.0%
Responses	377	367	290	1,364

Q19c
It helped me agree clear objectives for my work

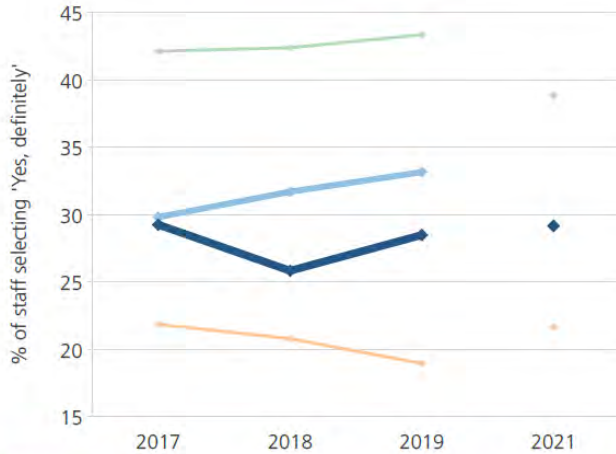
Note that Q19a-d were not asked in 2020. In interpreting these results, consideration should be given to the gap in the data series and evidence of changes to the response profiles over time.



	2017	2018	2019	2021
Best	46.8%	46.4%	46.7%	42.8%
Your org	27.5%	25.2%	27.3%	28.2%
Average	34.4%	34.3%	35.6%	30.2%
Worst	25.7%	23.0%	24.4%	21.6%
Responses	375	366	289	1,360

Q19d
It left me feeling that my work is valued by my organisation

Note that Q19a-d were not asked in 2020. In interpreting these results, consideration should be given to the gap in the data series and evidence of changes to the response profiles over time.

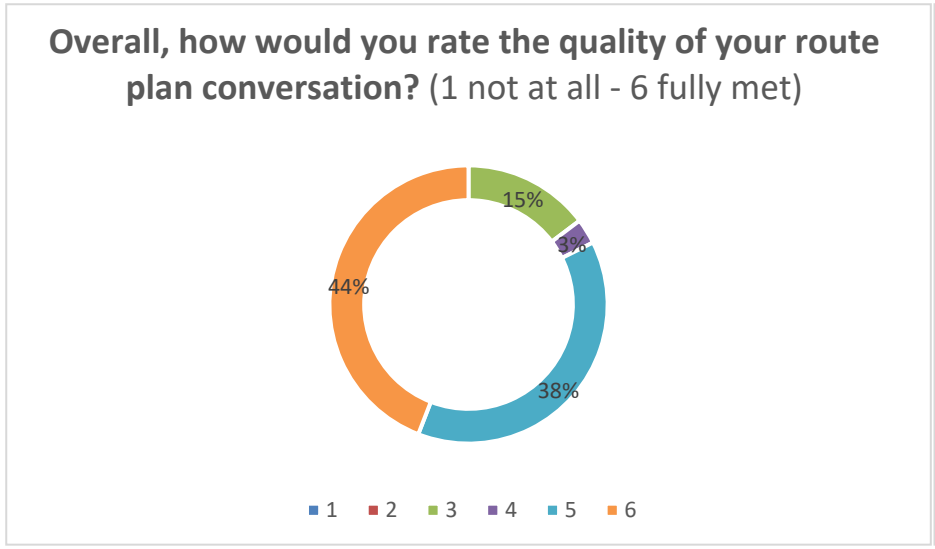


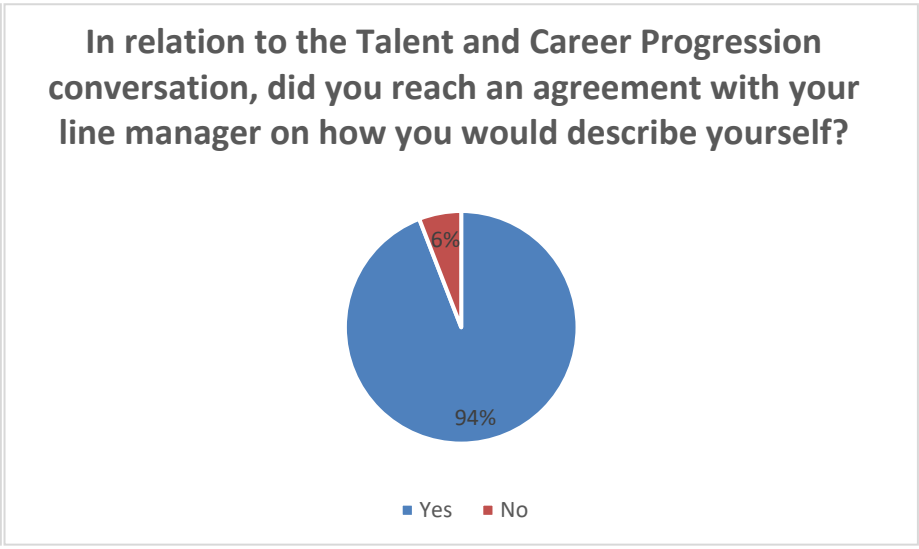
	2017	2018	2019	2021
Best	42.1%	42.4%	43.4%	38.9%
Your org	29.3%	25.8%	28.5%	29.2%
Average	29.8%	31.7%	33.2%	29.3%
Worst	21.8%	20.8%	18.9%	21.6%
Responses	377	368	289	1,359

Appendix 10 – WWL appraisals compliance and feedback

Reporting of My Route Plan Conversation shows the impact the pandemic has had on people accessing time to complete their appraisal. There is some indication of appraisals increasing, however as this has been a hot spot area for a number of years in the NSS, and personal development scores have been consistently declining for some time through YVS; meaning perhaps more attention is required to not only increase the compliance but also the effectiveness of the conversation.

Division My Route Planner	Jan-22	Nov-21	Oct-21	Oct-20	Oct-19
Community Services Area	73.6%	74.6%	76.4%	77.0%	74.4%
Medicine	70.3%	70.3%	71.3%	70.9%	85.1%
Surgery	68.5%	63.6%	61.3%	67.4%	82.4%
Specialist Services	75.8%	76.3%	76.2%	83.4%	91.6%
Corporate Services	79.6%	80.4%	82.3%	65.3%	92.8%
Estates & Facilities	74.5%	78.6%	77.0%	77.5%	86.0%
Finance	92.9%	83.1%	75.7%	85.5%	93.7%
Human Resources	76.9%	69.2%	69.4%	72.6%	94.5%
IM & T	94.7%	94.7%	94.6%	74.6%	97.0%
Trust Wide	**73.4%**	**73.1%**	**72.9%**	**74.3%**	**85.0%**





The Staff Engagement & Development Team routinely seeks feedback from people that have completed their Route Plan Appraisal. Based on 34 responses. Consideration towards:

- Increase the response rates on appraisal feedback.
- Consider further engagement on route plan appraisals, the brand and documentation.
- Increase access to appraisal workshop. Already doing via leadership onboarding and sharing through Trust comms and networks.
- Itchy feet conversations with staff, triangulate with exit interviews.

Agenda item: [25]

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	WWL M11 Balanced Scorecard
Presented to:	Board of Directors
On:	6 April 2022
Presented by:	Mary Fleming, Sanjay Arya, Rabina Tindal
Prepared by:	Data, Analytics and Assurance
Contact details:	BI.Performance.Report@wwl.nhs.uk

Executive summary

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

A new scorecard development is currently in the scoping stage and is part of the DAA Programme schedule.

Link to strategy
Patient
Partnership
Workforce
Site and Service

The WWL Way

Risks associated with this report and proposed mitigations

Financial implications
None currently highlighted.

Legal implications
None identified.

People implications
None identified.

Wider implications

Recommendation(s)
The Trust Board is recommended to receive the report, note the content, and advise of future requirements.

Report: M11 WWL Balanced Scorecard: February 2022

QUALITY & SAFETY

	Month	ON/OFF Track	Why?
Patient Safety (Safe)			
Never Events	*M09*	*On Track*	*0 in month, 2 YTD*
Number of Serious Incidents	*M08*	*Off Track*	*7 in month, 56 YTD*
Sepsis - Screening and Antibiotic Treatment (Grouped)	*M09*	*Off Track*	***Red Flag:** AE Off Track, Ward Off Track* ***Elevated Score:** Collection Suspended*
Serious Pressure Ulcers (Lapses in Care)	*M09*	*Off Track*	*1 Incident in month, 19 YTD (Community & Hospital Acquired)*
Serious Falls	*M09*	*Off Track*	*1 in month, 6 YTD*
Infection Prevention and Control (Grouped)	*M09*	*Off Track*	*4 / 6 in month, 5 / 6 YTD; Metrics Off Track*
Clinical Effectiveness (Effective)			
SHMI Rolling 12 months	*M05 2021*	*Off Track*	Latest position: 103.22 (September 2020 - August 2021)
National Patient Safety Strategy (Grouped)		*Under Development*	
Patient Experience (Caring)			
Complaints Responses	M09	*Off Track*	22.22% M09, 31.43% YTD; Target 90%
Improved Discharge (Grouped)		*Under Development*	
Patient Experience		*Under Development*	

ACTIVITY & EFFECTIVENESS

	Month	ON/OFF Track	Why?
A&E Performance (Single)	M11	Off Track	69.43% M11, 77.17% YTD; Target 95%
Cancer Performance (Grouped)	M10	Off Track	5 / 7 in month, 2 / 7 YTD; Metrics Off Track
RTT Performance (18 Weeks)	M11	Off Track	58.75% M11; Target 92%
RTT Performance (52 Weeks)	M11	Off Track	1530 patients waiting 52+ weeks (114 Waiting 104+ weeks)
Diagnostics Patients waiting under 6 weeks	M11	Off Track	76.70% M11; Target 99%
Recovery plan - NHS E/ I	M11	Off Track	122% M11
Recovery plan - WWL	M11	Off Track	82.38% of 2019 Activity; Target 90%

PEOPLE

	Month	ON/OFF Track	Why?
Employment Essentials			
Vacancy Rate	M11	Off Track	9.33% M11, 8.92% M10, 9.64% M9 Target 5.0%
Number of active Employee Relations cases (disciplinary, grievance, dignity at work, performance)	M11	Off Track	21 M11, 18 M10, 18 M9
Time to Hire- vacancy authorisation granted to start date (average days)	M11	Off Track	67.2 M11, 64.7 M10, 74.3 M9 Target 51 days
Rate Card Adherance- % adhering to rate card	M11	Off Track	62% M11, 50.3% M10, 52.8% M9 Target 85%
E-rostering- % rosters approved within 6 weeks	M11	Off Track	48% M11, 56% M10, 54% M9 Target 90%
Trust % Turnover	M11	On Track	9.87% M11, 9.51% M10, 9.34% M9 Target 10%
Your Voice Matters			
Your voice engagement score	*Q2*	*Off Track*	*3.91 Q2, 3.9 Q1 3.8 Q4 Target 4*
Your voice response rate	*Q2*	*Off Track*	*17.1% Q2, 16% Q1 18.0% Q4 Target 50%*
Your voice Wellbeing score	*Q2*	*Off Track*	*3.22 Q2 Target 4*
Learn and Grow			
Mandatory Training over rolling 12 months	M11	Off Track	88.5% M11, 88.5% M10, 89.8% M9 Target 95%
PDR`s over rolling 12 months	M11	Off Track	74% M11, 73.4% M10, 73.4% M9 Target 90% NB. Excludes M & D Staff
Steps for Wellness			
Sickness Absence	M11	Off Track	7.02% M11, 9.33%, M10, 7.71% M9 Target 4%
Special Leave Infection Precaution	M11	On Track	1.02% M11, 2.06% M10, 2.02% M9

FINANCE

Financial Position (£000s)

	In Month			Year to Date			H1	H2	Full Year
	Actual £000's	Plan £000's	Var £000's	Actual £000's	Plan £000's	Var £000's	Plan £000's	Plan £000's	Plan £000's
Income	38,839	38,201	639	423,897	414,891	9,006	221,052	232,040	453,092
Expenditure	(37,555)	(37,010)	(545)	(410,296)	(401,793)	(8,503)	(213,908)	(224,896)	(438,803)
Surplus / Deficit	(18)	(0)	(18)	32	(70)	102	(70)	0	(70)
Cash Balance	59,613	40,251	19,362	59,613	40,251	19,362	34,321	41,482	41,482
Capital Spend	2,306	705	(1,601)	12,993	10,319	(2,674)	6,302	4,720	11,022

Reported position : M11

Note: Showing February 2022 data where available. *Details in italics where latest month details have not been signed off or been presented to the relevant committee.*

M11 WWL Balanced Scorecard Commentary: February 2022

QUALITY & SAFETY

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

Patient Safety (Safe)

In Month 8, 7 incidents were reported to Commissioners via StEIS. These included pressure ulcer incidents and treatment delays as 2 themes. The Trust is working to analyse both issues; a corporate pressure ulcer improvement group is now established and a thematic review of treatment delays is underway to identify any concerns

Clinical Effectiveness (Effective)

The SHMI figures show that the Trust has reduced again in month and is now showing within the 'expected' range; the Mortality Review Group continues to meet to review this performance. The Trust has moved from the external Dr Foster system to the HED system that provides greater functionality in reviewing elements underneath the high level metric

Patient Experience (Caring)

Within month 9 the majority of complaints continue to relate to clinical treatment and communication. Whilst there was an increase in the percentage of complaints responded to, this month has seen a slight decrease due to the recent wave of Covid. Work has continued to support the clinical teams in completing responses to increase this percentage score.

ACTIVITY & EFFECTIVENESS

Summary:

The peak of the pandemic both in terms of admitted patients testing positive and staff sickness was seen in mid-January with a week-on-week positive trend thereafter in the decrease of patients testing positive and an increase in staff returning to work. The Trust reached its lowest number of covid+ patients at the end of February. However, the Trust continued to operate at a higher level of escalation due to continued high occupancy rates driven by the volume of No Right to Reside, attendances to A&E above capacity threshold, infection prevention guidance requiring segregated pathways.

The Trust is now 1 of 15 Trust's taking part in a national recovery plan to reduce occupancy levels delivered through four national programmes of work: 1. Hospital only discharge 2. Discharge Interfaces 3. Community Healthcare 4. Social Care. WWL is part of the first programme, Hospital only discharge, which very much fits with the plan already developed in response to the Trust's three operational priorities, Protect A&E, Recovery Elective Programme and Reduce Occupancy Levels. The Royal Albert Edward Site hosted a national team visit on the 21st of February where the Wigan Locality Discharge and Flow Programme, alongside the Hospital recovery Plan was presented. The Hospital Only Discharge plan has made good progress with fewer Ambulance hand over Delays and less patients waiting in A&E over 12 hours in February compared to the month before.

Month 11 saw the Trust reporting 114 people waiting over 104 weeks and is on trajectory to achieve its forecasted position as of 31st March 2022. WWL does not anticipate any patients on the active waiting list waiting beyond 104 weeks as of 30th June 2022, unless patients 'choose' to wait – these patients will be recorded in line with national guidance. Everything is being done to encourage patients to accept a date before the end of June.

In accordance with the mutual aid support as part of Greater Manchester Integrated Care System, mutual aid has been offered to GM Acute Provider Trusts to accommodate patients waiting 104 weeks by the end of June 2022 who cannot be accommodated at their local hospital due to capacity constraints, WWL has offered 288 slots to date. The transfer of these patients has been factored into the 104-week forecast which remains zero on 30th June.

There are 378 patients with a P2 (priority) status who currently do not have a date for Surgery – of these patients, 270 have waited beyond the recommended 4 weeks for treatment. This is a combination of orthopaedics and surgical patients, once all theatres are back online at the end of March this position is forecast to improve. All patients are clinically reviewed, and the independent sector capacity is used wherever possible, however the majority of P2 patients do not meet IS criteria even when infrastructure supports more complex patients. Increased utilisation of the Leigh site will support this position.

From the 28th of February Wrightington operated 9 theatres increasing to 10 theatres from 4th April, unfortunately the upgrade to Theatre 7 is delayed until May. Leigh Theatres open fully on Monday 28th March.

PEOPLE

Employment Essentials:

•ESR project now widened to the Workforce Systems improvement project.

•Operational planning return 2022/23 projects that by August 2022 we will have recruited to vacancy gap for our nursing workforce; will continue to see turnover at up to 10% thereafter. Uplift of B2-3 HCSWs now complete with plans to maintain the recruitment pipeline via the Caremaker role.

•New exit interview pilot, facilitated by the Guardian Service, to commence in Q1.

•Introduction of the Rainbow Badges Scheme - action plans from this by July 2022. EDI Champion Training is now operational. Steps4Wellness CPD event for all Wellbeing Champions focused on the Importance of ED&I on their Wellbeing.

Steps 4 Wellness:

•196 referrals to psychological support team to date. Average wait time from referral to assessment Oct-Dec is 5 weeks. Wait time for counselling Oct-Dec 20 weeks, due to staffing shortages. Ongoing Recruitment and staff return from sickness absence will increase throughput.

•ACT group running third cohort, mixed staff group, open offer. Steps 4 Mindful Living Programme & a new Steps4Wellness Step Challenge programmes are being delivered. Physical health business case has been approved; additional funding will be utilised to support with additional health promotion/prevention services/ resource to deliver these initiatives.

Learn and Grow:

•A large project is underway to implement an upgrade to the Learning Hub in collaboration with Traineasy Apprenticeships. 146 colleagues currently undertaking an apprenticeship across the Trust. 123 planned places on an apprenticeship across 19 different qualifications and 43 members of staff are studying towards a Functional Skills Maths and/or English.

Your Voice:

•Culture pilot programme paused and will relaunch in April. Preparations are also underway for the re-launch of Go Engage Teams programme in April.

•National Staff Survey 2021 results received (embargoed until the 30th March). WWL response rate was 29.5%, despite the low response rate we scored favourably in many areas against other comparator Trusts.

FINANCE

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

For the 'adjusted financial performance' which is the one measured by NHSE/I, the Trust is reporting a break even position in month 11 and a surplus of £0.1m year to date.

The Trust is forecasting to deliver the break-even year-end outturn plan agreed with GM & NHSE/I.

Cash is £59.6m at the end of month 11 which is £19.3m above the plan, the Trust has received a significant amount of cash via PDC capital allocations.

Capital expenditure is £12.9m year to date which is £2.6m more than planned.

The Capital Delegated Expenditure Limit (CDEL) for the Trust has been increased from £10.5m to £16.5m for this financial year.

Please see the monthly finance report for further commentary.

Note: Relating to February 2022 where available, or the latest details that have been signed off or presented to the relevant committee.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Revised Committee Terms of Reference
Presented to:	Board of Directors
On:	6 April 2022
Presented by:	Deputy Company Secretary
Prepared by:	Nina Guymer
Contact details:	T: 07880 154754 E: Nina.Guymer@wwl.nhs.uk

Executive summary

The terms of reference (ToR) for WWL's sub-Board committees are reviewed on an annual basis. This year, changes have been made in light of the recommendations of Deloitte, following their 'Well Led Review', as well as in line with the results of any committee effectiveness reviews undertaken.

At the Chairman's request, himself, the Director of Corporate Affairs and the Deputy Company Secretary carried out a review of the documents and made initial changes. The documents were subsequently shared with Non-Executive Director Committee Chairs for comment and then shared with Executive Director Leads, prior to final changes being made. The Executive Team have reviewed and endorse the changed made.

Please note that the Research Committee agreed to allow meetings to run until committee ToR are next up for review in 2023, given that they have only had two meetings since being established and have not had chance to 'test' their ToR. The Chairman is in agreement with this.

Link to strategy
NA

Risks associated with this report and proposed mitigations
NA

Financial implications
NA

Legal implications
NA

The WWL Way

People implications

The Deloitte review found that often, too many people are present in committee meetings. This has the effect of both diluting the quality and shifting the dynamic of discussions, often changing the approach to discussions from one of assurance to one of operation. It also takes up a significant amount of time of colleagues who would otherwise be fulfilling their day to day roles.

For this reason, attendees have been streamlined in the case of all committees. Moving forwards, subject matter experts will be invited to cover the relevant agenda items but then asked to leave the meeting on conclusion of the relevant item(s).

Additional changes are mainly administrative or have been made to update the list of groups which report to each committee.

Wider implications

NA

Recommendation(s)

- The Board is recommended to review and approve the committee terms of reference for 2022/23.

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

FINANCE AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

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

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

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

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

2. MAIN PURPOSE

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

2.2. Its key duties are as follows:

Finance

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

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

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

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

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

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

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

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

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

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

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

Performance

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

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

(n) To consider investment or divestment in services;

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

(p) To review and monitor progress of the digital strategy;

(q) To monitor delivery against the green plan;

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

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

Risk

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

Business cases

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

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

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

(iii) Gain assurance on the effectiveness of such investments through post investment appraisals

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

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

2.4. The Chair of the Committee will work with other assurance committee Chairs as required to ensure the delivery of a sound system of governance and assurance.

3. MEMBERSHIP

3.1. The membership of the Committee shall consist of:

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

(b) Chief Finance Officer;

(c) Chief Operating Officer; and

(d) Director of Strategy and Planning.

3.2. A representative of the Council of Governors shall be entitled to attend to observe the meeting.

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

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

4. SECRETARY

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

5. ATTENDANCE

5.1. Representative from the divisional leadership team and subject matter experts will be invited to attend meetings on an agenda driven basis by the Committee Chair and should be present only for the duration of the items in respect of which they have been invited.

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

5.3. The Committee Chair may also approve the attendance of observers, particularly members of staff, where attendance at assurance committee meetings is recommended as part of their development plan.

6. FREQUENCY OF MEETINGS

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

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

7. MINUTES AND REPORTING

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

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

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

7.4. The following groups shall report to the Committee:

(a) Digital Strategy Oversight Group;

(b) Global Training Education Steering Group;

(c) Greener WWL Steering Group

8. PERFORMANCE EVALUATION

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

9. REVIEW

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

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

PEOPLE COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

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

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

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

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

2. MAIN PURPOSE

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

(a) Approval and oversight of the implementation of the WWL People Strategy and Our Family, Our Future, Our Focus engagement programme;

(b) Approval of prioritised annual People objectives;

(c) Assuring the Board of compliance against key national and statutory workforce requirements, including the National People Plan and People Promise

(d) Developing strategic workforce recommendations for approval by the Board

2.2. The Chair of the Committee will work with other assurance committee Chairs as required, to ensure the delivery of a sound system of governance and assurance.

3. SCOPE OF RESPONSIBILITIES

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

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

- Employment Essentials

- Steps for Wellness
- Your Voice Matters
- Learn and Grow

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

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

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

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

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

(h) To ensure strategic alignment of the WWL People agenda with the NHS Long Term Plan, National People Plan, People Promise, HR / OD Futures report and NHSE/I mandated standards;

(i) To grow the recruitment brand and retention strategies;

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

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

4. MEMBERSHIP

4.1. The membership of the Committee shall consist of:

(a) Non-Executive Director Chair;

(b) Non-Executive Directors x2

(c) Director of Workforce;

(d) Chief Operating Officer;

(e) Chief Nurse;

(f) Medical Director;

4.2. A representative of the Council of Governors shall be entitled to attend to observe the meeting.

4.3. The Committee will be deemed quorate to the extent that two Non-Executive Directors and two Executive Directors, one being the Director of Workforce or their nominated deputy, are present. In the event that the Chair is not able to attend a meeting, one of the other Non-Executive Directors shall take the chair.

5. SECRETARY

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

6. ATTENDANCE

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

(a) Deputy Director of HR;

(b) Deputy Director of Staff Engagement & Organisational Development;

(c) Staff Side Chair

6.2. In addition, a representative from the divisional leadership team and subject matter experts relevant to agenda items may be invited by the Chair to attend for their agenda item(s) only.

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

6.4. The Committee Chair may also approve the attendance of observers, particularly members of staff, where attendance at assurance committee meetings is recommended as part of their development plan.

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

7. FREQUENCY OF MEETINGS

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

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

8. MINUTES AND REPORTING

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

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

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

(a) Local Negotiating Group;

(b) Educational Governance Group;

(c) Partnership Group;

(d) Workforce Divisional Quality Executive Group

(e) Equality Diversity and Inclusion Strategy Group (People)

9. PERFORMANCE EVALUATION

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

10. REVIEW

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

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

AUDIT COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

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

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

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

2. MAIN PURPOSE

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

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

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

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

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

2.4. The Chair of the Committee will work with other assurance committee Chairs as required to ensure the delivery of a sound system of governance and assurance.

3. MEMBERSHIP

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

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

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

4. SECRETARY

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

5. ATTENDANCE

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

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

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

5.4. The Committee Chair may also approve the attendance of observers, particularly members of staff, where attendance at assurance committee meetings is recommended as part of their development plan.

6. FREQUENCY OF MEETINGS

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

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

7. DUTIES

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

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

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

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

(ii) areas where judgment has been exercised;

(iii) adherence to accounting policies and practices;

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

(v) the schedule of losses and special payments;

(vi) any unadjusted statements; and

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

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

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

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

7.2. With respect to internal control and risk management:

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

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

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

(d) Review the Trust's risk management strategy prior to its presentation to Board for approval;

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

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

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

7.3. With regard to corporate governance:

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

7.4. With regard to internal audit:

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

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

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

(i) adequate resourcing;

(ii) its coordination with external audit;

(iii) meeting relevant internal audit standards;

(iv) providing adequate independence assurances; and

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

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

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

7.5. With regard to external audit:

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

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

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

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

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

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

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

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

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

7.6. With regard to Standing Financial Instructions:

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

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

(c) Review the Scheme of Reservation and Delegation.

7.7. With regard to other matters:

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

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

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

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

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

8. MINUTES AND REPORTING

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

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

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

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

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

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

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

8.5. The following sub-groups shall report to the Audit Committee:

(a) Caldicott Group

(b) Risk Management Group

(c) Senior Information Risk Officer Meeting

9. PERFORMANCE EVALUATION

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

10. REVIEW

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

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

QUALITY AND SAFETY COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

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

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

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

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

2. MAIN PURPOSE

2.1 The Committee will enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to:

(a) Promote safety and excellence in patient care;

(b) Identify, prioritise and manage risk arising from clinical care;

(c) Ensure effective and efficient use of resources through evidence-based clinical practice;

(d) Protect the health and safety of Trust employees;

(e) Ensure compliance with legal, regulatory and other obligations.

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

2.3. The Chair of the Committee will work with other assurance committee Chairs as required, to ensure the delivery of a sound system of governance and assurance.

3. QUALITY STRATEGY ROLE

3.1 To review and recommend to the Board the Quality Strategy of the Trust, and to monitor progress against the strategy and other improvement plans that may impact on clinical quality.

3.2 To ensure there are robust systems for monitoring clinical quality performance indicators within Divisions and to receive reports on clinical quality performance measures.

3.3 Review and monitor the process and outcomes of Quality Impact Assessments relating to significant service changes and transformation programmes to gain assurance that there will be no unforeseen detrimental impact on quality of care for patients.

3.4 In response to requests from Board, or where appropriate as decided by the Committee, monitor the implementation of improvement plans in respect of quality of care, particularly in relation to incidents (never events), survey outcomes (safety culture elements of the NHS staff survey) and similar issues.

4. COMPLIANCE AND REGULATION ROLE

4.1 To receive and consider the necessary action in response to external reports, reviews, investigations or strategies (from the Care Quality Commission, NHS England and NHS Improvement, HM Coroner, PHSO and other NHS bodies such as Royal Colleges).

4.2 To monitor the Trust's responses to relevant external assessment reports (including reports from the Care Quality Commission) and associated implementation plans.

4.3 To receive commentary on the Care Quality Commission's Insight Report in respect of the Trust.

5. CLINICAL GOVERNANCE AND RISK MANAGEMENT ROLE

5.1 To review assurance reports mandated to be received by the Board that may impact on clinical quality, for example, quarterly mortality reports, maternity compliance against NHS Resolution safety standards.

5.2 Through reports from the Quality Governance Group monitor and obtain assurance regarding the effectiveness of processes, systems and structures for good clinical governance at the Trust, and to seek their continuous improvement.

5.2 To received regular reports on the ASPIRE clinical quality accreditation and internal mock inspection reports, to ensure effectiveness and that actions arising from them are addressed in a timely and appropriate manner under the management oversight of the Quality Governance Group.

5.3 To receive regular reports from the following groups to gain assurances of the completion of improvement plans to arising from areas of concern: Mortality, Medicines Management, Infection Prevention and Control, Safeguarding, Occupational Safety and Health.

5.4 To review the Board Assurance Framework (Patients) and corporate risks escalated by the Risk Management Group in accordance with the Trust's risk management strategy to seek assurances regarding mitigating action.

6. SAFETY CULTURE ROLE

6.1 To review the themes, trends and monitor improvements related to incident management (including incidents involving staff and patients), inquests and litigation.

6.2 To gain assurance that appropriate feedback mechanisms are in place for those reporting incidents and that a culture of openness and transparency in respect to incident reporting is encouraged and supporting the speaking up agenda.

6.3 To ensure that where necessary, action plans to address incident related themes, trends and/or required improvements, are developed and monitored.

6.4 To ensure that the NHS England/Improvements Just Culture guide is implemented by all staff across the Trust.

7. PATIENT EXPERIENCE ROLE

7.1 To consider reports from the Patient Experience and Engagement Group and other sources of feedback (such as Healthwatch) on all formal and informal patient feedback, both positive and negative, and to consider further action in respect of matters of concern.

7.2 To consider the results of national patient surveys and reviews such as PLACE that may impact on clinical quality, to gain assurance that actions arising from them are addressed in a timely and appropriate manner under the management oversight of the patient Experience Group.

7.3 To review the themes, trends and monitor improvements relating to complaints and concerns.

7.4 To ensure that where necessary, action plans to address complaint themes and trends are developed and monitored.

8. CLINICAL AUDIT AND EFFECTIVENESS ROLE

8.1 To ensure there is a comprehensive clinical audit programme in place to support and apply evidence-based practice, implement clinical standards and guidelines, and drive quality improvement.

8.2 To ensure that care is based on evidence of best practice/national guidance and recommendations from national audits and external bodies such as the National Confidential Enquiry into Patient Outcomes and Death are responded to.

9. MEMBERSHIP

9.1 The membership of the Committee shall consist of:

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

(b) Chief Nurse;

(c) Medical Director; and

(d) Chief Operating Officer.

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

9.3 The Committee will be deemed quorate to the extent that two Non-Executive Directors and two Executive Directors are present.

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

10. SECRETARY

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

11. ATTENDANCE

11.1 The following participants are expected to attend meetings of the Quality and Safety Committee:

(a) Associate Director of Governance and Patient Safety

(b) Divisional Nurse Director for each clinical division;

(c) Director of Operations for each clinical division;

11.2 In addition, subject matter experts relevant to agenda items may be invited by the Chair to attend for their agenda item(s) only.

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

11.4 The Committee Chair may also approve the attendance of observers, particularly members of staff where attendance at assurance committee meetings is recommended as part of their development plan.

12. FREQUENCY OF MEETINGS

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

12.2 Additional meetings may be held on an exceptional basis at the request of the Committee Chair or any three members of the Quality and Safety Committee.

13 MINUTES AND REPORTING

13.1 Formal minutes shall be taken of all Committee meetings.

13.2 Once approved by the Committee, the minutes should be presented to the Board for information.

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

13.4 The following sub-groups shall report to the Quality and Safety Committee:

(a) Clinical Audit and Effectiveness Group

(b) CQC Stakeholder Group

(c) Divisional Quality Executive Groups

(d) Equality Diversity and Inclusion Steering Group (Patients)

(e) Infection Prevention and Control Group

(f) Medicines Management Strategy Group

(g) Mortality Group

(h) Occupational Safety and Health Group

(i) Patient Experience and Engagement Group

(j) Patient Safety Group

(k) Quality Champions Group

(l) Safeguarding Effectiveness Group

14. PERFORMANCE EVALUATION

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

15. REVIEW

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

Agenda item: [XX]

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Monthly Trust Financial Report – Month 11 (February 2021)
Presented to:	Finance and Performance Committee
On:	30th March 2022
Presented by:	Ian Boyle [Chief Finance Officer]
Prepared by:	Senior Finance Team
Contact details:	E: David.A.Hughes@wwl.nhs.uk

Executive summary

	In Month			Year to Date		
	Actual £000's	Plan £000's	Var £000's	Actual £000's	Plan £000's	Var £000's
Income	38,839	38,201	639	423,897	414,891	9,006
Expenditure	(37,555)	(37,010)	(545)	(410,296)	(401,793)	(8,503)
Financial Performance	(2)	(1)	(2)	129	(1)	130
Cash Balance	59,613	40,251	19,362	59,613	40,251	19,362
Capital Spend	2,306	705	(1,601)	12,993	10,319	(2,674)

Key Messages:

- The Trust has agreed a balanced budget with NHSE/I and the Greater Manchester system for the second half of the 2021-22 financial year.
- The block contract and system top up funding arrangements have been extended to the end of the financial year, as national tariff remains suspended.
- In month 11, the Trust reported a break-even position. The Trust is reporting a surplus of £0.1m year to date.

The WWL Way

- Cash is £59.6m at the end of Month 11.
- Capital spend is £2.3m in month and £13.0m year to date.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Board Diversity Policy
Presented to:	Board of Directors
On:	6 April 2022
Presented by:	Director of Corporate Affairs
Prepared by:	Director of Corporate Affairs
Contact details:	E: paul.howard@wwl.nhs.uk

Executive summary

In 2020, the Board of Directors approved its first Board Diversity Policy and agreed that it would be reviewed on an annual basis thereafter. A review has been conducted internally and feedback was also sought from an external consultant who authored the new Race Equality Code.

No changes are proposed to the policy at this time, however the Board is requested to note that diversity information in relation to the board is included within the annual report and accounts each year. This is currently in the process of being prepared in respect of FY2021/22, and will include statistical information as well as information around equality and diversity in the wider organisation. We have also commissioned some focused work around adoption of the Race Equality Code during FY2022/23.

Link to strategy

One of the strategic priorities of the organisation is to be an employer of choice. One of the fundamental parts of the WWL People Promise – Employment Essentials – confirms that we will value and embrace diversity and create a workplace where everyone can flourish. The content of the report supports this approach at board-level.

Risks associated with this report and proposed mitigations

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

Financial implications

There are no financial implications arising from this report.

The WWL Way

Legal implications

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

People implications

Operation of this policy is intended to result in positive people implications.

Wider implications

There are no wider implications to highlight.

Recommendation(s)

The Board of Directors is recommended to approve the Board Diversity Policy as presented.

Board Diversity Policy

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

1. Introduction and scope

1.1. At Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust we are committed to the principles of equality, diversity and inclusion, both across the organisation and at board level. We recognise the benefit and value of diversity and we are committed to the creation of an inclusive culture where everyone has the opportunity to achieve their potential.

1.2. This policy applies specifically to the Board of Directors and there are separate policies which cover diversity and inclusion across our wider workforce.

2. How appointments are made

2.1. The appointment of executive directors is the responsibility of the Remuneration Committee, which comprises all non-executive directors and the Chief Executive (except in relation to the appointment of a Chief Executive where it comprises the non-executive directors alone) and the committee acts under delegated authority from the board. The appointment of a Chief Executive also requires the approval of the Council of Governors.

2.2. Non-executive directors are appointed by the Council of Governors at a general meeting. Recommendations as to appointment are provided by a dedicated committee, the Nomination and Remuneration Committee, which oversees the recruitment process on the council's behalf.

2.3. The Remuneration Committee's terms of reference require it to regularly review the structure, size and composition of the board (including the balance of skills, knowledge and experience) and to make recommendations to the board or the Nomination and Remuneration Committee of the Council of Governors for any changes.

2.4. The terms of reference of the Nomination and Remuneration Committee require it to periodically review the balance of skills, knowledge, experience and diversity of the non-executive directors and, having regard to the views of the board and relevant guidance on board composition, make appropriate recommendations to the Council of Governors.

3. Policy statement

3.1. We believe that a broad range of skills, backgrounds, knowledge and experience is a key component of an effective board.

3.2. All appointments to the board will be made on merit against objective criteria, in the context of the overall balance of skills and backgrounds that the board needs to maintain in order to remain effective. Protected characteristics will be taken into consideration generally when evaluating the skills, knowledge and experience desirable to fill each board-level vacancy.

3.3. This policy sets out the process to be followed by the Remuneration Committee (for executive director vacancies) and the Council of Governors through its Nomination and Remuneration Committee (for non-executive director vacancies) during the recruitment process in order to attract candidates from diverse backgrounds who would enhance the balance of skills and backgrounds on the board.

4. Encouraging candidates from different backgrounds

4.1. The relevant committee will encourage the participation of candidates from diverse and under-represented backgrounds during recruitment processes in the following ways:

- when using an executive search firm, we will seek to engage one that is a signatory to the Executive Search Firms' Voluntary Code of Conduct;
- we will ensure that the brief given to the search firm (where used) and the candidate information pack include appropriate emphasis on diversity of skills and background, independence of approach and other personal qualities in addition to the usual requirements around career experience and compatibility with the values and behaviours of the organisation with a view to enhancing the overall effectiveness of the board;
- we will work with the search firm (where used) to design an inclusive search process that is open and accessible to candidates from any background and which encourages the widest possible field, and we will do this ourselves where the vacancy is managed in-house;
- we will encourage the search firm (where used) to produce long lists which include candidates from under-represented backgrounds of appropriate merit, and we will do so ourselves where the vacancy is managed in-house;
- we will consider high-performing senior executives from under-represented backgrounds who may not have previous board experience in executive and non-executive director roles, subject to the requirement for potential candidates to meet minimum requirements;
- we will ensure that all voting members of the final interview panel have completed appropriate training in recruitment which includes issues such as unconscious bias; and
- we will ensure that our interview panels are in themselves diverse.

4.2. Both committees are responsible for considering succession plans for directors and when non-executive directors are coming towards the end of their fixed term of office the Nomination and Remuneration Committee considers whether to recommend their reappointment to the Council of Governors. In carrying out these responsibilities, the committees shall have regard to this policy and the composition and skills requirements of the board at that time.

5. Responsibilities of the Chair

5.1. The Chair will ensure that boardroom diversity is considered as part of the annual evaluation of the board's effectiveness.

5.2. The Chair will ensure that a bespoke and comprehensive induction programme is provided to each new director which aims to address any gaps in a new director's knowledge and which is designed to be inclusive.

5.3. The Chair will take on an ongoing mentoring role for new directors, and may arrange for buddying arrangements to be implemented, with the agreement of the new director and the proposed buddy. As part of this arrangement, the potential for reverse mentoring will also be taken into account.

6. Monitoring and reporting

6.1. The annual report of the foundation trust shall include information on the policy on diversity and inclusion used by the committee, including the policy objectives and how this links with the foundation trust's strategy. It will also include information on how the policy has been implemented and progress on achieving objectives.

7. Review

7.1. This policy shall be reviewed by the Board of Directors on an annual basis.

7.2. The policy will continue to be informed by guidance from relevant reviews conducted in other sectors, such as the Hampton-Alexander Review (2020) on gender and the Parker Review (2020) on ethnicity.

Title of report:	GTEC Governance
Presented to:	Finance and Performance Committee
On:	06 April 2022
Presented by:	Director of Strategy & Planning
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Executive summary

There has been some longstanding ambiguity about how the governance of the GTEC programme articulates with Trust Board and sub-committees. The programme is an important part of the Trust's business, delivering international recruits to fill critical workforce gaps, but also making a financial contribution to the bottom line. It was originally established with significant good will and entrepreneurial drive from our consultants but is increasingly becoming a complex business model that requires appropriate organisational governance.

This report recommends that, for governance purposes, we separate the commercial and client roles that the Trust has. The commercial element offers both opportunity and risk and is best overseen by the Chief Finance Officer, reporting to the Finance & Performance Committee. The client element should be led by the relevant senior health professional – the Medical Director for doctors and the Chief Nurse for nurses and AHPs – supported by the Director of Human Resources. Assurance of the client-side element should be received by the People Committee. Matters of a commercial nature should, if necessary, be escalated from F&P to Board and similarly matters related to international recruitment performance should be escalated from People Committee to Board.

The Steering Group should continue to be chaired by the Chief Finance Officer but be structured to separate out the commercial and client business and the appropriate Executive Director should be present to provide leadership on the relevant items.

Link to strategy

GTEC is of strategic importance to WWL. It an innovative service that generates income outside of core NHS contracts and delivers international recruits that enable us to improved care to our patients.

Risks associated with this report and proposed mitigations

None.

Financial implications

There are no financial implications associated with the proposals, but GTEC itself has financial risks, which this paper argues are better managed and mitigated through these proposals.

Legal implications

None. Although separation of commercial from client issues enables a greater focus on future delivery models, which may have legal implications.

People implications

No immediate implications, but this proposal formalises a line management relationship between the lead consultant and a non-medical executive director. Whilst not unprecedented, this will need sensitive handling to continue to enjoy the good will of medical staff and the arrangements may need support from the Medical Director

Wider implications

Good governance enhances the Trust's reputation and has a positive impact on both future recruitment and new business.

Recommendations

- Separate out commercial and client issues
- The CFO takes formal responsibility for line management
- The Function reports formally to F&P for commercial and financial issues
- International recruitment as a service to WWL has a client lead and reports to People Committee as part of the overall recruitment and learning assurance
- The GTEC Steering Group should be restructured to reflect these recommendations

Report

Background

1. The Global Training and Education Centre (GTEC) is part of WWL Teaching Hospitals Foundation Trust. It employs c31 WTE with an annual pay budget of c£1.2m and the team is based in office accommodation at Wrightington Hospital.

2. GTEC recruits, trains (in association with Edge Hill University) and assimilates International Nurses & Doctors in training for WWL and for a range of other NHS Bodies, for which it receives income.

3. Whilst GTEC is an "overhead" to WWL, the entire program makes a positive contribution to the trust bottom line on an annual basis.

4. The Trust has a long history of utilising training doctors from overseas to fill gaps in our rotas and providing those trainee doctors with a formal education package (originally in conjunction with UCLAN but now with Edge Hill). This programme was known as the MCH programme. In the early years the programme brought approx. 10 doctors per year into the UK about 5 years ago the volumes increased dramatically with upwards of 90 doctors per year coming to the UK.

5. A proposal to create a similar programme for nurses was discussed and a business case was approved in December 2019 to set up the Global Training and Education Centre. GTEC is now responsible for the Medical Learners Programme (MLP) which is the rebranded MCH programme and the new Nursing Learners Programme (NLP).

Governance

6. At present, the program is led by an Orthopaedic Consultant and the activities of GTEC are overseen by the GTEC Steering Group. This is chaired by the CFO, which has Executive & NED representation. The minutes of this meeting feed into trust Board oversight via the People Committee.

7. Following previous ETM discussions, the Director of Strategy and Planning was asked to propose a new approach to governance, addressing the following issues.

    - As GTEC provides a service to the Trust, do we align to the Occupational Health model, whereby we separate BAU management of GTEC and the client relationship element of GTEC?

    - Is the People Committee the correct place for governance to feed into? For example, the People Committee chair is not currently on the steering group?

    - Where should line management of GTEC sit, given it performs a recruitment and training function?

Analysis

8. GTEC is a complex business model that operates as a commercial entity within WWL, but also provides an essential international recruitment service to the Trust. The Trust therefore has a role as both a commercial host and a client.

9. The organisational process to agree investments in GTEC and the scrutiny of international recruitment performance and quality together with the different funding models can often be conflated, which adds a layer of complexity to governance. In other parts of our business, notably Occupational health, we have found that this complexity can be better managed by handling commercial and client issues separately. This becomes even more important when there are multiple clients or different delivery lines.

10. It makes sense for the Medical Director to be the senior client for doctor international recruitment and for the Chief Nurse to the senior client for nursing or AHP international recruitment, but it does not necessarily mean that these roles are best placed to manage a commercial entity. So, it is recommended that these two aspects of GTEC are considered separately for governance purposes.

<u>Commercial Governance</u>

11. GTEC is a significant commercial function. As well as having a team of over 30 people and a budget of over £1m, its business model requires use of multiple contracts and management of multiple client relationships. The various service lines need to be costed and then prices calculated to cover those costs and a contribution. Any overheads need to be judged on the basis of both delivering current business and growing future business and absorbed in the prices appropriately. There will be marketing considering too.

12. Whilst GTEC does make a valuable contribution to the Trust's I&E, there are both significant opportunities and risks in this business model. The opportunities to grow are obvious, given the increasing demand for international recruits and WWL's track record, but there are risks of over extension and cash flow. A grace period bestowed on students paying their fee during Covid has caused a debt issue which currently stands at £929k.

13. For these reasons, it makes sense for commercial governance to fit within the finance function under the CFO.

14. GTEC may lend itself to a completely separate entity both to de-risk some of the financial issues from WWL and to provide greater flexibility, including treatment of capital and carrying balances over from year to year. Pursuing a different legal model would again best be overseen by the finance function.

15. The commercial element of GTEC should therefore report to F&P for assurance purposes.

<u>Client Governance</u>

16. In principle, WWL could buy international recruitment services from a variety of external providers. The performance of GTEC should be judged against that possibility and managed separately, as far as possible, from running a commercial entity. International recruitment should also be seen as one of a range of recruitment and retention options to provide the necessary workforce and the relative contributions of each option should be considered on their own merits to produce optimum results rather than skewed towards international recruitment as a default because we provide the service.

17. For this reason, it is sensible for the client requirements to be overseen separately by the relevant professional lead.

18. The client element of GTEC should report to People Committee through the relevant senior client ED.