Board of Directors - Public Meeting

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

Boardroom, Trust Headquarters

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Agenda

13:30 - 13:31
1 min

10. Declarations of Interest

Information *Mark Jones*

13:31 - 13:33
2 min

11. Minutes of Previous Meeting

Approval *Mark Jones*

11. Minutes - Public Board - 3 Aug 2022 v1.pdf (9 pages)

13:33 - 13:48
15 min

12. Chair's Opening remarks

Information *Mark Jones*

Verbal Item

13:48 - 14:08
20 min

13. Chief Executive's report

Information *Silas Nicholls*

13. Board Report_CEO_October 2022_APPROVED.pdf (3 pages)

14:08 - 14:43
35 min

14. Committee chairs' reports

Information *NEDs*

14.1. Audit

No additional vebal update

14.1. AAA Audit - Sept 2022.pdf (2 pages)

14.2. Finance and Performance

Alison Tumilty

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

14.3. People

Lynne Lobley

14.3. AAA _ People - 5 Sept 2022 NG AB LL.pdf (2 pages)

14.4. Research

Clare Austin

14.4. AAA - Research - Sept 2022.pdf (1 pages)

14.5. Quality and Safety

Francine Thorpe

14.5. AAA QS - Aug22.pdf (2 pages)

14:43 - 14:53
10 min

15. Board assurance framework

Information *Paul Howard*

15. BAF Report October 2022 Board Meeting.pdf (28 pages)

14:53 - 15:08
15 min

16. Agenda item not used

15:08 - 15:23
15 min

17. IPC board assurance framework

Information *Rabina Tindale*

17. IPC BAF Report at 16 September 2022. 25.9.2022.pdf (17 pages)

15:23 - 15:38
15 min

18. Safeguarding annual report

Information *Rabina Tindale*

18. WWLTH Safeguarding Annual Report 2021 FINAL.pdf (30 pages)

15:38 - 15:38
0 min

19. Winter Planning

Information *Mary Fleming*

19. Winter Planning Sep TB.pdf (5 pages)

15:38 - 15:58
20 min

20. Integrated performance report

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

20. Board of Directors M5 2223 Integrated Performance Report.pdf (5 pages)

15:58 - 15:58
0 min

21. University hospital escalation

Information *Richard Mundon*

21. UHS Board Update Paper September 2022 v5.pdf (6 pages)

15:58 - 15:58
0 min

22. Finance Report

Discussion *Ian Boyle*

22. Trust Financial Report 22-23 August month 5 Board.pdf (10 pages)

15:58 - 15:58
0 min

23. Consent Agenda

23.1. Review of well-led action plan

Information/Decision *Paul Howard*

23.1. FINAL Well-led action plan - Oct 2022.pdf (13 pages)

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

Approval *Alison Balson*

23.2 EDI Annual Report 2021-22.pdf (37 pages)

15:58 - 16:00
2 min

24. Date, time and venue of next meeting

Information *Mark Jones*

Wednesday 07 December, 12:15 - 4:15pm, Boardroom, Trust Headquarters

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

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

HELD IN PUBLIC ON 3 AUGUST, 1:15PM

BY VIDEOCONFERENCE

Present:	Mr M Jones	Chair (in the Chair)
	Prof S Arya	Medical Director
	Prof C Austin	Non-Executive Director
	Mrs A Balson	Director of Workforce
	Mr I Boyle	Chief Finance Officer
	Lady R Bradley	Non-Executive Director
	Dr S Elliot	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
	Ms R Tindale	Chief Nurse
	Mrs F Thorpe	Non-Executive Director
	Mrs A Tumilty	Non-Executive Director
In attendance:	Mr J Baker	Shadow Board Member (observer)
	Mr C Clarke	Observer
	Mrs K Forrest	Shadow Board Member (observer)
	Mrs N Guymer	Deputy Company Secretary (minutes)
	Ms H Hendricksen	Shadow Board Member (observer)
	Mrs A Luxon	Shadow Board Member (observer)
	Ms K Knowles	Shadow Board Member (observer)
	Ms H Shelton	Shadow Board Member (observer)
	Ms C Wannell	Shadow Board Member (observer)

The Board reconvened following an adjournment.

109/22 Declarations of interest

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

110/22 Minutes of the previous meeting

The minutes of the previous meetings held on 8 June 2022 were **APPROVED** as a true and accurate record.

111/22 Action log

The update provided in the action log was received and noted.

80/22 Safe Nurse staffing

The Chief Nurse advised in respect of this action that an update will be provided to the Quality and Safety Committee (Q&S) at their next meeting, through the safe staffing report to clarify that there is no direct correlation between patient harm and reduced staffing levels and that staffing shortfalls are reviewed by matrons at least twice daily, in tandem with patient acuity, to mitigate risk of harm to patients. The report will be brought for the review of the Board biannually and to Q&S quarterly. She requested closure of the action which was agreed.

76/22(a) Staff story

The Medical Director advised that neither formal nor informal forums currently exist for advance nurse practitioners or physician associates and agreed to provide a further update on work done in this regard at the next meeting.

The Board received and noted the updates.

112/22 Chair's opening remarks

The Chair welcomed members of the public to the meeting. He noted that some members of WWL's Shadow Board were present at the meeting. He explained that these colleagues are taking part in a practical development exercise and expressed support from the Board in this regard.

The Board received and noted the update.

113/22 Chief Executive's report

The Deputy Chief Executive began by reporting positively, following recent discussions with the Deputy Place Based Lead for the Healthier Wigan Partnership and advised that she had felt a real sense of enthusiasm for collegiate working between the two bodies moving forwards. She went on to describe the biggest challenge to the Trust currently, being the rising number of 'no right to reside patients' (NRTR). Concerns have been escalated to the Greater Manchester (GM) Chief Operating Officers' meeting, as well as the Provider Federation Board, with a proposed plan set out in terms of the way forwards. She highlighted that a large part of the problems is caused by a reduction in the number of patients returning to reside within the care home sector. WWL will therefore pilot from September 2022, the discharge of patients in to care home settings with WWL 'fall sitters' accompanying them. A further blocker is the nationally mandated discharge to assessment forms, which prescribe (rather than describe) what must be provided for a patient in a care home. The Integrated Care Board (ICB) have expressed support for a move away from using this document, since it is often seen to prescribe an overly high acuity package of care which deters care homes from taking patients due to concerns that they are unable to provide this.

The Board received and noted the update.

114/22 Committee Chairs' reports

The Chair handed over to the Non-Executive Director Chairs of the sub-Board Committees, to allow them to present their bimonthly reports.

(a) Audit Committee

Mr I Haythornthwaite, Chair of the Audit Committee summarised the report which had been circulated in advance of the meeting.

No queries were raised.

(b) Finance and Performance Committee

ii. Mr A Tumilty, Chair of the Finance and Performance Committee (F&P), gave a summary of the report which had been provided in advance of the meeting. She noted that a further meeting had taken place during the previous week and that this would be reported at the following Board meeting. The proximity of the two meetings was noted and it was agreed that following the next F&P meeting, efforts would be made to draft and approve the report quickly. So that it could be circulated to the Board prior to the Board meeting.

iii. No queries were raised.

(c) People Committee

Mrs L Lobley, Chair of the People Committee gave a summary of the report which had been provided in advance of the meeting.

The Chair queried how the issues of bullying and harassment for black and minority asian staff are being addressed.

The Chief People Officer described how the newly established Equality Diversity and Inclusion networks will facilitate the generation of feedback and ideas amongst those who are part of the networks, including both members of those groups or 'allies' who do not actually share the characteristics themselves.

Mrs F Thorpe noted that on a recent visit to the Staff Wellness Lounge she had discovered that some staff had been unaware that it existed or that they were permitted to use the facility and queried the planned method for publicising this.

The Chief People Officer appreciated that often, global email communications are not received or read by all staff and that going forwards the staff engagement associates and staff side representatives will be invited to assist with this by spreading the spoken word out on their visits around the Trust sites.

Lady R Bradley queried the recruitment and retention plan to reduce vacancies by October 2022 and what it is anticipated that this reduction will be.

The Chief People Officer noted that the majority of vacancies are with nursing and that the Global Training and Education Centre pipeline will address these in the main. She added that the workforce plan will be presented at the next People Committee, including a graph which plots achievement against the set trajectory.

The Chief Nurse added that the retention programme and work around staff development will further strengthen the position.

The Board received and noted the updates provided.

115/22 Board assurance framework (BAF)

The Director of Corporate Affairs summarised that the document provided addresses the corporate objectives and key risks to their delivery, reminding the Board that it is not intended to act as a risk register.

The Chief People Officer noted that there is no risk profiled for objective CO6 but that one would be formulated at the upcoming Divisional Quality Executive Group around leadership capacity and capability, which will be included in the following iteration of the document.

Prof C Austin queried the biggest challenge to staffs' personal development and whether this impacts on retention.

The Chief People Officer advised that the Trust has an apprenticeship plan, a learning plan and a learning needs analysis which has been recently conducted but that due to time and financial constraints, these are not deliverable, therefore they will be revised. Moving forward the review will be done in July and August so that any shortfall with funding can be included in the business planning cycle for the following year.

Lady R Bradley noted that in some cases, achievement of one corporate objective may hinder achievement of another and queried how this is managed.

The Director of Corporate Affairs explained that the BAF is scrutinised by the Executive Team prior to being presented to the Board and that where it is considered that there are competing interests, this is discussed. He agreed that moving forwards, this should be highlighted in the verbal report to the Board.

Mr I Haythornthwaite queried whether the financial risk identified is still tolerable.

The Chief Finance Officer advised that until the forecast changes and it becomes evident that WWL can not deliver that forecast it should remain but it does require reviewing on a monthly basis.

Mr A Tumilty added that the BAF risks continue to be developed and that F&P acknowledge that they will be ever changing.

Mrs L Lobley queried how the Board can be assured that operational risks are being escalated appropriately.

The Director of Corporate Affairs clarified that this operational risks do not relate to delivery of strategic objectives. He explained that these are managed by the Risk Management Group, which is chaired by the Chief Executive with input from colleagues at various levels and specialisms. Risks scoring 15 or above are reviewed at each meeting and escalated as required . The Deputy Chief Executive added that operational risks are also discussed at each monthly divisional assurance meeting.

Mrs F Thorpe queried whether the risk to delivery of objective CO15, around developing local relationships and ensuring that these align to WWL's priorities, is correctly articulated.

It was agreed that work would need to be undertaken to ensure that the document takes account of the importance of partnership working for urgent care and how this affects delivery of CO12.

ACTION: Deputy Chief Executive

The Board received and noted the update.

116/22 Integrated performance report

Mrs L Lobley queried whether the report could contain additional figures in some areas to identify the position across the whole of GM to allow for benchmarking, particularly due to the post pandemic position in many areas. The Chair agreed to discuss this with the Chief Executive on his return.

Mrs A Tumilty noted that complaints responses are currently low.

The Chief Nurse advised that work is ongoing to address this and that it is reported in to Q&S who will retain oversight – the document will be updated prior to the next Board meeting to set out progress made in this area.

The Medical Director noted the number of serious incidents incidents reported by WWL and that the number of reports submitted by each Trust is not available in the public domain. He had been trying to obtain this to allow for benchmarking, although it was proving difficult.

The Deputy Chief Executive suggested that she provides an update, following the recent F&P meeting which had taken place in the previous week. She advised that WWL are achieving ahead of their cancer plan, as well as 78 week and 52 weeks standards and are due to reach the 104-week milestone by June 2022, the number of people clinically prioritised as urgent is reducing and theatre utilisation is at 83%, where the national standard is 81%. The waiting list has stabilised for the first time in 18 months. She noted the potential for NHSI/E teams to request at any time to review WWL's position here and that, if that happened she is confident with the processes and operations that WWL has in place. She assured the Board that no patients are being disadvantaged due to clinical lists, which are compiled based on clinical priority.

Lady R Bradley noted the position in respect of the 'did not attend' (DNA) rate for outpatients and queried whether there is a digital solution.

The Deputy Chief Executive reported that WWL's text reminder service was deactivated during the pandemic but that currently there is no funding identified to roll this out again across all specialities. It is being used in some areas and she is expecting a report back on suggested funding solutions as the benefit of this service has been recently acknowledged by the Executive Team and the reduction in DNAs of 2% in a recent pilot scheme was considered positive. She clarified that the business case figure could have been agreed by ETM but that other business cases were reviewed at a similar time which were considered to be more urgent and to pose a more significant risk to patient safety such as that relating to the staffing for the breast one stop service.

The Board received and noted the scorecard and additional updates provided.

117/22 Review of well led action plan

The Director of Corporate Affairs noted the recommended closure of action seven and advised that the remaining actions are on track to be closed before the end of the financial year, although proposed extensions to two of the action due dates. He reminded the Board that they had agreed to invite Deloitte back to review WWL's progress against the plan in 12 months' time and that this would include a review of feedback from the Shadow Board programme. He reported that the programme had been positively received by participants thus far and that the development of these individuals will be carried forward by the organisation, despite the action being recommended for closure.

The Board received the report, noted its content and **APPROVED** closure of action seven and the revised deadlines for actions one and four.

118/22 Q4 2021/22 learning from deaths report

The Medical Director gave a summary of the report provided.

Mrs A Tumilty noted WWL's position in respect of the rising summary hospital-level mortality indicator (SHMI) figure, she queried whether this is of concern.

The Medical Director advised that it is and this will therefore be discussed at the next Q&S meeting and included in the associated AAA report.

Lady R Bradley noted the prevention of future deaths (PFD) notice received by both WWL and a mental health trust and queried when and how the issue of a lack of synchronicity between the records held by WWL and the Greater Manchester Mental Health Trust will be dealt with.

The Medical Director noted the difficulties in being able to share records between organisations and that it has been set out in the response to the PFD that unfortunately this is not within WWL's gifts to do currently.

Lady R Bradley queried whether patients who have waited a long time for care on a waiting list and who die before they received treatment are recorded anywhere in the data.

The Medical Director advised that WWL have committed to reviewing deaths occuring within the community, even where patients are not under the care of the community service division and that these will be examined by medical examiners going forward, caveating that currently it is unlikely that all incidents will be captured.

Mrs F Thorpe noted adequate assurance provided that WWL we are complying with the nationally mandated requirements for reporting deaths, although she felt that there should be more detail included in the report to identify the learning and actions being taken as a result.

The Medical Director agreed to include this in the next report, which would be presented to Q&S in the first instance.

ACTION: Medical Director

Mrs L Lobley asked whether there is there evidence that any patient pathways are not as effective as they could be and that this is affecting deaths, particularly in terms of frail and elderly patients who may be ready for discharge.

The Medical Director explained that he had no cause for concern here, highlighting the frailty service now provided in A&E and the step down service now operating through the Jean Hayes Reablement Unit.

The Deputy Chief Executive added that the virtual ward team have been asked to turn their attention to frailty in terms of those leaving hospital and how they can support these patients.

The Board received the report and noted its content.

119/22 Freedom to Speak Up (FTSU) mid year report

Mrs A Tumilty noted that this item had been included on the consent agenda but was concerned with the fact that staff use this service as they report that they did not think their concerns would be taken seriously if reported elsewhere.

The Chief People Officer noted the need to link the FTSU service with the piece of work around compassionate leadership and the change in culture aimed to ensure staff feel comfortable to speak up and are aware of the action taken following reports made to the service.

The Board received and noted the report.

120/22 Consent agenda

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

1. THAT the finance report be received and noted.

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

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

4. THAT Lady R Bradley be **APPOINTED** as the Senior Independent Director with immediate effect.

121/22 Questions from members of the public

No queries were raised by any members of public present at the meeting and none had been submitted in advance of the meeting.

122/22 Date time and venue of the next meeting

The next meeting of the Board of Directors will be held on 5 October 2022, 12.15 to 4.15pm, in the Boardroom at Trust Headquarters.

Action log

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
8 Jun 2022	76/22(a)	Staff story	Consider whether a forum exists, or should be established, for Advanced Nurse Practitioners and Physicians Associates, if likely to benefit this group	Medical Director and Chief Nurse	5 Oct 2022	Deferred. Verbal update to be provided.
3 Aug 2022	115/22	Board Assurance Framework	Discuss with the Risk Manager the amendment of CO15 to take account of the importance of partnership working for urgent care and how this affects delivery of CO12.	Deputy Chief Executive	5 Oct 2022	Verbal update to be provided.
3 Aug 2022	118/22	Q4 2021/22 learning from deaths report	Included more detail in the report to identify the learning and actions being taken as a result.	Medical Director	5 Oct 2022	The information requested will be included in the Dec 2022 report.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	05/10/22
Presented by:	Chief Executive
Prepared by:	Director of Communications and Stakeholder Engagement
Contact details:	T: 01942 822170 E: anne-marie.miller@wwl.nhs.uk

Executive summary

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

Link to strategy

There are reference links to the organisational strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

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

Legal implications

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

People implications

There are no people risks associated with this report.

Wider implications

There are no wider implications associated with this report.

Recommendation(s)

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

Report

I know I speak on behalf of WWL when I say how incredibly saddened we were by the news of Her Majesty Queen Elizabeth's passing last month, and our heartfelt condolences continue to be with the Royal Family at this time. Her Majesty devoted her life to public service, and it was our proudest moment when she awarded the NHS the George Cross for its compassion and courage of the last 74 years, in particular during the COVID-19 pandemic. With that said, our teams were quick to respond to the demands of the Bank Holiday, which understandably took place at short notice, to make sure safe care for our patients could continue to the best possible standard.

Since our last board meeting, colleagues were informed that Ian Boyle, our Chief Finance Officer (CFO), will be leaving WWL at the end of November to take up the role of CFO at the Northern Care Alliance NHS Group. On behalf of the Board of Directors I'd like to place on record our thanks to Ian for everything he has achieved during a period of transition and challenge for the NHS and wish Ian all the very best for the future. In line with any Board appointment, we have commenced the robust recruitment process for our next Chief Finance Officer, ensuring interim arrangements are in place before Ian leaves the Trust.

Managing the balance in our priorities is essential to providing the safest and most effective care possible, which is why our winter planning and preparations are vital this year. Our focus must remain on providing urgent and emergency care to patients who need it the most, but this runs parallel with maintaining and maximising our elective recovery capacity to ensure that we stay on course to eliminate 78-week waits by March 2023. The elective recovery work at Wrightington Hospital is leading the way, not only for WWL, but in Greater Manchester as one of a number of dedicated elective recovery hubs within the region.

A major contributor in our winter planning is providing protection from the impacts of COVID-19 and flu. It is our commitment as an organisation to protect each other, our families, our patients and the wider public of the Wigan Borough and surrounding areas, and it remains of paramount importance for us to ensure that colleagues at WWL take up the COVID-19 booster vaccination this autumn as soon as possible. Our staff vaccination programme began on Tuesday 20th September with a phased process of invitations currently being worked through to ensure the best level of protection is available to all. Flu vaccinations are also due to start later this month, a vaccination which carries a great deal of significance every year in how we can work to prevent avoidable illness and hospital admissions.

Delayed discharge is one of the major challenges we are dealing with at this time. We are working with partners to increase short-term care home capacity and working differently with our services on admission avoidance to lower the number of beds being occupied in our hospitals. We have been making positive progress with this throughout September and our goal is for the number of patients who have 'no right to reside' to continue to decrease, freeing up bed spaces for those who critically depend on them. Our community services and Virtual Hub have played key roles within this process, particularly when it comes to admission avoidance and the promotion of self-care.

Our Virtual Hub service model offers three tailored approaches to providing care for patients in their own homes through what are known as the Virtual Hospital, Monitoring@Home and Self-Monitoring@Home, which are based on the differing levels of care and monitoring our patients require. The feedback from patients suggests they are becoming more and more confident with self-monitoring and generally feeling more comfortable within their own home settings than they would be if they had a prolonged stay in hospital.

The Jean Heyes Reablement Unit at Leigh Infirmary also provides support with patient flow and discharge by helping patients recover and return home more quickly, in a safe and supported manner. I was delighted to visit the unit with our Chair, Mark Jones, members of the Executive Team, MP for Leigh James Grundy and the Leader of Wigan Council, Councillor David Molyneux, for the official opening of the unit in September. We were joined by members of Jean's family, including her widower, Bill Heyes who unveiled the plaque in Jean's memory. The unit is named

after the late Jean Heyes, who provided more than 50 years of service at WWL and was a passionate supporter of reablement care, the very model being used at the unit. The team of therapists, nurses, GPs, hospital consultants and social care staff are providing an excellent standard of service to our patients and helping them to maximise their potential to live full lives post-discharge.

We received more good news at Leigh Infirmary in September, with the announcement that our ambitious plan to develop and progress a £10million Community Diagnostic Centre (CDC) received formal approval. The new CDC, which forms part of our plans to further invest in services at our Leigh site, will be an expansion of our current services and will provide a modern 'one stop shop' for diagnostic and healthcare facility. The CDC will increase the range of diagnostic tests available at Leigh and offer an increase in capacity, further contributing to our aim of becoming a premier centre for rehabilitation, diagnostics, and outpatient services. Building work is set to commence in 2023, with CT and MRI scanning facilities due to be installed to match those already available at our Wrightington and Wigan sites. Once finished, we expect to be able to treat a potential of 40,000 additional patients per year.

I was delighted to learn that a number of our staff and Trust initiatives have been shortlisted for a number of external awards, including for UK Best Employer of the Year for Nursing Staff at the Nursing Times Workforce Summit and Awards in November. WWL's Steps4Wellness Team have also been named as finalists in the Staff Wellbeing Initiative category at the National Orthopaedic Alliance's Excellence on Orthopaedics Awards. We have received two short listings at the NHS Communicate Awards, the first for Communications Officer, Megan Crank in the NHS Rising Star category and for the second year running in the Board Commitment to Communications category. Nominations have also been submitted for the Chief Allied Health Professionals Officer Awards, the National Institute for Health Research (NIHR) Greater Manchester Health and Care Research Awards, Intensive Care Society Awards and Health Service Journal (HSJ) Partnership Awards.

In September we hosted the first in-person Long Service Awards ceremony since before the COVID-19 pandemic, the 39th ceremony of its kind. Colleagues who have worked at WWL for 20, 30, 40 and 50 years were celebrated on the day, with 32 members of staff in attendance at the Medical Education Centre. I heard first hand from our Chair Mark Jones, that it was a great event and an example of the positive working culture and environment colleagues have created for each other at WWL. At the end of the month our volunteers were also recognised with a similar ceremony, celebrating those who have hit long service milestones for volunteering at the Trust.

In addition to this type of internal recognition, Friday 14th October 2022 marks the return of our staff awards ceremony, the Staff Thanks and Recognition (STAR) Awards. We received 404 nominations from a wide variety of services within the Trust, and the STAR Awards has already provided our staff with a much-needed boost in preparation for the challenging winter months ahead. I look forward to attending the sponsored ceremony alongside 250 colleagues.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Committee report

Report from:	Audit Committee
Date of meeting:	21 September 2022
Chair:	Ian Haythornthwaite

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

ALERT
▪ The Committee does not wish to alert the Board in respect of any issues.
ASSURE
▪ The Board Assurance Framework provides assurance that the correct processes and procedures are in place to monitor delivery of the corporate objectives and maintain appropriate oversight of corporate risks to delivery. ▪ The counter fraud report provided assurance that the counter fraud measures in place across the trust effectively address the level of fraud related activity taking place. ▪ The internal audit follow up report provided assurance that WWL is implementing audit recommendations. ▪ The Committee received the freedom to speak up report and took assurance that this service and its processes are functioning as they should be.
ADVISE
▪ Following concerns being raised, the Committee was advised of the new processes being put in place to monitor patients bringing valuables and jewellery in to the hospital and requested that they are able to monitor these processes moving forwards. ▪ Following queries raised around waivers, the Committee agreed that the procurement team will be invited to future meetings to provide more insight in this area. ▪ The external auditor's quarter 1 update and benchmarking report were received. ▪ The internal audit two years summary provided assurance that the organisation is actively closing off outstanding audit issues. ▪ The Committee received two internal audit reports on the data protection and security toolkit and pressure ulcers in respect of which moderate and substantial assurance were received respectively. In respect of the former it was explained that the threshold for moderate used is that set by NHS Digital and is therefore higher than those used in other audits. It was advised that most Trusts receive a moderate rating here. ▪ The Committee received the minutes of its reporting groups.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED
▪ Deep dives were carried out in to two areas of risk scored at 15 plus and provided assurance that the correct processes for managing those risks are in place. o Risk 2111: Clinical waste – the Committee were assured around the processes in place to mitigate this risk. o Risk 2384: District nurse staffing capacity and capability – processes in place to address this risk provided assurance to the Committee, although it was noted that sign off and implementation of the transformation plan and additional associated risks identified during that process will require ongoing monitoring. The risk will therefore be brought back for the consideration of the Committee if necessary.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	People Committee
Date of meeting:	5 September 2022
Chair:	Lynne Lobley

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

ALERT

- Following the staff story provided by a Vascular Physiotherapist, the Committee noted that succession planning for this role and other smaller services must be mapped out to ensure the stability of services moving forwards.
- The Committee had concerns around how the impact of the wider labour market shortages may affect WWL's turnover, especially associated with the unregistered clinical workforce, administrative & clerical and estates & facilities roles. This aligns to the areas with the most significant turnover with less than 12 months' service (where the percentage of leavers with less than 12 months' service is around 25%).
- The Trust is currently spending above the NHSE agency ceiling profile but have plans to reduce this expenditure – for example 10 senior house officer level positions have been approved to reduce run rate and have been recruited to. A rate card (the hourly rate of pay for bank / agency workers) is underway, including a benchmarking process. WWL have in place exit plans to ensure that off framework agencies are not used moving forwards.
- The fair experience for all report showed that, during the 2-month reference period, BAME colleagues (3 cases) were 6 times more likely to enter the formal disciplinary process than white colleagues. The disciplinary scrutiny and review panel reviewed the known facts for those cases along with the associated context and was satisfied that formal disciplinary investigation was warranted in each case (alleged fraud, sexual harassment – where a previous file note had been issued for similar concerns and falsification of clinical records).
- The findings from the team stress management pilot show the level and impact of presenteeism within the teams involved. The teams valued the process as a positive engagement opportunity and identified many simple actions that could be easily implemented at local level by managers to address issues that cause stress in those teams.

ASSURE

- The team stress management programme provides good evidence that the Trust is taking a positive and structured approach to the HSE stress management standards. It's targeted roll out will further support this evidence base.
- The staff story illustrated how informal research activity is being completed in non-medical teams and highlighted how valued allied health professionals are as members of specialist teams.
- Corporate objective CO10 around meeting the financial plan and delivering efficiencies is now being aligned with the workforce efficiencies agenda. A risk profile has been added

for objective CO6 around the capability and capacity of line managers, as well as HR and staff side colleagues, as the organisation moves towards a person-centred approach to people management policy, which moves away from trigger, rule and escalation-based approaches.

- Governance processes are now in place around workforce efficiencies through the Pay Review Group and work to deliver revised rate cards and spend reduction plans by the end of September 2022 is on track. There is now a clear programme of work in place to look at how WWL can reduce the requirement for temporary workers, reduce cost, improve the governance and create efficiencies around the recruitment and onboarding processes. The 'people digital' systems are also being used to ensure transparency and support scrutiny here.
- There is now a centralised team co-ordinating the rollout of the various 'people digital' projects due to their interdependencies. Planned project deliverables that have been achieved to date include matching ESR establishment to the finance ledger. Roll out plans for e-rostering, self-service and Empactis are all on target.
- The divisions now all have retention groups in place, feeding into our strategic retention group and Our Family, Our Future, Our Focus Staff Engagement Group.

ADVISE

- The performance dashboard provides appropriate assurance and sets moving targets aligned to delivery plans / improvement trajectories (where appropriate), which allows for monitoring to ensure that the Trust is on track for delivery on an ongoing basis. Targets will be kept under regular review and will change based on the improvement trajectory for delivery. As the dashboard is developed into the overarching business intelligence interactive performance dashboard, trend over time data will become more visual and transparent in its display.
- A forecasting tool is now being used for recruitment and retention, which incorporates all of the recruitment pipelines and turnover and retirement projections. This will be used at Trust and divisional level to monitor progress and to forecast recruitment & retention activities. As it develops further, it will also be used to help predict issues with future service stability.
- The fair experience for all report now includes dignity at work and grievances, which supports progression towards meeting corporate objective CO6 around culture and civility and aids triangulation here.
- Good assurance was provided that the freedom to speak up processes are working to agreed timelines and that there are plans for freedom to speak up publicity during speaking up month in October.
- The medical appraisal & revalidation report was recommended to the Board of Directors for approval.
- The equality, diversity and inclusion report was approved for publication.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- Risks were discussed in the context of the corporate objectives as outlined above.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Research Committee
Date of meeting:	5 September 2022
Chair:	Clare Austin

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

ALERT

- The Committee discussed the ongoing challenges in meeting the requirement for 20 joint appointments at consultant level with a University, needed to meet the current criteria for university hospital status. The Committee felt the criteria is unfair, unreasonable and counter to government policy. The Committee agreed that WWL as an organisation should take more robust action to address this. Associated recommendations for the Board will be set out in a paper accompanying this report.

ASSURE

The Committee were assured:

- By the improving level of research related engagement across the organisation
- By the broadening of clinical research leadership and clinical leads (including appointments from nursing and allied health professionals and community division
- That the Trust is now actively seeking to increase funding to support time for research for all types of staff.
- By the work done towards developing the research culture across the organisation including:
  - The inclusion of research as a metric in the ASPIRE ward accreditation scheme;
  - The multidisciplinary input into research including the Edge Hill University think tanks;
  - Feedback obtained via a recent survey and associated feedback/follow up on this
- That the Trust is on track to achieve the average research capacity funding of £200k plus per year by 2024/25 required to meet the criteria for University Teaching Hospital
- By the ongoing monitoring of engagement and research activity
- That the Ashton Research Hub is now established and will soon be operational

ADVISE

- The Ashton Research Hub will be due to hold a formal opening ceremony shortly, for which some Board attendance will be sought

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- There is a risk to delivery corporate objective CO16 and achievement of the university hospital association criteria, which the Board is already aware of.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

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

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

ALERT

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

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

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

ASSURE

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

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

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

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

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

ADVISE

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

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

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

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

Title of report:	Board Assurance Framework (BAF) Report
Presented to:	Board of Directors
On:	5 October 2022
Presented by:	Director of Corporate Affairs
Prepared by:	Head of Risk Director of Corporate Affairs
Contact details:	T: 01942 822027 E: paul.howard@wwl.nhs.uk

Executive summary

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

Link to strategy

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

Risks associated with this report and proposed mitigations

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

Financial implications

There are no financial implications associated with this report.

Legal implications

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

People implications

There are no 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 (BAF) provides a robust foundation to support our understanding and management of the risks that may impact the delivery of Our Strategy 2030 and the annual corporate objectives 2022/23.

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

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

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

2. Risk Rating Matrix

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

RISK RATING (LIKELIHOOD x IMPACT)

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

Table 1

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

3. **BAF Review**

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

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

4. New Risks Recommended for Inclusion in the BAF

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

4.2 The following new risks have been escalated to the BAF since the last Board meeting in August 2022:

- ID 3532: Person Centred People Management
- ID 3533: Urgent and Emergency Care – Winter Pressures

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

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

6. Review Date

6.1 The next scheduled review of all risks on the BAF is December 2022.

7. Recommendations

7.1 The Board are asked to:

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

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Board assurance framework

2022/23

The content of this report was last reviewed as follows:

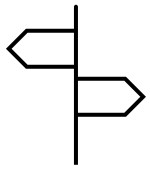
Quality and Safety Committee:	October 2022
Finance and Performance Committee:	September 2022
People Committee:	September 2022
Audit Committee:	September 2022
Executive Team:	September 2022

“ **assurance** (/əˈʃɔːrəns/) *noun*

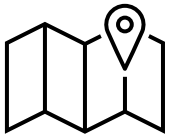
(In relation to board assurance) Providing confidence, evidence or certainty that what needs to be happening is actually happening in practice ”

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

How the Board Assurance Framework fits in

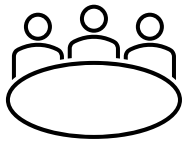


Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how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

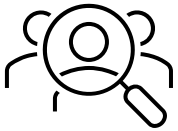


Corporate objectives: Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives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

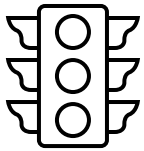
Board Assurance Framework: The board assurance framework provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains risks that are most likely to materialise and those that are likely to have the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



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



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



Reporting: To make the Board Assurance Framework as easy to read as possible, we use visual scales based on a traffic light system to highlight overall assurance. Red indicates items with low assurance, amber shows items with medium assurance and green shows items with high assurance.

Understanding the Board Assurance Framework

RISK RATING MATRIX (LIKELIHOOD x IMPACT)

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

DIRECTOR LEADS

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

DEFINITIONS	
Strategic ambition:	The strategic ambition that the corporate objective has been aligned to – one of the 4 Ps (patients, people, performance or partnerships)
Strategic risk:	Principal risks that populate the BAF; defined by the Board and managed through Lead Committees and Directors.
Linked risks:	The key risks from the operational risk register which align with the strategic priority and have the potential to impact on objectives
Controls:	The measures in place to reduce either the strategic risk likelihood or impact and assist to secure delivery of the strategic objective
Gaps in controls:	Areas that require attention to ensure that systems and processes are in place to mitigate the strategic risk
Assurances:	The three lines of defence, and external assurance, in place which provide confirmation that the controls are working effectively. 1st Line functions that own and manage the risks, 2nd line functions that oversee or specialise in compliance or management of risk, 3rd line function that provides independent assurance.
Gaps in assurance:	Areas where there is limited or no assurance that processes and procedures are in place to support mitigation of the strategic risk
Risk Treatment:	Actions required to close the gap(s) in controls or assurance, with timescales and identified owners. Five T's - Terminate, Transfer, Tolerate, Treat, Take the Opportunity.
Monitoring:	The forum that will monitor completion of the required actions and progress with delivery of the allocated objectives

Our approach at a glance

Our Strategy 2030

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

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

FY022/23 Corporate Objectives

Patients

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

People

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

Performance

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

Partnerships

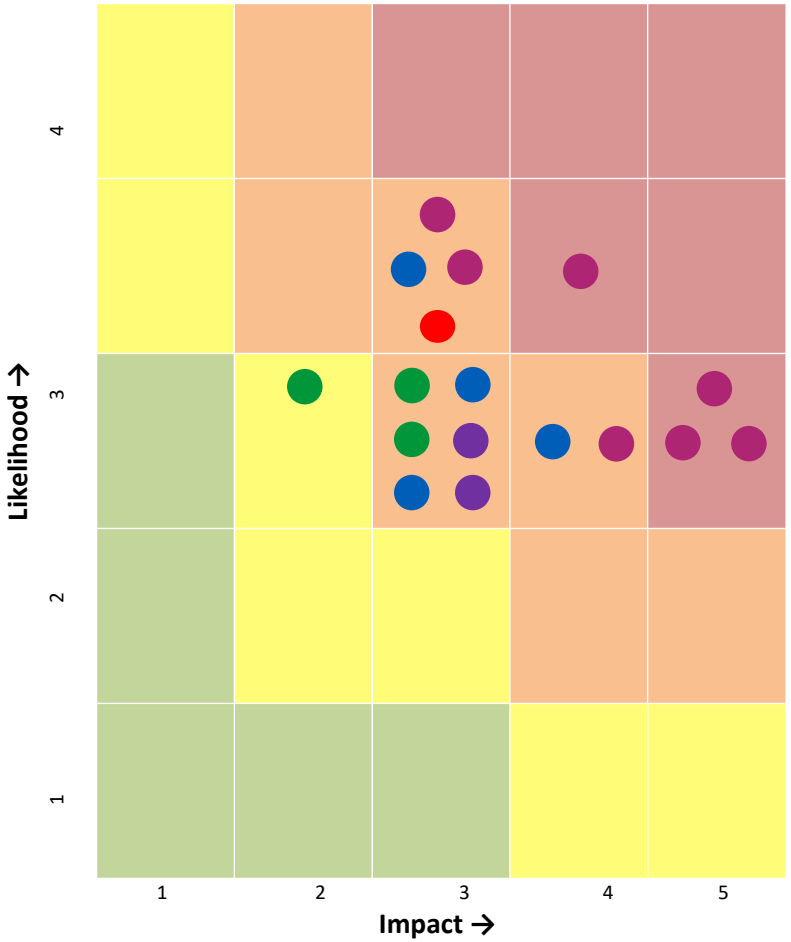
We will…
- Positively impact on the social and economic factors of our Borough
- Develop effective relationships within Wigan Borough and Greater Manchester for the benefit of our patients
- Make progress towards becoming a University Teaching Hospital

Risk management

Our risk appetite position is summarised in the following table:

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

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



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

Patients

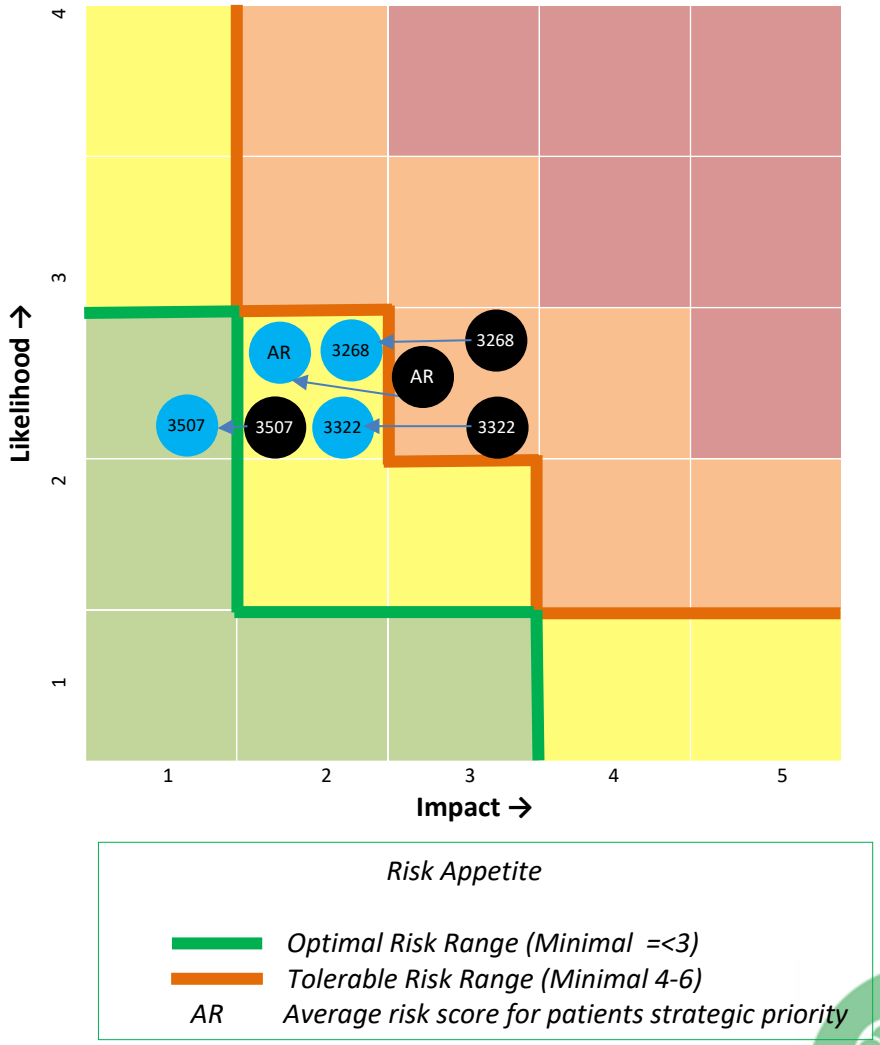
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

Monitoring: Quality and Safety Committee

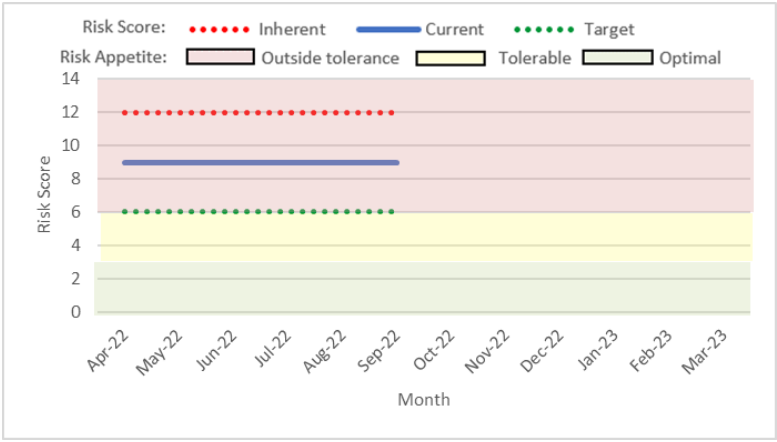
The following corporate objectives are aligned to the **patients** strategic priority:

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

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

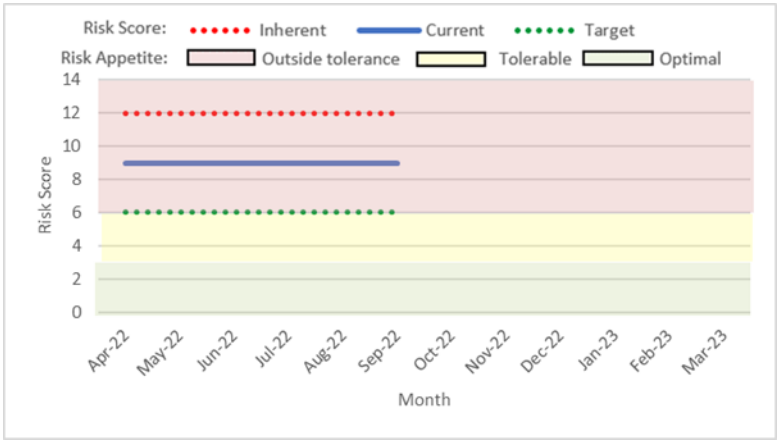


Corporate Objective: **CO1** Improve the safety and quality of clinical services							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 1: Clinical Services - Recognition, screening and treatment of the deteriorating patient**						
	Risk Statement:	There is a risk that patients who are deteriorating are not appropriately clinically escalated due to non-identification of sepsis, AKI or baseline observations resulting in mortality related to sepsis and AKI.						
Lead Committee	**Quality and Safety**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal	
Lead Director	**MD**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Safety, quality of services & patient exp.	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	3270	
Date of last review	**21.09.22**	**Risk Rating**	12. High	9. High	6. Moderate	**Risk treatment**	Treat	



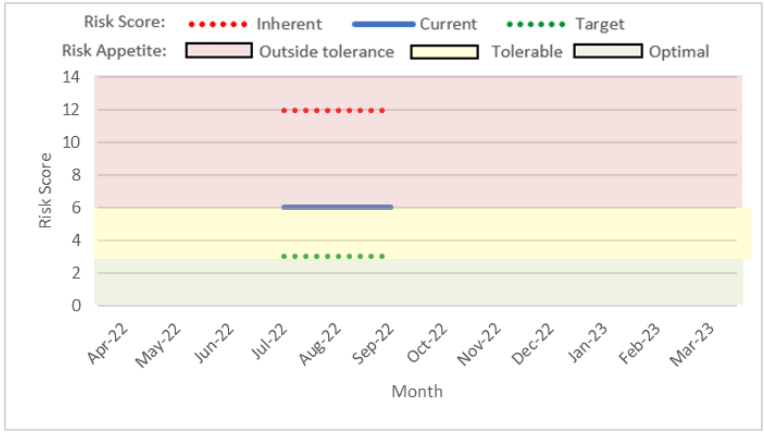
Strategic Opportunity / Threat Linked Risk	Existing controls	Gaps in existing controls	Assurances (and date last seen)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3268)** 3270 – Consultant cross cover from SRFT for AKI service	• This is a dedicated corporate objective for FY2022/23. • Rapid Improvement Group. • Sepsis QI group. • Sepsis Improvement Plan. • Sepsis live in HIS. • Visibility of AKI and Sepsis Nurse in clinical areas • AKI and sepsis audits undertaken. • Themed SIRI panel on sepsis in Sept 2021 focused on improvement work and highlighted achievements to date.	• Workload demands for AKI and Sepsis nurses. • AKI Improvement Plan needs to be developed.	**2nd Line:** • Quality & Safety Committee August 22.	• No gaps currently identified.	1. Deteriorating Patient Improvement Group continues to meet monthly.	Monthly

Corporate Objective: **CO3** Improve the delivery of harm free care								**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 2: Harm Free Care - Avoidable Pressure ulcers**							
	Risk Statement:	There is a risk that our systems and processes, coupled with challenged staffing, may not facilitate the swift identification of potentially avoidable pressure ulcers resulting in harm to our patients.							
Lead Committee	**Quality and Safety**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal		
Lead Director	**CN**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Safety, quality of services & patient exp.		
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	3323		
Date of last review	**21.09.22**	**Risk Rating**	12. High	9. High	6. Moderate	**Risk treatment**	Treat		



Strategic Opportunity / Threat Linked risk	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3322)** 3323 – Tissue viability team capacity	• Pressure ulcer link nurses trained within areas. • 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. • Datix improvements started to better capture pressure ulcer management.	• 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. • under resourcing of Tissue Viability Team.	**2nd Line:** • Quality & Safety Committee August 22	• No gaps currently identified.	1. Harm Free Care Business Case to be drafted. 2. Continue to accurately record NEWS, PEWS and MEWS. 3. Continue the roll out of human factor training.	31.10.22 CN 31.03.23 CN 31.03.23 CN

Corporate Objective: **CO4** Improve the quality of care for our patients								**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 3: Ward accreditation programme**							
	Risk Statement:	There is a risk that future waves of covid may affect the supernumerary status of ward leaders, due to the impact of covid on staffing levels in clinical areas, challenging the achievement of silver accreditation level. This is a single person service with paper based scoring and reporting which may also influence the speed of the roll out.							
Lead Committee	**Quality and Safety**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal		
Lead Director	**CN**	**Likelihood**	4. Likely	2. Unlikely	1. Rare	**Risk category**	Safety, quality of services & patient exp.		
Date risk opened	**20.07.22**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	-		
Date of last review	**21.09.22**	**Risk Rating**	12. High	6. Moderate	3. Low	**Risk treatment**	Treat		



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3507)**	• The Accreditation assessments are currently underway and to date wards assessed have achieved a bronze rating.	• Accreditation project plan to be developed.	**2nd Line:** • Quality & Safety Committee August 22	**2nd Line:** • Project plan to go to NMAHP, NMALT and new Quality Assurance Group.	1. Accreditation project plan to be developed by Clinical Quality Lead and service transformation lead.	30.11.22 CN

People

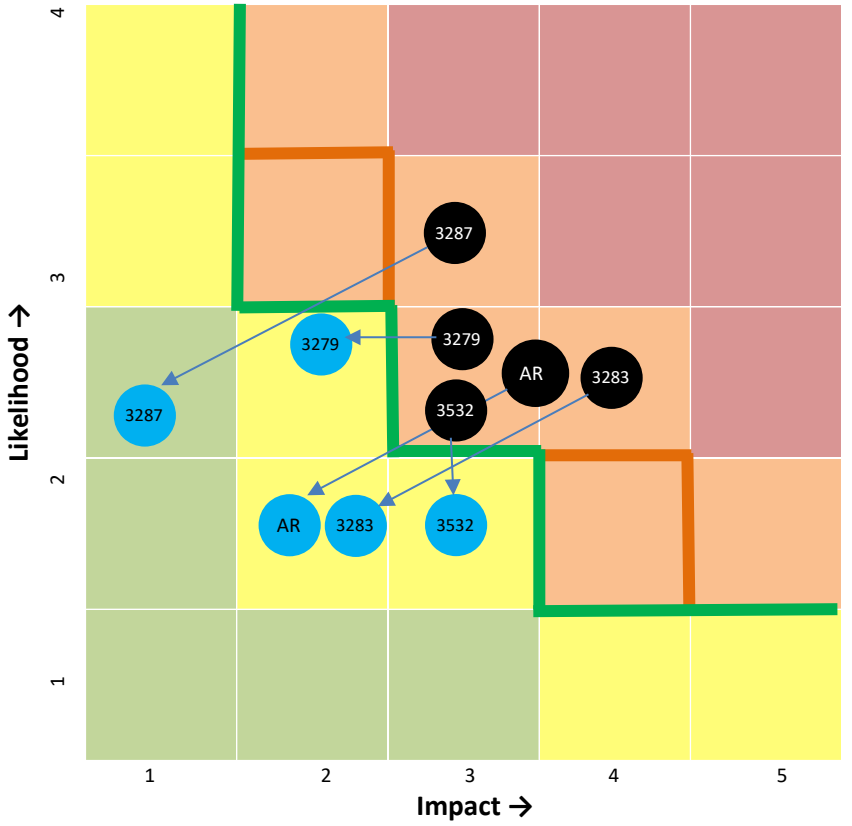
To create an inclusive and people-centred experience at work that enables our WWL family to flourish

Monitoring: People Committee

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

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

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



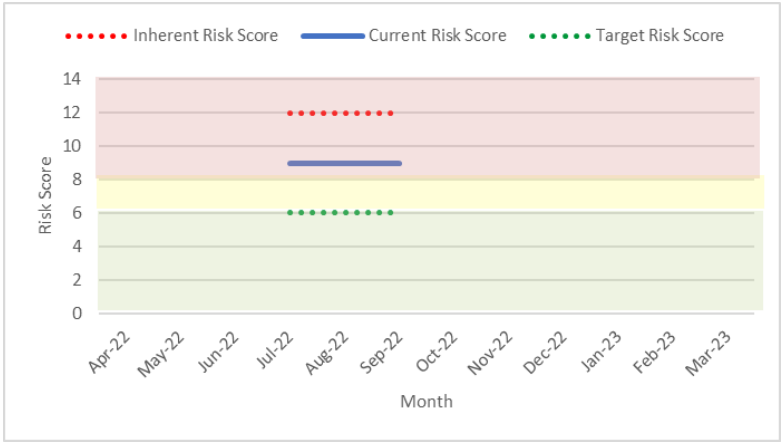
Risk Appetite

Optimal Risk Range (Cautious =<6)

Tolerable Risk Range (Cautious =<8)

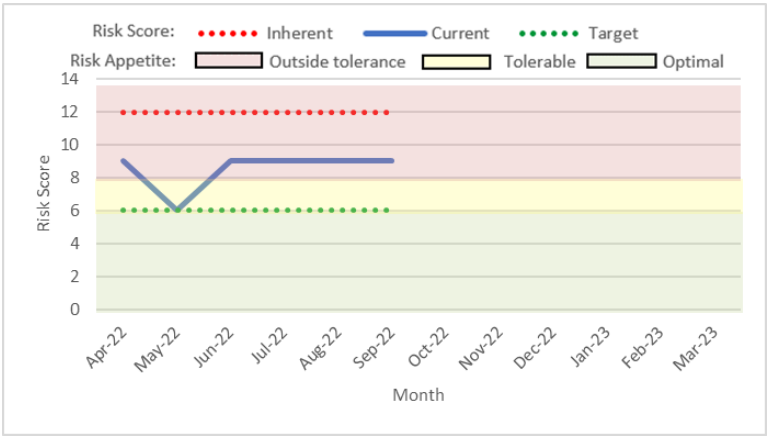
AR *Average risk score for people strategic priority*

Corporate Objective: CO6 Make working at WWL a positive experience, where everyone has a voice that matters							**Overall Assurance Level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 4: Person centred people management**						
	Risk Statement:	There is a risk, given the significant culture shift required, that leaders may not have the capacity and capability to embed out just and learning culture through compassionate and person-centred people management, resulting in lower engagement levels, potential for increased turnover and a poor industrial relations climate.						
Lead Committee	**People**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**CPO**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Staff Experience	
Date risk opened	**19.08.22**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	-	
Date of last review	**23.09.22**	**Risk Rating**	12. High	9. High	6. Moderate	**Risk treatment**	Treat	



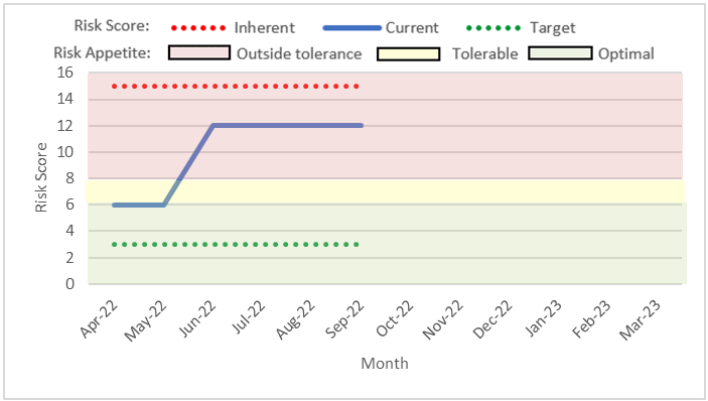
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **ID 3532**	• Civility and behaviour framework • Just & learning culture protocol • Divisional HR support • Disciplinary triage panel	• HR policy review – person centred policies • Full line manager & HR training programme – people centred people management.	**2nd Line:** • Feedback from line manager listening sessions (July) • ETM paper (August) – people management training proposal • Just culture & civility training programme place allocation (ETM September 2022)	None identified.	1. WWL HR policy handbook development (completed in partnership) 2. NW well-being and attendance management policy 3. NW well-being and attendance management leadership development 4. Development of WWL training programme – HR team, staff side & line managers for roll out in 2023/24 5. Senior leaders (divisional), HR & staff side to complete Just & Learning Culture and Civility training programme provided by Northumbria University. Places commissioned and cohorted for January launch	2. March 2023 – Strategic HR Lead 2. October 2022 – NW HRDs 2. December 2022 – NW HRDs 4. March 2023 – Strategic HR Lead January 2024 – Associate Director of Employee experience & well-being

Corporate Objective: CO7 Support the health and wellbeing of our colleagues							**Overall Assurance Level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 5: Participation in preventative and restorative wellbeing activities**						
	Risk Statement:	There is a risk that sufficient time may not be available for staff to participate in preventative and restorative wellbeing activities within working hours, due to workload pressures and vacancies, resulting in lower engagement levels and evidence suggests this will reduce the success of the programme.						
Lead Committee	**People**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**CPO**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Staff Wellbeing	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	-	
Date of last review	**23.09.22**	**Risk Rating**	12. High	9. High	6. Moderate	**Risk treatment**	Treat	



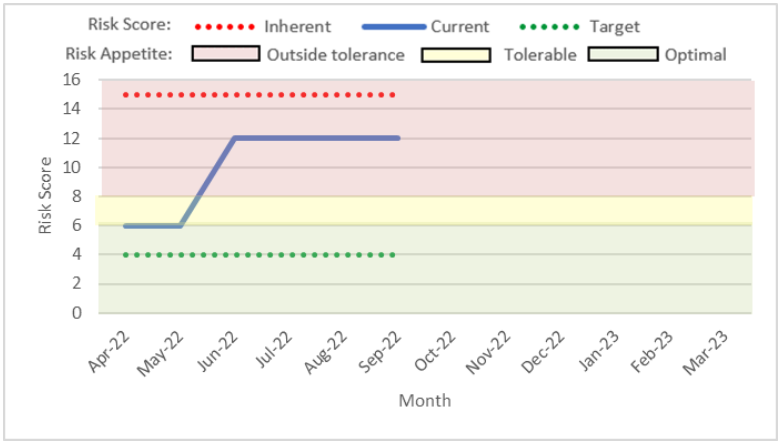
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **ID 3279**	• Your Voice Survey – well-being score. • Steps 4 Wellness Service enhancements. • Targeted in-reach activities in high-risk areas. • Wellbeing walkabouts. • Re-prioritisation and amendment of offers.	• Commitment to roster time for people to be released as needed. • Recruitment & retention update (People Committee June 2022 & September) • Additional medical SHOs business case (ETM July)	**2nd Line:** • All staff Team Brief session (July 2022) • Team stress management pilot completion (evaluation at People Committee September) • Well-being update (staff engagement steering group September 2022)	None identified.	1. Strategic needs assessment to be completed working with divisional teams. 2. Divisional well-being plans that are prioritised and implementation monitored through divisional assurance reviews. 3. Recruitment to vacancies (including international recruitment) – performance against trajectory.	November 2022 - Consultant clinical Psychologist November 2022 – Divisional Triumvirate & S4W team March 2023 – DCN & DCPO (+ recruiting managers)

Corporate Objective: **CO8** Ensure inclusion and belonging for all –ED&I							**Overall Assurance Level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 6: Fairness and compassion - workforce EDI expertise and supporting infrastructure**						
	Risk Statement:	There is a risk that EDI may not be embedded in everything we do, due to a lack of sufficient workforce awareness about EDI and we do not have substantive Workforce EDI resource, resulting in failure to deliver the EDI objectives, strategy and our statutory duties under the Equality Act.						
Lead Committee	**People**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**CPO**	**Likelihood**	5. Almost certain	4. Likely	1. Rare	**Risk category**	Staff Capacity and Capability	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	3231	
Date of last review	**23.09.22**	**Risk Rating**	15. Significant	12. High	3. Low	**Risk treatment**	Treat	



Strategic Opportunity / Threat	**Existing controls**	**Gaps in existing controls**	**Assurances (and date)**	**Gap in assurances**	**Risk Treatment**	**Due Date / By Whom**
Threat: **ID 3287** 3231- Culture of psychological safety, civility and compassionate leadership	• Workforce EDI specialist recruited (fixed term contract until January 2023). • EDI strategy approved. • Expanded staff networks supported. Training in place for network sponsors and EDI Champions. • Three independently assessed schemes approved for implementation – Rainbow Badge, Disability Confident & Race Equality Standard.	• No ongoing funding commitment	**2nd Line:** • EDI report to People Committee June 2022. • Workforce EDI objectives (People Committee – June 2022). • EDI workshop scheduled 19.09.22 **3rd line** Messenger review – highlights the need to improve EDI awareness and to increase diversity (June 2022).	No substantive EDI workforce resource to support delivery against strategic aims set out in the strategy. Workforce and leadership awareness of EDI and associated responsibilities	1. Embed colleague diversity networks. 2. Gap analyses and action plans from the three assessments. 3. Review shadow running of EDS 3 (2022) process in 2022-23. 4. Awareness and engagement programme for all (with specific focus on leadership EDI responsibilities). 5. EDI workforce objectives delivery. 6. Business case / business planning process regarding Workforce EDI specialist role. 7. EDI corporate objective cascade to all senior leaders.	Complete Workforce EDI lead – Nov 2022 Workforce EDI lead – March 2023 Workshop scheduled (Sept) Board & senior leaders training commissioned (Nov) Workforce EDI lead -March 2023 In year resolved. Substantive business case CPO –October 2022 (business planning) Divisional triumvirates & Corporate heads of service following Sep 2022 workshop (delayed due to additional bank holiday – to be rescheduled in October)

Corporate Objective: CO9 Create an environment where we are always learning, and everyone flourishes								**Overall Assurance Level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 7: Personal Development**							
	Risk Statement:	There is a risk that the prioritised learning needs analysis cannot be delivered due to funding constraints and / or inability to release staff for training, resulting in increased turnover and / or a lack of continued professional development for colleagues.							
Lead Committee	**People**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious		
Lead Director	**CPO**	**Likelihood**	5. Almost Certain	4. Likely	2. Unlikely	**Risk category**	Staff Capacity & Capability		
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	2. Minor	**Linked risks**	-		
Date of last review	**23.09.22**	**Risk Rating**	15. Significant	12. High	4. Moderate	**Risk treatment**	Treat		



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

Performance

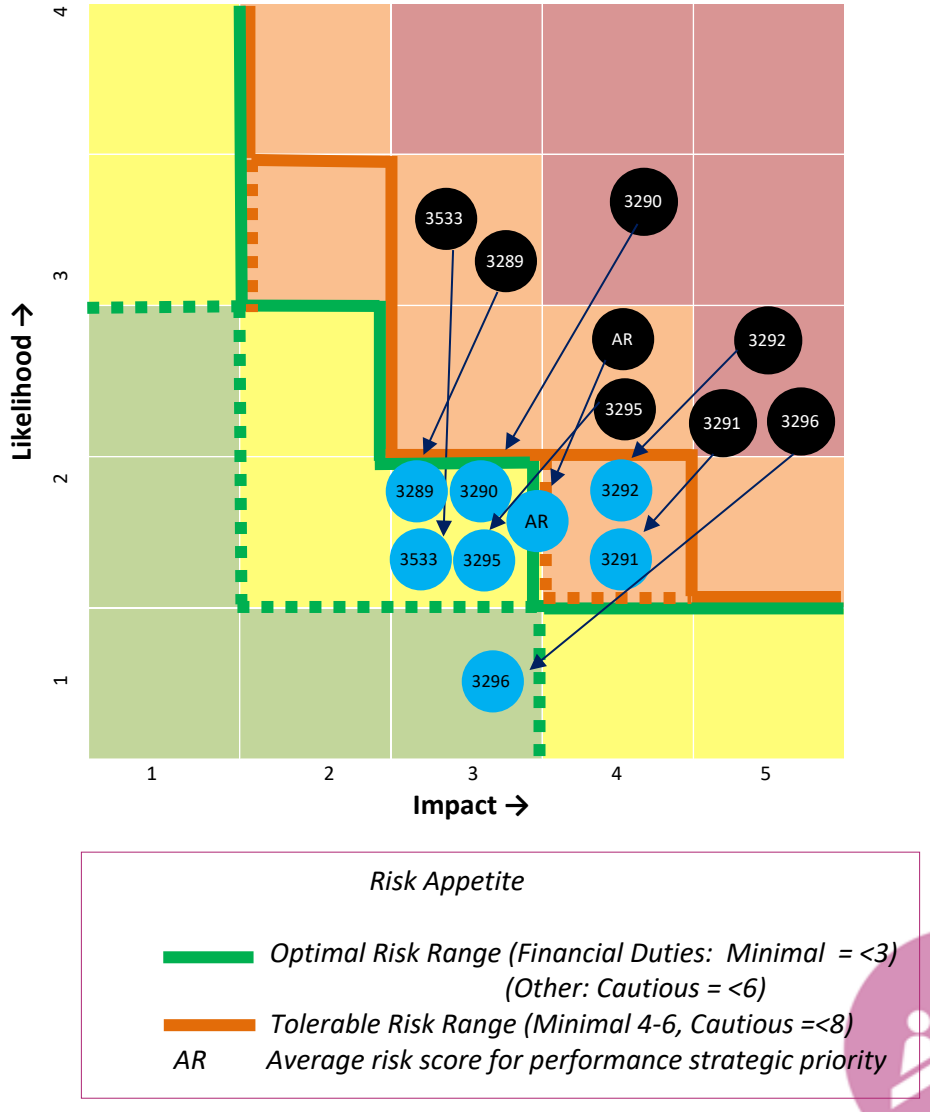
Our ambition is to consistently deliver efficient, effective and equitable patient care

Monitoring: Finance and Performance Committee

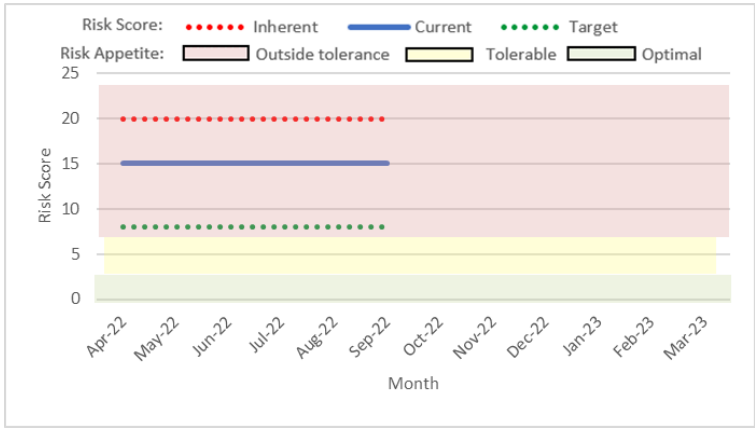
The following objectives are aligned to the **performance** strategic priority:

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

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

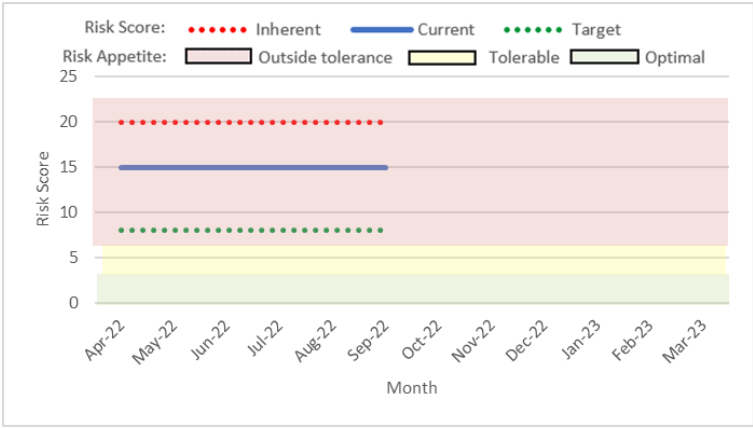


Corporate Objective: **C10** Deliver our financial plan, providing value for money services							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 8: Financial Performance: Failure to meet the agreed I&E position**						
	Risk Statement:	There is a risk that the Trust may fail to fully mitigate in year pressures to deliver key finance statutory duties resulting in the Trust receiving significantly less income than the previous financial year.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current**	**Target Risk**	**Risk Tolerance**	Minimal	
Lead Director	**CFO**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Financial Duties	
Date risk opened	**19.10.21**	**Impact**	5. Critical	5. Critical	4. Major	**Linked risks**	-	
Date of last review	**16.09.22**	**Risk Rating**	20. Significant	15. High	8. High	**Risk treatment**	Treat	



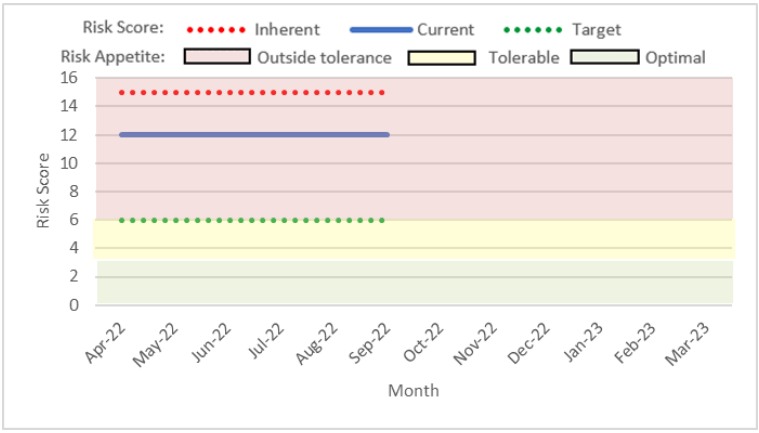
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3292)**	• Final plan signed off by Board and submitted to NHSEI - 20th June 2022. • CIP in place with actions as described in PR2. • Continued lobbying via Greater Manchester in respect of additional funding which is appropriate for current clinical capacity (Ext.) • Robust forecasting including scenario planning for worst, most likely and best case • Executive oversight of CIP & Financial performance through RAPID & Divisional Assurance Meeting • Pay control group established with scrutiny and rigour over agency spend in line with national agency controls	• Pay award funding not confirmed • System and locality reporting in infancy • Covid spend not reducing in line with funding received • Awaiting operational planning guidance for 23/24	**2nd Line:** • Finance & Performance Committee Sept 22 1st Line: Monthly RAPID meetings for applicable divisions	• No gaps currently identified.	1. Recovery actions to be developed for Executive scrutiny and sign off 2. Forecast for covid spend to be signed off through Divisional Assurance Meetings with budget adjusted to reflect improvements 3. HFMA Financial Sustainability: Getting the Basics Right review to be independently assessed by MIAA	Oct 22 CFO Q3 CFO/DCEO Q3 CFO

Corporate Objective: **C10** Deliver our financial plan, providing value for money services							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 9: Financial Sustainability: Efficiency targets & Balance Sheet**						
	Risk Statement:	There is a risk that efficiency targets will not be achieved, resulting in a significant overspend and that there is insufficient balance sheet flexibility, including cash balances, to mitigate financial problems.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current**	**Target Risk**	**Risk Tolerance**	Minimal	
Lead Director	**CFO**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Financial Duties	
Date risk opened	**19.10.21**	**Impact**	5. Critical	5. Critical	4. Major	**Linked risks**	-	
Date of last review	**16.09.22**	**Risk Rating**	20. Significant	15. High	8. High	**Risk treatment**	Treat	



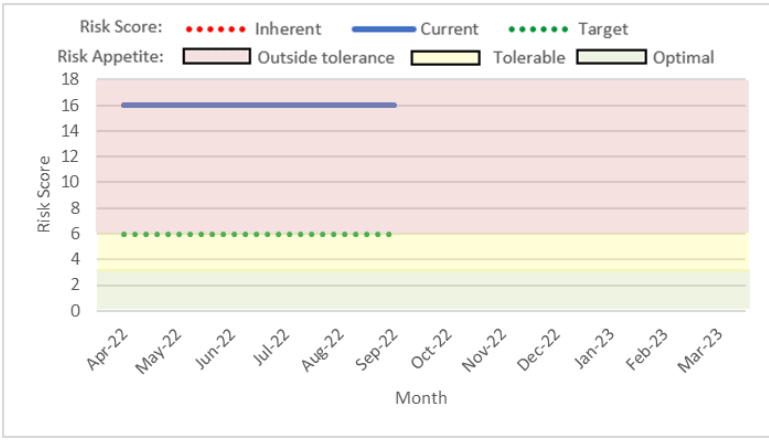
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3291)**	• Revised CIP delivery approach following review by Mersey Internal Audit Agency. • Monitored via Divisional Assurance Meetings, with additional escalation through RAPID if Divisional delivery is off plan. • Further oversight at Executive Team, F&P Committee and Board of Directors. • Work is ongoing across the GM system on developing a joint approach to productivity and cross cutting efficiency (Ext). • Transformation Board input & oversight. • Effective credit control including monitoring debtor and creditor days and liquidity with oversight through SFT. • Effective monthly cash flow forecasting reviewed through SFT	• Level of unidentified CIP • High proportion of CIP is non recurrent and non cash releasing	**2nd Line:** • Finance & Performance Committee July 22	• CIP currently not forecast to deliver the plan as at Month 5.	1. RAPID recovery meetings held with specific divisions as applicable based on agreed metrics. 2. Monthly updates on CIP presented to Executive Team, with regular updates at Trust Management Committee. 3. Engagement in GM Efficiency Programme work including productivity workstream chaired by WWL Deputy CEO (Ext)	31.03.23 CFO/DCEO 31.03.23 CFO/DCEO 31.03.23 CFO/DCEO

Corporate Objective: C10 Deliver our financial plan, providing value for money services								**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 10: Estates Strategy - Capital Funding**							
	Risk Statement:	There is a risk that there is inadequate capital funding to enable priority schemes to progress. Due to uncertainties around capital funding arrangements the strategy may assume that more investment can be made than is available.							
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal		
Lead Director	**CFO**	**Likelihood**	3. Possible	3. Possible	2. Rare	**Risk category**	Financial Duties		
Date risk opened	**19.10.21**	**Impact**	5. Critical	4. Major	3. Moderate	**Linked risks**	-		
Date of last review	**16.09.22**	**Risk Rating**	15. Significant	12. High	6. Moderate	**Risk treatment**	Treat		



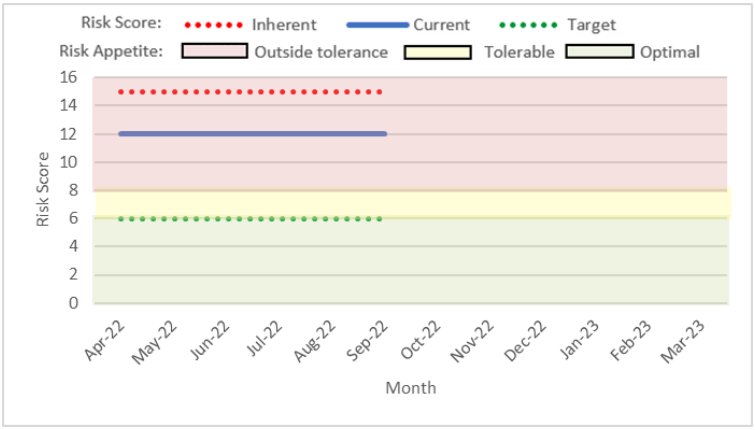
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3295)**	• Lobbying via Greater Manchester (Ext). • Capital Priorities agreed by Executive Team & Trust Board. • Cash for Capital investments identified. • Bids informally approved for centrally funded Community Diagnostic Centre and TIF Additional theatre at Leigh Hospital. • Reprioritisation of additional capital schemes to ensure the capital programme is reflective of organisational priorities • 3 year capital allocations available to inform more longer term system planning • Strategic capital group established with oversight of full capital programme	• Impact of cost of living rise in terms of project costs and timescales • GM overcommitment of capital programme • Delays in confirmation around national funding for CDC and TIF	**2nd Line:** • Capital plan forecast to deliver in full • Finance & Performance Committee Sep 22	No gaps in assurance	1. Close monitoring of Capital spend in line with trajectory 2. Development of capital reporting through the refreshed DFM App	31.03.23 CFO Q4 CFO

Corporate Objective: C10 Deliver our financial plan, providing value for money services							Overall Assurance level	Medium
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 11: Activity not in line with the funding available**						
	Risk Statement:	There is a risk that the cost of delivering activity exceeds the funding available because we have to use additional bank/agency or independent sector provision, or we are unable to access ERF funding if we exceed our trajectory. If the activity plan is not achieved it could result in clawback of ERF monies already received.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current**	**Target Risk**	**Risk Tolerance**	Minimal	
Lead Director	**CFO**	**Likelihood**	4. Likely	4. Likely	2. Unlikely	**Risk category**	Financial Duties	
Date risk opened	**19.10.21**	**Impact**	4. Major	4. Major	3. Moderate	3. Moderate	-	
Date of last review	**16.09.22**	**Risk Rating**	16. Significant	16. Significant	6. Moderate	**Risk treatment**	Treat	



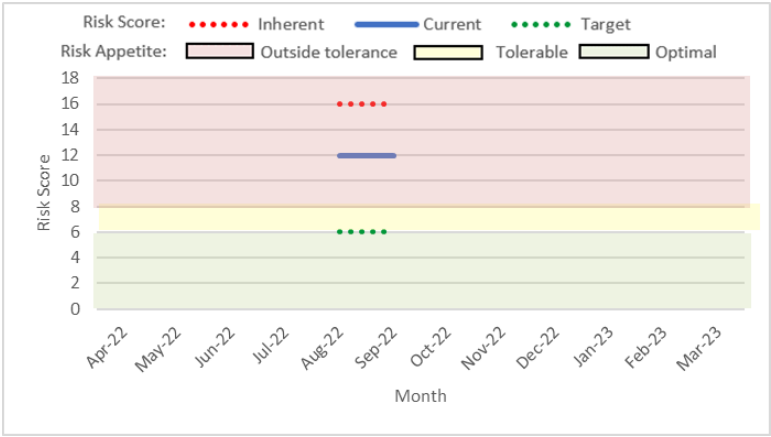
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3290)**	• The financial plan agreed triangulates with the activity plan. • GM Elective Recovery Reform Group in place with two programmes of work; (1) capacity and demand across GM and (2) reform. Deputy Chief Executive attends for WWL. (Ext.) • Reviewing how we can address the issue by activating elective recovery fund at GM level. (Ext) • Continue to access independent provider capacity.	No formal confirmation that there will be no clawback of ERF for underachievement of the electivity activity plan	**2nd Line:** • Finance & Performance Committee Sep 22	• No gaps currently identified.	1. Follow the national guidance to assume no clawback of ERF funding unless told otherwise.	31.03.23 CFO

Corporate Objective: **CO11** To minimise harm to patients through delivery of our elective recovery plan							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 12: Elective services - Waiting List**						
	Risk Statement:	There is a risk that demand for elective care may increase beyond the Trust's capacity to treat patients in a timely manner, due to challenges of restoring services presented by covid, workforce and IPC measures, increase in cancer referrals, no right to resides backlog and late repatriations from the independent sector, resulting in potentially poor patient experience, deteriorating health, more severe illness and late cancer diagnosis.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**DCE**	**Likelihood**	5.Almost Certain	4. Likely	2. Unlikely	**Risk category**	Performance Targets	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks IDs**	3136,3432, 3020,3360	
Date of last review	**05.09.22**	**Risk Rating**	15. Significant	12. High	6. Moderate	**Risk treatment**	Treat	



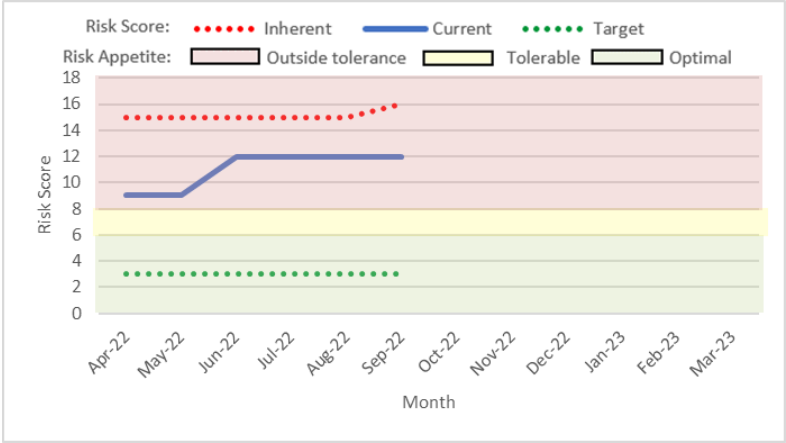
Opportunity / Threat Linked Risks	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: (ID 3289) **3136** Symptomatic breast imaging waiting times **3432**Counselling waiting times **3020** Waiting list Dermatology **3360** children with hearing loss waiting list	• Delivered 104 week wait and on track to deliver cancer backlog plan. • Patient lists managed by risk stratification treating in clinical priority order and long waits. • Winter Plan – elective programme with mutual aid across Greater Manchester.	• 78 week wait to be addressed. • Increase in cancer referral rate. • Lack of capacity to undertake reviews of allocated risk stratification across all specialties. • Meeting new care demands such as increasing cancer referral rates and reduced bed capacity due to covid admissions and no right to reside. • Addressing care backlogs as a direct consequence of the pandemic, specifically the increase in the backlog of patients on follow up waiting lists, DNAs and patient cancellations. • Late repatriations from the independent sector. • National IPC guidance to open up capacity.	**2nd Line:** • Finance & Performance Committee July 22. • WWL Winter Plan session August 2022	• No gaps in assurance currently identified.	1. Continue with existing controls applied to 104 week wait to identify the most clinically at risk patients and eliminate 78 weeks wait. 2. Continue with actions applied to improve 52 week position. 3. Monitor number of P2 on the waiting list through Financial and Performance Report	31.03.23 DCE 31.03.23 DCE Bi-monthly DCE

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



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3533)** **3500** Prolonged stay in the ED waiting room **3423** ED – Increase in attendances and insufficient patient flow	• **Worst Case Scenario Planning -** Risk stratification – treating in clinical priority order and long waits. • **Additional Capacity** – bid with Healthier Wigan Partners for capital monies to increase the number of beds to address the backlog in no right to resides. • **Admission avoidance** e.g. virtual hub, same day emergency care (SDEC). • Sequential use of every bed. • Delayed discharge Wigan. • Health and wellbeing offer to staff.	• 12 hour wait not improving. • Delayed ambulance turnover times.	**2nd Line:** • WWL Winter Plan session – 25.08.22 • Finance & Performance Committee Sep 22	• No gaps in assurance currently identified.	1. Work closely with colleagues in Wigan locality to reduce no right to reside by 20% and reduce 12 hour waits. 2. Implement Winter Plan focussing on risk stratification, additional capacity and admission avoidance to reduce 12 hour waits in the Emergency Department.	31.03.23 DCE 31.10.22 DCE

Corporate Objective: C13 Progress towards becoming a Net Zero healthcare provider							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 14: Estate Strategy - net carbon zero requirements**						
	Risk Statement:	There is a risk that Net Zero may not be delivered, due to investment not being available, resulting in failure to deliver the Green Plan and legislative requirements						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**CPO**	**Likelihood**	4. Likely	3. Possible	1. Rare	**Risk category**	Sustainability /Net Zero	
Date risk opened	**19.10.21**	**Impact**	4. Major	4. Major	3. Moderate	**Linked risks**	-	
Date of last review	**16.09.22**	**Risk Rating**	16. Significant	12. High	3. Low	**Risk treatment**	Treat	



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

Partnerships

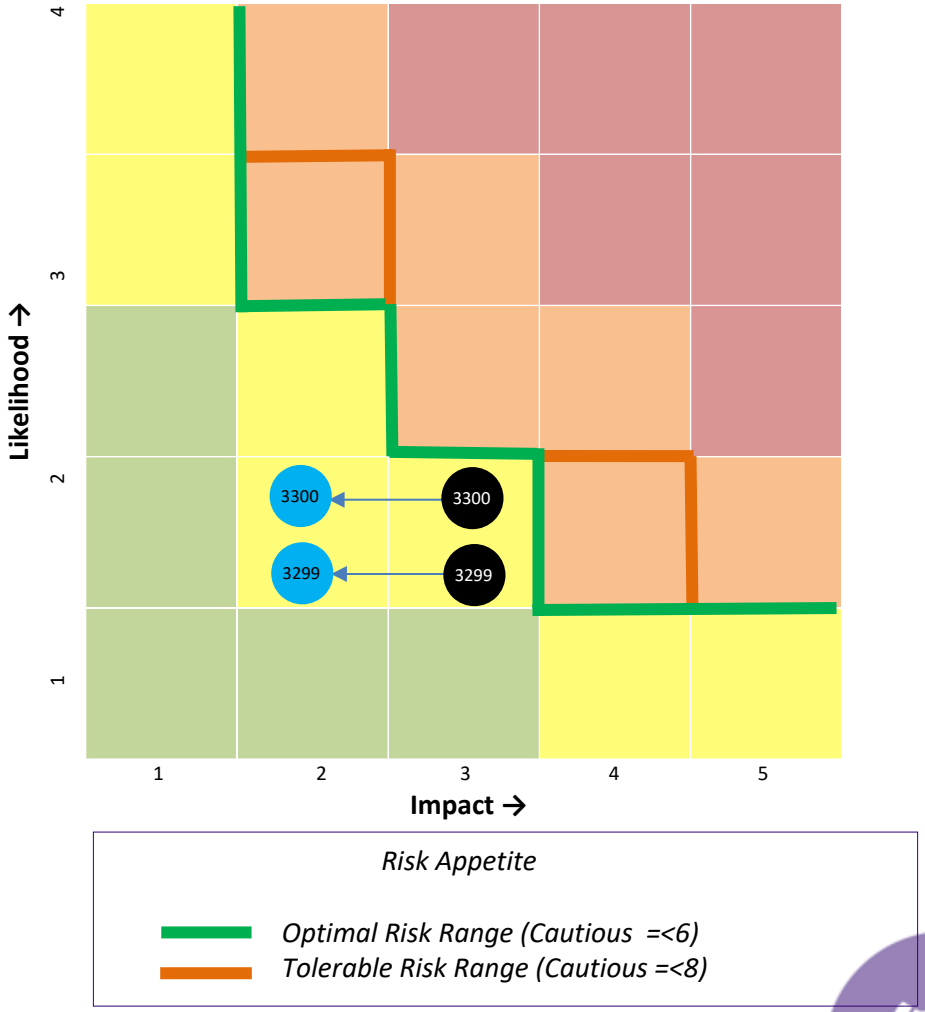
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

Monitoring: Board of Directors

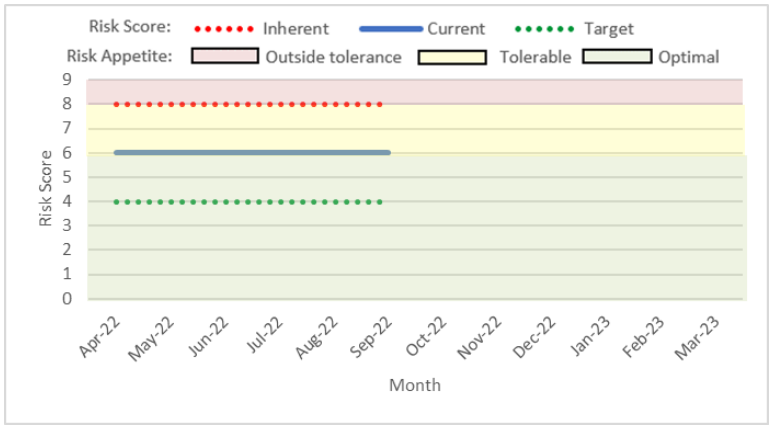
The following objectives are aligned to the **partnerships** strategic priority:

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

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

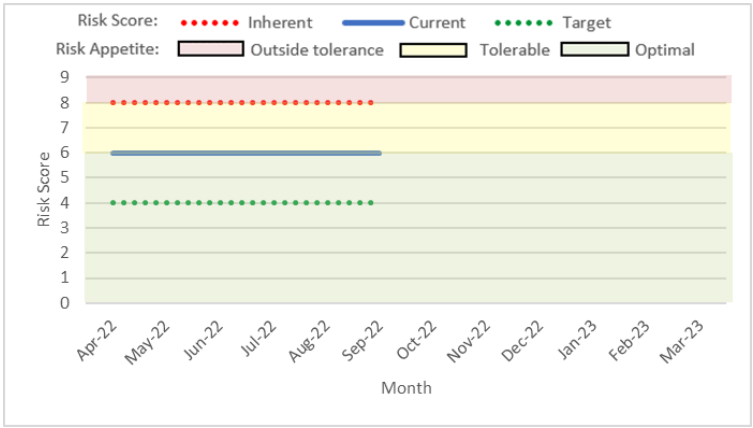


Corporate Objective: **CO15** Develop effective relationships within Wigan Borough and Greater Manchester for the benefit of our patients							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic	**Risk Title:**	**PR 15: Partnership working - CCG changes**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



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

Corporate Objective: **CO16** Make progress towards becoming a University Teaching Hospital							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 16: University Teaching Hospital - University Hospital Association criteria**						
	Risk Statement:	There is a risk that all the criteria that the University Hospital Association have specified may not be met, due to two key areas which we may find difficult to achieve, resulting in a potential obstacle towards our ambition to be a University Teaching Hospital.						
Lead Committee	**Board of Directors**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**MD**	**Likelihood**	4. Possible	3. Likely	2. Unlikely	**Risk category**	Strategy	
Date risk opened	**19.10.21**	**Impact**	2. Minor	2. Minor	2. Minor	**Linked risks**	-	
Date of last review	**22.09.22**	**Risk Rating**	8. High	6. Moderate	4. Moderate	**Risk treatment**	Treat	



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3299)**	• Project documentation including action log in place.	•A core number of university principal investigators. There must be a minimum of twenty consultant staff with substantive contracts of employment with the university with a medical or dental school which provides a non-executive director to the Trust Board. These individuals must have an honorary contract with the Trust in question. •For Trusts in England, an average Research Capability Funding allocation of at least £200k average p.a. over the previous two years.	**2nd Line:** • Board of Directors	**2nd Line:** • University Hospital Group – meeting due in Oct 22.	1. Risk to be quantified at the next University Hospital Group meeting.	MD Oct 22

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	IPC Board Assurance Framework update.
Presented to:	WWL Board of Directors
On:	5 October 2022
Presented by:	Rabina Tindale, Chief Nurse, Director IPC
Prepared by:	Julie O'Malley, Deputy Director IPC
Contact details:	T: 01942 773115 E: Julie.omalley@wwl.nhs.uk

Executive summary
This report provides an update on progress with the IPC BAF (version 1.8, published 24.12.2021) following receipt of the last update report, with the ongoing gaps in assurance and evidence of assurance/ activity listed below, against the 10 compliance criteria of the Health and Social Care Act 2008. The IPC BAF will be reviewed at the next IPC Group. An updated NHSE IPC BAF is still awaited.

Gaps in Assurance and Mitigating Actions – are listed within a summary below with full detail available within the table at Appendix 1.

- **Microbiology provision within the Trust:** Sustained but limited Microbiology provision continues within the Trust with no dedicated Microbiologist responsible for the IPC Doctor role employed within the Trust. This is included within the Organisational Risk register and reviewed by the Risk Management Group.
- **The demands on the IPC workforce** continues on the background of depleted team capacity, the continuing COVID-19 Pandemic, competing priority from other HCAI and the On-call commitment required by the team. Financial support has been requested to secure funding for

investment in the IPC Service to support succession planning and support to all WWL Service Directorates. Review of the IPC structure and work plan are in progress with a focus on an integrated service. Risk assessments have been submitted for review.

- **The IPC Audit Programme** continues to be modified in response to COVID-19 and the capacity of the IPC Team. The incidence of COVID-19 cases reported within the Trust continues to impact on bed capacity and the response required by the IPC Team to deliver a full IPC audit programme.
- **The continuing COVID-19 Pandemic** requires services to manage the capacity and demand of COVID-19 cases, against the impact and competing demands of other healthcare associated infections and recovery/ elective care programmes.
- **Within the Trust there is limited side room capacity** to consistently enable isolation as required, for patients with confirmed or suspected infections, not limited to COVID-19. All identified COVID-19 positive in-patients are transferred to designated COVID-19 positive areas. The IPC Team attend daily bed meetings and support bed managers with decision making, including during IPC On-call provision. A Datix is completed if a patient cannot be isolated and mitigating IPC actions and measures are implemented to maintain safety whilst bed management colleagues continuing to secure isolation capacity.
- **Limited capacity to segregate respiratory and non-respiratory patient** with the consolidation of two resuscitation areas into one area within the ED department without adaption of the environment. Review and planning in operation for the consideration of safe, risk assessed options.
- **Mandatory IPC e-learning modules:** A small month on month decrease in compliance demonstrated with the Trust target of 95% not achieved during at the point of reporting, for the IPC modules. Full quarter 2 data will be included at the report.
- **Hand hygiene and PPE compliance** is below expected standard in some ward areas. The focus on IPC compliance will continue to support improved compliance and ownership within the divisions, within the capacity of the IPC Team and through the IPC Group. A Gloves Off Campaign Steering Group is in operation and will commence during October 2022. The reintroduction of the full audit programme, pilot of new hand hygiene and PPE audit tools and clear signage for waste segregation will focus on standard IPC compliance.

Evidence of Assurance/ Activity

- **Changes to testing arrangements in line with current NHSE/ UKHSA guidance implemented.** Asymptomatic Lateral Flow Device (LFD) testing for patients and staff is currently paused COVID-19 Testing continues for all patients and staff with respiratory symptoms.
- **The COVID-19 Vaccine Booster Programme** will commence in September 2022.
- **Winter Planning Meetings** are now in operation.
- **Planning for the anticipated National changes in PPE supply** , procurement, and mask supply in plan. WWL mask Face fit testing system and process is in operation including completed mask fit testing database, register of trained mask fit testers and testing availability for staff.

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

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

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

Legal implications
The Code of Practice on the prevention and control of infection links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014/15.

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 to comply with the requirements the Health and Social Care Act and CQC Regulatory action.

Recommendation(s)
The Executive Team are requested to acknowledge the key points in this paper and continue to support the implementation of actions required to enable compliance with national guidance and reduce hospital onset COVID-19 infection.

Appendix 1. Infection Prevention and Control (IPC) Board Assurance Framework (BAF). Last updated 16 September 2022:
The information included within the table notes the changes within each of the 10 compliance criteria of the Health and Social Care Act 2008.

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 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.	**At 16.9.2022:** ▪ Winter Planning Meeting are operational within the Trust ▪ Testing arrangements are in line with NHSE/ UKHSA Guidance published on 24.8.2022. ▪ Asymptomatic patient LFD testing was paused on 5.8.2022 within WWLFT. Testing continues for all symptomatic patients. ▪ All COVID-19 positive in-patients continue to be transferred to designated COVID-19 positive areas. ▪ Planning options are being considered by multi-disciplinary team for the patients receiving care in the resuscitation area of the ED department, with a focus segregation of respiratory and non-respiratory patient and ventilation as a result of plans to consolidate two resuscitation areas into one area. ▪ External Ventilation specialist review and plans for resus area requirements undertaken, with further input requested. ▪ Peer review of resus area requirements undertaken. ▪ Support requested from NHSE IPC Lead. ▪ Current In-patient visiting: Two visitors per patient with duration of one hour.	Limited options for segregation within the ED Department if consolidate two resuscitation areas into one area. Limited Isolation capacity. Unknown COVID-19 status of staff and patients may lead to increase in COVID-19 transmission if IPC Measures not optimal.	Options appraisal and support with approval for segregation/ ventilation within the ED Department. Patient placement/ isolation priority managed in collaboration with Operations Team, IPC Team, and Estates/ Facilities. Education and learning support, and audit of practice.

	▪ Collaboration with Operations Team, IPC Team/ Microbiology continues to support patient flow and capacity.		
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.	**At: 16.9.2022:** IPC measures remain in place within the trust in line with National guidance/ NHSE/ UKHSA and National IPC Manual. ▪ 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. ▪ Face mask wearing continues in Clinical settings: Hospital site and Community settings.	A modified IPC Audit Programme continues due to the increasing demand on capacity of the IPC Team in response to COVID-19 and a background of staffing vacancies and annual leave and sickness within the Team. Dedicated COVID-19 ward areas continue to be operational. The Trust continues to experience an increased demand on bed capacity and isolation capacity The Band 8a acting-up role funding will end on 30.9.20222, post holder will return to a Band 7 role. The role had been specifically identified for the Community Division. Band 4 Admin role flexible retirement from November 2022	Resource and investment within the Trust IPC Service required. August/ September 2022: Support with identifying funding for IPC Staffing. Discussion with Finance/ Budget Lead to progress recruitment to Band 5/6 and Band 3 roles (within budget limits) to enable succession planning for the IPC Team. Band 7 IPC Junior Matron commence post on 1.9.2022. Discussion and planning for the restructure of the IPC Team and work programme in progress, within the financial/ budget limitations and a focus on an integrated IPC Service.

		Band 7 retirement application in plan for January 2023.	
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.	**At 16.9.2022:** ▪ Measures consistent with the hierarchy of control measures are consistently reviewed in line with current UKHSA Guidance**.** ▪ PPE/ RPE requirements in line with Trust Policies and SOPs and the National IPC Manual. ▪ The use of FFP3 masks by staff continues in COVID-19 positive areas ▪ The NHS: National IPC Manual updated: July 2022 ▪ Reporting to the Trust Board, ETM and Chief Nurse. ▪ Input to and collaboration with operational flow and bed capacity with joint working between IPC, Bed Management and Operations Teams continues. ▪ Global/ IPC communications shared with all staff ▪ Wearing of face masks continues in all clinical/ patient facing areas, including corridors ▪ Mask fit Testing programme continues, with access available to staff to attend.	Limited options for segregation/ ventilation within the resuscitation area of the ED Department, see above. Limited Isolation capacity. Unknown COVID-19 status of staff and patients may lead to increase in COVID-19 transmission if IPC Measures not optimal.	Options appraisal and support with review, design, and approval for segregation/ ventilation within the ED Department as above. Patient placement/ isolation priority managed in collaboration with Operations Team, IPC Team, and Estates/ Facilities. Education and learning support, and audit of practice.
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.	**At 16.9.2022:** ▪ Trust process continues with specific pathways from point of entry segregation and testing: On identification of positive result, patients transferred to a positive ward.	None	None

	▪ Outbreaks are identified and reported in line with guidance definition to Regional Team (2 or greater, hospital onset cases connected in time and space). ▪ Pause in asymptomatic patient and staff testing in line with current NHSE/ UKHSA guidance published on 24.8.2022.		
There are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.	**At 16.9.2022:** ▪ IPC Team provide supportive visits to clinical/ practice areas in both hospital and community settings within limits of capacity and demand. ▪ IPC Team target support to ward areas during outbreaks and periods of increased incidence of COVID-19.	Limited availability due to the increasing demand on the capacity of the IPC Team in response to COVID-19, additional IPC priorities against a background of staffing vacancies, annual leave, and sickness within the Team.	Deputy DIPC supporting the team operationally during periods of increased demand.
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).	**At 16.9.2022:** ▪ Steering Group for the Gloves Off Campaign commenced meeting preparing for delivery of the campaign. ▪ Baseline data gathering in progress. ▪ New Hand hygiene and PPE audit tools being piloted on specific ward areas. ▪ The IPC Audit Programme continues for all aspects of IPC Practice, standard IPC precautions, COVID-19 safe measures. ▪ The IPC Team target audit activity due to the impact of COVID-19 and competing IPC priorities.	The demand on the IPC workforce has increased on the background of depleted team capacity and the continuing impact of the emerging variant and increasing incidence of COVID-19. The Band 8a acting-up role funding will end on 30.9.20222, post holder will return to a Band 7 role.	Resource and investment within the Trust IPC Service required. Support with identifying a funding for the IPC Staffing is in progress. Band 7 IPC Junior Matron commenced post 1.9.2022. Discussion with Finance/ Budget Lead to progress recruitment to Band 5/6 and Band 3 roles (within budget limits) to enable succession planning for the IPC Team.

		Band 4 Admin role flexible retirement from November 2022 Band 7 retirement application in plan for January 2023	Discussion and planning for the restructure of the IPC Team and work programme in progress, within the financial/ budget limitations.
The application of IPC practices within this guidance is monitored, e.g., ▪ Hand hygiene ▪ PPE donning and doffing training ▪ Cleaning and decontamination	**At 16.9.2022:** ▪ Steering Group for the Gloves Off Campaign commenced meeting preparing for delivery of the campaign. ▪ Baseline data gathering in progress. ▪ New Hand hygiene and PPE audit tools being piloted on specific ward areas. ▪ The IPC Audit Programme continues for all aspects of IPC Practice, standard IPC precautions, COVID-19 safe measures. ▪ The IPC Team target audit activity due to the impact of COVID-19 and competing IPC priorities.	Compliance with hand hygiene and PPE continues to require improvement within some ward/ service areas.	Divisional, service and ward ownership is expected and must be supported and reinforced through within the Divisions and the IPC Group. IPC messaging and learning opportunities delivered at ward level. Quality improvement initiatives: Gloves off Campaign. Steering Group meeting during September 2022.
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.	**At: 16.9.2022:** There are currently 5 makes and model of mask used by the Trust. The country of manufacture is indicated below. 1. Drager 1730+ 2. Kolmi (Small & Medium) 3. GVS31000 4. 3M1863+ / 3M9330+ 5. Handanny	The make and model of mask used by individual staff is reliant on the mask fit test result, and whilst there are various FFP3 masks available not all are compatible for wearing by all staff. The Department of Health and Social Care (DHSC) PPE Portal	The Health and Safety Team are discussing any potential consequences of the DHSC PPE Portal withdrawal with Procurement and a plan is being drafted to ensure supplies of the masks staff are tested to remain available. Full Support, a former supplier of FFP3 masks to

		continues to supply the Trust with FFP3 masks however, this is anticipated to cease in March 2023. All models of masks have been procured through the National NHS Buyers; however, the location of manufacture, whilst believed to be the UK in most cases, is to be confirmed by the buyers.	the Trust, with great mask fit test results pre-pandemic, also being approached to re-establish supply chain. A response from the National NHS Buyers is outstanding regarding the manufacturing location of each mask.
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
A systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	**At 16.9.2022:** ▪ ED resus area segregation: Adaption of the environment and ventilation requirements. Options are being considered for the segregation of respiratory and non-respiratory patient receiving care in the resuscitation area of the ED department. ▪ Role outline for IPC Doctor/ Microbiologist provided to the Medicine Directorate Manager.	No IPC Doctor/ Microbiologist in post to provide specialist input for ventilation approval.	Review and approval of ventilation options by Executive Team. Recruitment of Microbiologist with IPC Doctor responsibility role.
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	**At 16.9.2022:** Microbiology provision: Two WTE in post (Permanent and Locum) as: ▪ One part time Microbiologist (3 days)	Limited Microbiology support available within the Trust.	Three Microbiologist currently providing a specific/ limited remit, via

	▪ One full time Locum Microbiologist provides remote/ virtual support 5 days per week with a specific/ limited remit. ▪ One part time Locum Microbiologist provides remote/ virtual support 2 days per week with a specific/ limited remit.	No Microbiologist/ Infection Control Doctor in post to support the IPC Nursing Service and lead on specific IPC Doctor role, i.e., IPC Group (formerly Committee, Policy, Decontamination, Ventilation, antimicrobial stewardship role.	virtual/ remote service arrangement. Microbiology service/ Pharmacist support role discussed at Risk Management Group. Microbiology provision remains on Organisational Risk Register Assessment: reviewed by Risk Management Group Two IPC Risk Assessments currently subject to the review process: *Lack of Microbiology support to IPC Nursing Service* and *IPC Service unable to deliver service due to lack of specialist staff*. Both awaiting review at Risk Management Group.
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
No Changes to note for Criteria 4 at time of reporting.			
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**
Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory	**At 16.9.2022:** Limited capacity to segregate within ED. IPC, Estates, Operations and ED Teams are collaborating to identify options	**16.9.2022:** Limited capacity to segregate within ED.	Options to be presented and discussed at ETM for approval.

infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance.	to enable segregation/ Respiratory/ Non-Respiratory Pathways.		
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.	**At 16.9.2022:** Mandatory training: ▪ IPC Level 1: Compliance reporting: July 2022: 92% and August 2022: 91% ▪ IPC Level 2: Compliance reporting: July 2022: 81% and August 2022: 80% ▪ IPC Team target support to ward areas during outbreaks and periods of increased incidence of COVID-19.	Drop in compliance for Mandatory training at point of reporting. Limited capacity of the IPC Team in response to COVID-19, additional IPC priorities against a background of staffing vacancies, annual leave, and sickness within the Team.	Communication and reminders to staff for training completion. Discussion with Finance/ Budget Lead to progress recruitment to Band 5/6 and Band 3 roles (within budget limits) to enable succession planning for the IPC Team. Review of IPC Structure and work programme.
Adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	**At 16.9.2022:** ▪ Steering Group for the Gloves Off Campaign commenced meeting preparing for delivery of the campaign. ▪ Baseline data gathering in progress in preparation for improvement initiative.	PPE compliance is below expected standard in some ward areas.	Audit programme will continue, in conjunction with campaign.
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
No Changes to note for Criteria 7 at time of reporting.			
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance	**At 16.9.2022:** ▪ Patient testing is in operation in line with current NHSE/ UKHSA guidance at 24.8.2022 ▪ Asymptomatic patient LFD testing was paused on 5.8.2022. ▪ Testing continues for all symptomatic patients. ▪ All COVID-19 positive in-patients continue to be transferred to designated COVID-19 positive areas. ▪ Patients for transfer to Care Home, Hospice	None	None
Staff testing protocols are in place	**At 16.9.2022:** ▪ Staff Testing arrangements are in line with NHSE Guidance published on 24.8.2022. ▪ Asymptomatic staff LFD testing was paused on 5.8.2022. ▪ Symptomatic staff to continue LFD testing, with responsibility to order own testing kits and report results via GOV.Portal	Staff compliance required	Staff messaging, communications continue

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).	**At 16.9.2022:** No change from last report.	16.9.2022: Limited Microbiology input to review Policies and SOPs robustly, specifically with reference to treatment and clinical management of infections.	Microbiologist recruitment remains an organisational risk reviewed by the Corporate Risk Group

Staff are supported in adhering to all IPC policies, including those for other alert organisms.	**At 16.9.2022:** No change from last report.	Operational pressures have impacted upon compliance with Mandatory IPC Training, data as above	Frequent updates and reminders from Training Team.
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.	**At 16.9.2022:** Work in progress to provide clear signage labels to be positioned to support correct segregation and disposal of waste.	Staff non-compliance with correct waste disposal.	Waste lead actioning change required.

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
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)	**At 16.9.2022:** Trust vaccination programme has been planned and will commence on 20.9.2022 with a planned schedule in-line with National Vaccination Programme/ UKHSA Guidance	None	None
A fit testing programme is in place for those who may need to wear respiratory protection.	**At 16.9.2022:** The Trust has invested in a central Mask Fitting Service (Mon-Fri) which is available to all staff, including students and bank/agency staff working for WWL.	None	None
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.	**At 16.9.2022:** COVID-19 Vaccination programme to commence 20.9.2022 (Influenza to commence October 2022) Trust Staff: Global communication commenced for Vaccination Programme	None	None

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. ▪ 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.	**At 16.9.2022:** A process for COVID-19 risk assessment for new employees and current staff members remains in place and is subject to review. Detail of compliance with the process is limited.	None	None
Vaccination and testing policies are in place as advised by occupational health/public health.	**At 16.9.2022:** ▪ Vaccination SOP in line with National guidance is in place. ▪ NHSE/ UKHSA Guidance change: NHS Asymptomatic staff LFD testing paused on 31.8.2022. ▪ Weekly vaccine meetings reinstated in July 2022.	None	None
Staff required to wear FFP3 reusable respirators undergo training that is compliant with PHE national guidance (*not active*) and a record of this training is maintained and held centrally/ ESR records;	**At 8.9.2022:** Reusable respirators are used by a small cohort of non-clinical staff. Testing carried out by Central Mask Fitting Service who are trained by RPA Ltd to relevant HSE standards. Record of fit test result held on central database.	None	None
Staff who carry out fit test training are trained and competent to do so;	**At 8.9.2022:** A register of trained mask fit testers is maintained, and all staff have	None	None

	completed the half-day Mask Fitting Train the Trainer Course. This course is repeated every 2-years.		
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;	**At 8.9.2022:** The Trust offers a selection of 5 types of disposable respirators which wearers may be tested to. Wearers are provided with a test to each specific model as part of fit testing process – repeated every 2 years or sooner if there is a change related to the wearer which may affect fit.	Some staff have been seen wearing an FFP3 mask, which when cross referenced to the central register, there is evidence that a fit test has not taken place.	Ongoing promotion regarding the need for a face fit test. Collaborative work between the Central Mask Fitting Service and Ward-based Mask Fit Testers to reduce the likelihood of this happening. Regular correspondence to all staff inviting them to take part in a mask fit test. Central Mask Fitting Team walk-abouts. Swiftqueue for easy access booking of a mask fit test.
all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	**At 8.9.2022:** ▪ Communication to all staff of requirement to be tested to multiple models. ▪ Use of porta count machine is facilitating two / three tests per appointment	The make and model of mask used by individual staff is reliant on the mask fit test result, and whilst there are various FFP3 masks available not all are compatible for wearing by all staff.	Where necessary staff will be tested on each model available until a secure fit to 2 different mask models has been achieved. If a secure fit to a 1st or 2nd mask cannot be achieved, wards and departments will need to ensure a mechanical

			respirator and hood is available for use.
A record of the fit test and result is given to and kept by the trainee and centrally within the organisation;	**At 8.9.2022:** ▪ Record sheet completed by mask fit tester – information duplicated onto register for upload onto central mask fit database. ▪ Wearer takes record sheet with instruction to share with line manager and keep own copy.	None	None
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;	**At 8.9.2022:** ▪ Record sheet completed by mask fit tester – information duplicated onto register for upload onto central mask fit database. ▪ Wearer takes record sheet with instruction to share with line manager and keep own copy. Invited for further appointment where possible to facilitate testing to alternative mask model(s).	None	None
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.	**At 8.9.2022:** ▪ Where a fit test is failed or refused (e.g., due to facial hair for religious reasons) an alternative Powered Air Respiratory Hood is offered. ▪ Wearers are trained by the mask fit team in the assembly, checking, donning, wearing, doffing, decontamination, disassembly, storage of the powered respirators. Hood wearers are issued with a maintenance guide, pre use checklist and inspection record (in line with manufacturer instructions) which is periodically audited. This information is also on the intranet and a copy kept with the equipment.	None	None

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;	**At 8.9.2022:** Information held on Health and Safety Dashboard.	None	None
Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing.	**At 16.9.2022:** ▪ UKHSA Testing guidance change on 24.8.2022. Pause in LFD testing NHS staff no longer performed twice weekly symptomatic testing. Global communication to staff informed the change in arrangements. ▪ All symptomatic staff can continue to order LFD test kits from the GOV portal and report the results directly to the GOV portal. ▪ Staff sickness and absence monitoring is now in line with Trust HR Policy.	The COVID-19 status of asymptomatic staff is now unknown and could impact on infection transmission if optimal IPC measures are not implemented. Impact on COVID-19 related staff sickness absence arrangements and staff testing/ absence	Communication, education, and support for staff to maintain optimal IPC compliance. Messaging and communications reinforcing the need staff LFD testing if respiratory symptoms present. An audit programme in place. New Hand hygiene and PPE audit tool being piloted on specific ward areas.

Title of report:	Safeguarding Annual Report 2021-2022
Presented to:	Board of Directors
On:	5th October 2022
Presented by:	Rabina Tindale – Chief Nurse
Prepared by:	Carlene Baines – Assistant Director of Safeguarding
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Executive summary

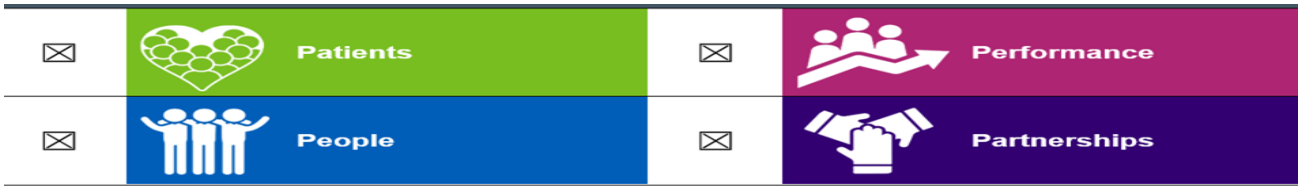
The Safeguarding Annual Report provides an opportunity to reflect on the breadth and quality of safeguarding activity across Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust (WWLTH) during the period April 2021 to March 2022. Noting themes and trends, risks and mitigations through a 'Think Family' lens it aims to provide the necessary assurance in relation to the discharge of associated statutory responsibilities. The report seeks to acknowledge past achievements whilst identifying key priorities for the year ahead. Good progress in relation to our ambitions as set out in the streamlined 2020-21 Annual Report was maintained despite the impact and challenges faced by the ongoing Covid-19 Pandemic. WWLTH recognises that one of the most important principles of safeguarding is that it is 'everyone's responsibility'. All agencies seeking to provide support to and safeguarding of the residents of Wigan Borough have inevitably needed to adapt and refocus to ensure the immediate needs of children, adults, their families, and carers are prioritised and met. The recovery post-Covid has presented significant challenge throughout the last twelve months but despite this the WWLTH Think Family Safeguarding Service has not only delivered on day-to-day business but has striven to innovate, progress and improve via targeted workstreams and individual development embracing fully a shared team vision.

The core business of safeguarding continued across the organisation despite the disruption resulting from the redeployment of staff, increased levels of sickness and high acuity of need. The WWLTH Think Family Safeguarding Service maintained provision of safeguarding interventions, albeit modified at times, whilst managing significant increase in demand across the whole safeguarding spectrum against a backdrop of reduced capacity and escalating complexity.

The WWLTH Think Family Safeguarding Service is ambitious for the year ahead and has a clear vision of ongoing innovation and improvement which is underpinned by the 'WWL Way 4wards'. There will be a launch of the Think Family Safeguarding Strategy, delivery of which will be supported by the Think Family Safeguarding Service Workplan aligned to the Trust Corporate objectives and considerate of both the Wigan Safeguarding Adult Board and Wigan Safeguarding Children Partnership strategic priorities.

The Trust is committed to safeguarding and promoting the welfare of all our patients, staff and communities which is reflected in the safeguarding leadership and commitment demonstrated at all levels.

Link to strategy



Risks associated with this report and proposed mitigations

The Trust, and the Think Family Safeguarding Service, is preparing for the pending implementation of Liberty Protection Safeguards (LPS), now likely to be in 2023 but potentially delayed further to 2024. The draft Code of Practice has closed to consultation however the NHS as a whole awaits clear direction to support execution of the necessary adjustments resulting from the proposed changes. Safeguarding Effectiveness Group (SEG) meets on a monthly basis and remains fully updated with clear action plans highlighting the work required to ensure the Trust is ready to respond. In a similar vein, the recent independent review of Children's Social Care and resultant 'Case for Change' will undoubtedly have a knock-on effect on health services due to the impact of system factors. It is likely that there will be a revision of partnership and multi-agency working both nationally and locally resulting in changes to frontline service delivery in relation to safeguarding interventions.

The wider context of safeguarding will continue to pose challenges for the Think family Safeguarding Service and the organisation as a whole. There is a requirement to carry out a review of the current Safeguarding Service structure, much of which is complete, with consideration given to any additional resource or service redesign required to ensure continued effective discharge of statutory obligations. Mitigation against identified risk resulting from increased demand will be managed via appropriate processes such as presentation of business cases both internally and to the newly established Integrated Care System (ICS) to consider requirement for additional investment.

Financial implications

WWLTH have a statutory obligation to safeguard adults and children; not adhering to statutory requirements could have financial implications due to potential negligence complaints and detrimental media interest.

Legal implications

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust has a statutory responsibility for ensuring that the services provided by the organisation have safe and effective systems in place which safeguard adults, children, and young people at risk of abuse, neglect, and exploitation. Safeguarding adults and children is also integral to complying with legislation, regulations and delivering cost effective care.

People implications

Safeguarding adults and children focuses on the safety and well-being of all patients but provides additional measures for those least able to protect themselves from harm or abuse. Safeguarding practice is a fundamental part of patient safety and wellbeing and the outcomes expected of the NHS.

Wider implications

Monitoring of safeguarding activity within WWLTH, in line with Wigan Safeguarding Adult Board (WSAB), Wigan Safeguarding Children Partnership (WSCP) and NHS Greater Manchester Integrated Care System Wigan (NHS GM Wigan) reporting requirements enables analysis of safeguarding themes and trends against set objectives. Delivery against agreed action plans as a result of this analysis will assist in developing a competent, confident workforce able to proactively deliver holistic health care to achieve improved outcomes for adults, children and families who need additional support.

Recommendation(s) – Key priorities for 2022/2023

- WWLTH Safeguarding Strategy to be finalised, underpinned by comprehensive Safeguarding Workplan linked to WWL way 4wards and incorporating review of WSAB/WSCP priorities

- Completion of internal review of WWL Think Family Safeguarding Service with any proposed restructure/business case to be presented to SEG for consideration in the first instance

- Think Family Safeguarding Training Strategy and associated Training Needs Analysis to be finalised and endorsed by the Trust; this will support ongoing developments to ensure WWLTH effectively maintains compliance against mandated Safeguarding Training targets whilst establishing a confident and competent workforce able to safeguard children and adults at risk

- Sustain and build robust Safeguarding Supervision offer across WWLTH ensuring all staff have personal resilience and professional motivation to support safeguarding issues

- Monitor and review Mental Capacity Act/Deprivation of Liberty Safeguard compliance with Quality Standards to support development of robust Trust wide Liberty Protection Safeguards Implementation Action Plan; Senior Leadership support at all levels is required to consider wider training, resource, and capacity impacts across the organisation

- Business Intelligence Unit and Data Analyst support to assist in the creation of robust Safeguarding Data Dashboards to facilitate accurate data retrieval which in turn will assure data integrity promoting accurate analysis of themes and trends, capacity and demand and enable effective sharing of health safeguarding data across the ICS via WSAB, WSCP and Community Safety Partnership (CSP)

Safeguarding Effectiveness Group (SEG) and subsequent committees, such as Quality and Safety Committee, to whom this Annual Report will be presented are asked to receive the content and consider the principles outlined within the recommendations and key priorities section. Further detail and oversight of safeguarding activity, inclusive of the performance of the Think Family Safeguarding Service to demonstrate assurance, will be provided via various internal and external forums with the main approving body of any associated papers, policy, service delivery plans and wider partnership activity remaining as the Safeguarding Effectiveness Group.

1 Safeguarding Annual Report - Introduction

1.1 This is the first Safeguarding Annual Report written following the establishment of a Think Family Safeguarding Service which has transformed considerably over the past twelve months and has embraced a change in leadership, vision, and approach to the concept of 'Think Family'. Whilst there have been preceding annual reports it is timely to utilise the 2021/22 overview to showcase how the service has developed significantly following a difficult period evidenced within internal and external reviews and has now emerged with an identity in its own right to raise the profile of safeguarding at all levels and across all Divisions of the Trust.

1.2 A joint children and adult approach has been adopted in line with the Trust's shared safeguarding agendas and principals. This report will provide assurance that the Trust is fulfilling its duties and responsibilities in relation to promoting the welfare of children, young people, adults and their families or carers who come into contact with services.

1.3 This report summarises safeguarding activity in relation to Safeguarding Adults and Children during 2021/22 (April 2021-March 2022) inclusive of information relating to both acute and community settings. Maternity Services safeguarding data overview and performance data in relation to Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) figures is featured.

1.4 Additional insight into the safeguarding of patients and staff affected by Domestic Abuse is presented via overview of WWLTH HIDSVA activity with further context and detail being provided in relation to safeguarding health input into the multi-agency Children First Partnership Hub and Wigan Complex Safeguarding Team.

1.5 A summary of mandatory Safeguarding Training compliance as reported at year end is contained alongside details of additional bitesize and bespoke safeguarding training packages designed to enhance and improve practitioner knowledge, skills, and competence in relation to identified areas of learning resulting from wider partnership reviews.

1.6 The 2021/22 Safeguarding Annual Report will provide the Trust Board with an overview of the local, regional, and national context of safeguarding, safeguarding practice within the Trust including progress and developments whilst giving assurance that the Trust is meeting its statutory obligations. Key priorities for the year ahead will be detailed to cement the drive and commitment of the Organisation and the Think Family Safeguarding Service moving forwards.

1.7 The term 'safeguarding' is all encompassing and seeks to ensure children, young people, and adults at risk live a life that is free from abuse and neglect. The promotion of independence and wellbeing whilst maintaining dignity and advocating choice is paramount. Safeguarding includes the early identification and/or prevention of harm, all forms of exploitation, and abuse by adherence to national guidelines and legislative frameworks. Local multi-agency procedures and commitment to wider system and partnership agendas is necessary and by disseminating 'lessons learnt' and promoting best practice the Think Family Safeguarding Service strive to improve health outcomes for patients and families, staff, and the community as a whole.

1.8 The Trust discharges part of its responsibility for Board-level assurance, scrutiny, and challenge of safeguarding practice within the Trust, in line with the statutory requirements of *Section 11 Children Act (2004), Working Together to Safeguard Children (2018), the Mental Capacity Act 2005* and the *Care Act 2014*. In addition to the requirements of the *Children Act (2004),* WWLTH as a registered provider with the Care Quality Commission (CQC), must have regard for the Regulations as established under the *Health and Social Care Act (2008)*.

1.9 This year there have been reported increases, both nationally and locally, in reports of Domestic Abuse, serious violence and exploitation in many forms. The backdrop of Covid-19, social isolation, poverty, and fragile mental health have far reaching consequences for individuals, families, and

communities. There is a need to ensure we engage in trauma-informed practice; to recognise lived experience and not see safeguarding incidents as isolated events. Trauma-informed practice helps us understand the necessity of working with others to address fundamental issues therefore leading to trauma responsive care. The subsequent progression to delivery of trauma responsive approaches helps bring about recovery and healing through the promotion of trust and resilience.

2 Governance Arrangements for Safeguarding

2.1 WWLTH is accountable for ensuring that its own safeguarding structure and processes meet the required statutory requirements of the *Children's Act (2004), the Care Act (2014)* and other statutory and national guidance. The safeguarding roles, duties, and responsibilities of all organisations in the National Health Service (NHS) including WWLTH, are laid out in the NHS England 'Accountability and Assurance Framework' which was published in 2015 and updated in 2022.

2.2 The Trust is statutorily required to maintain certain posts and roles within the organisation in relation to safeguarding; these have been fulfilled throughout 2021/22.

2.3 The Chief Nurse has executive responsibility for safeguarding; be that adults at risk, children, and Children in Care (CiC) and also represents WWLTH on both Wigan Safeguarding Adult Board (WSAB) and Wigan Safeguarding Children Partnership (WSCP) Executive Groups.

2.4 The Deputy Chief Nurse is portfolio holder for safeguarding and is the direct line manager for the Assistant Director of Safeguarding. Named Nurses for Safeguarding Adults, Safeguarding Children, Named Midwife Safeguarding and since July 2022 Named Nurse for Children in Care are directly line managed by the Assistant Director of Safeguarding. The Named Professionals provide the organisation with operational advice, support and input influenced by strategic vision and awareness. The Named professionals are committed to supporting the workforce in understanding safeguarding, embedding it into everyday business to improve outcomes.

2.5 A team of Think Family Safeguarding Practitioners assist in fulfilling the role and duties required to deliver against statutory obligations with a number of Specialist Practitioner roles inclusive of Specialist Nurses Safeguarding Adults, Specialist Nurses Safeguarding Children, Hospital (Health) Independent Domestic and Sexual Violence Advocates (HIDSVAs), Children First Partnership Specialist Nurse (previously MAST – Multi Agency Safeguarding Team), Specialist Nurse Complex Safeguarding (supporting Wigan Multi-agency response to Child Exploitation), Specialist Nurses for Children in Care (from July 2022) and MCA/DoLS Lead.

2.6 The Think Family Safeguarding Service is supported by a skilled and committed administration team comprising of Safeguarding PA, Children in Care Co-ordinator, Safeguarding and CiC Administrators. An overview of the Think Family Safeguarding Service Structure can be found in ***Appendix 1***.

2.7 The Think Family Safeguarding Service is additionally supported by the Named Doctor for Safeguarding Adults, Named Doctor for Safeguarding Children and Named Doctor Children in Care.

2.8 The service offers a Think Family approach across all acute and community services in a blended team comprising of Adult and Children practitioners holding a wide range of skills and knowledge. The service offers support, leadership, advice, and training whilst ensuring attendance and participation in external meetings across WSAB/WSCP subgroups, Community Safety Partnership (CSP) and Domestic Abuse Strategic Oversight Board (DASOB) to ensure appropriate WWLTFT information sharing and participation in local and national safeguarding initiatives.

2.9 The WWLTHT safeguarding governance arrangements include the WWLTHT Safeguarding Effectiveness Group (SEG) chaired by the Chief Nurse. SEG, with membership comprising of Non-Executive Director with lead for Safeguarding, Divisional Directors of Nursing and Midwifery, Senior Safeguarding Leads, Designated Professionals representing NHS GM Wigan, and lead professionals

responsible for Learning Disability Services alongside Admiral Nurse representation reports to the Trust Board via the Executive Quality and Safety Committee. ***Appendix 2*** details the agreed Terms of Reference. The purpose of SEG is to provide assurance in regard to safeguarding arrangements, compliance, and activity, to approve reports for internal and external dissemination whilst assessing and monitoring risk in relation to organisational safeguarding duties.

2.10 The Think Family Safeguarding Service also provide assurance to NHS GM Wigan (formally Wigan Borough Clinical Commissioning Group) via Integrated Quality and Safety Group through the Greater Manchester 'Clinical Commissioning Groups Safeguarding Children, Young People and Adults at Risk – Contractual Standards 2021-22'. An annual Validation Visit is completed onsite by the Designated Safeguarding Professionals to review and monitor compliance against statutory safeguarding responsibilities using the 'NHS Provider Safeguarding Audit Tool'; consideration of presented evidence to demonstrate good practice occurs alongside scrutiny of relevant policies, procedures, and pathways.

3 Think Family Safeguarding Service Activity

3.1 The mandatory prompt for safeguarding concerns within the WWLTH HiS system continues to generate notifications (referrals) from acute services to the Safeguarding Adult and Children Teams. The HiS system is also utilised to process 'orders' to the HISDVA service when Domestic Abuse is identified as a concern whilst application of restrictions under Deprivation of Liberty Safeguards (DoLS) and associated MCA are captured via categorised HiS alerts, as is the case for Learning Disability notifications.

3.2 The capture of community and maternity safeguarding activity is less defined and is often reliant on the screening of Datix alerts, practitioner initiated or scheduled Safeguarding Supervision or contact with 'duty' Think Family Safeguarding Practitioners. Work is ongoing to ensure a robust process of data capture of community services safeguarding activity via SystmOne alongside revision of the use of Maternity Special Circumstances Referral Form (SCRF) and the email system of referral utilised by some services requesting the support of HIDSVA in particular.

3.3 Notification and referral processes in relation to safeguarding activity is a key work stream for the service that will be revised and monitored via both the Think Family Safeguarding Service workplan and Wigan Domestic Abuse Strategic workplan.

3.4 Acute notifications in relation to safeguarding concerns for adults **(n=6184)** and children **(n=2163)** have increased year on year. Whilst comparative data for children is not available due to limitations and changes of data collection methods it is noted that Adult Safeguarding activity within acute settings across the Trust has seen a **35%** increase since 2020/21.

Figure 1. HiS Notifications to Think Family Safeguarding Service relating to Adult Safeguarding

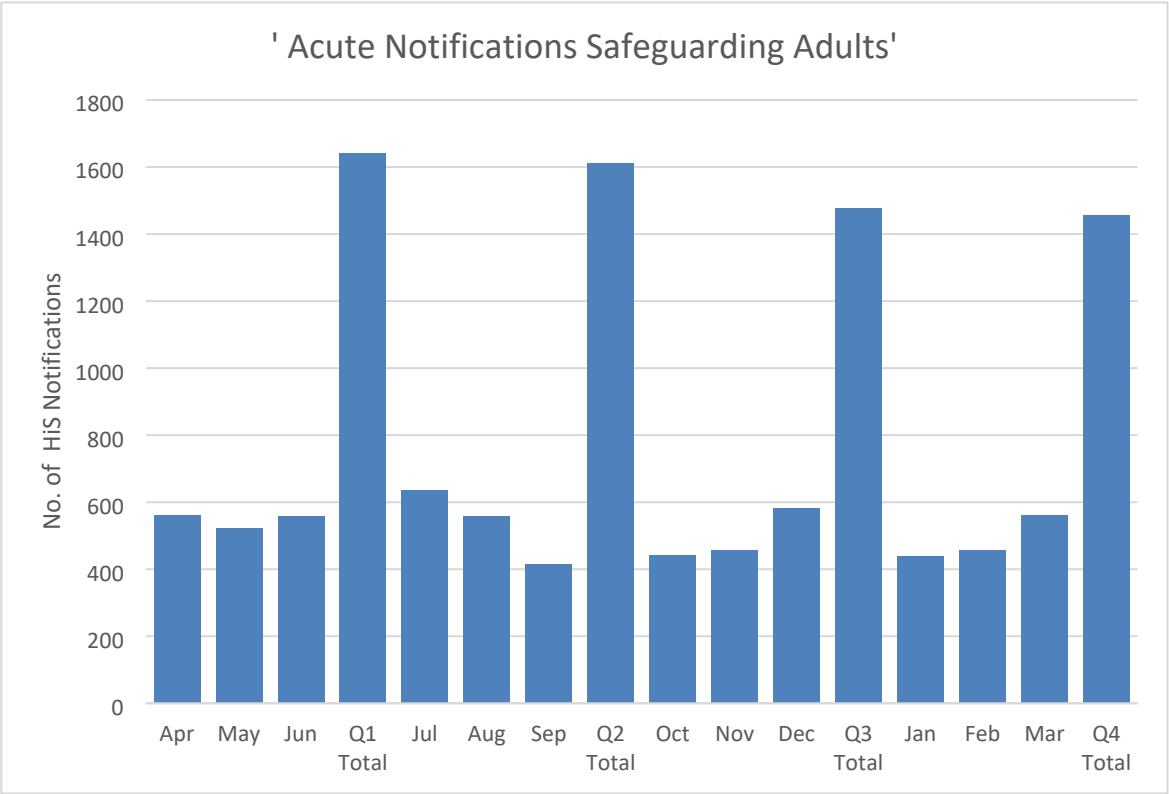
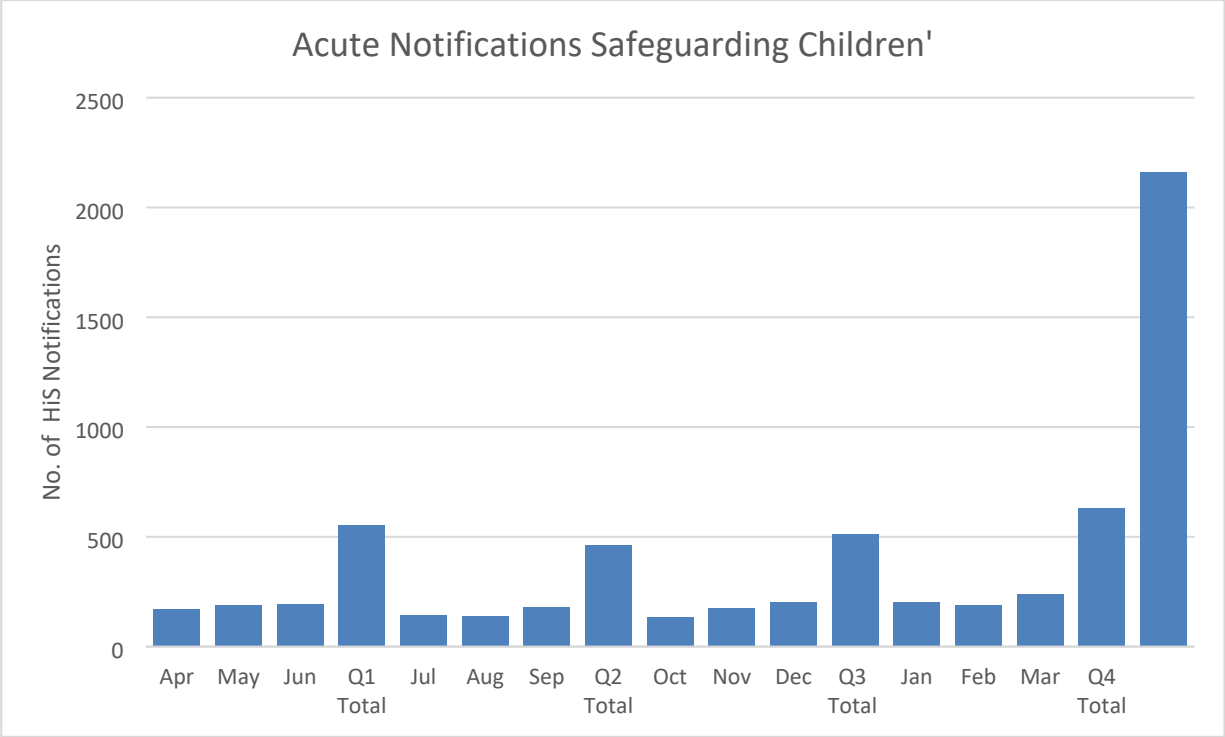
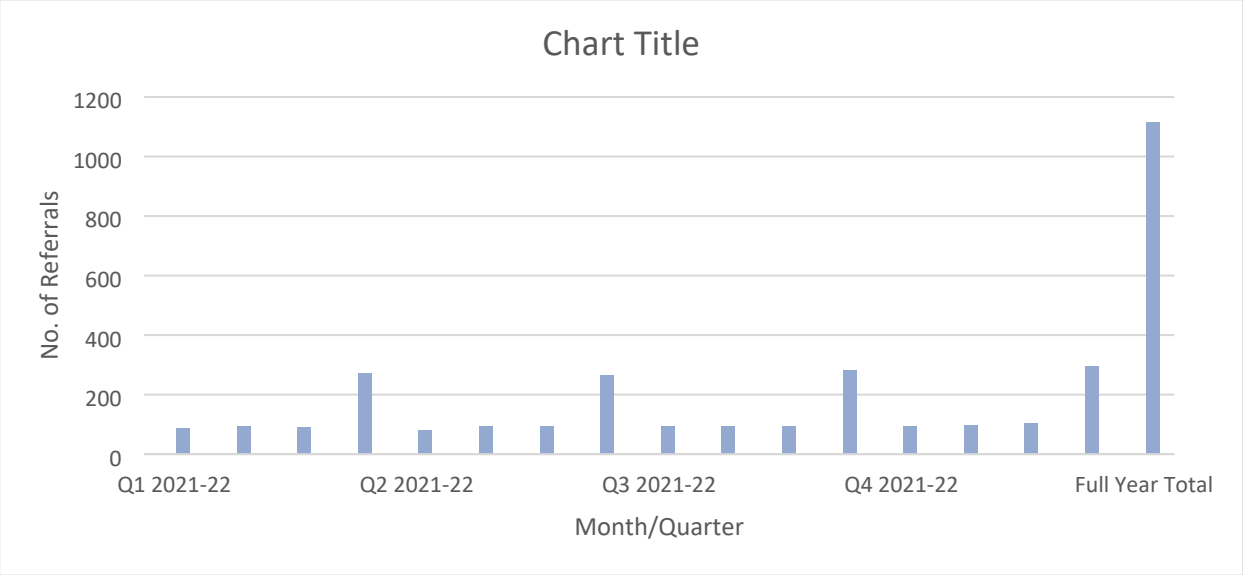


Figure 2. HiS Notifications via HiS in relation to Safeguarding Children Concerns



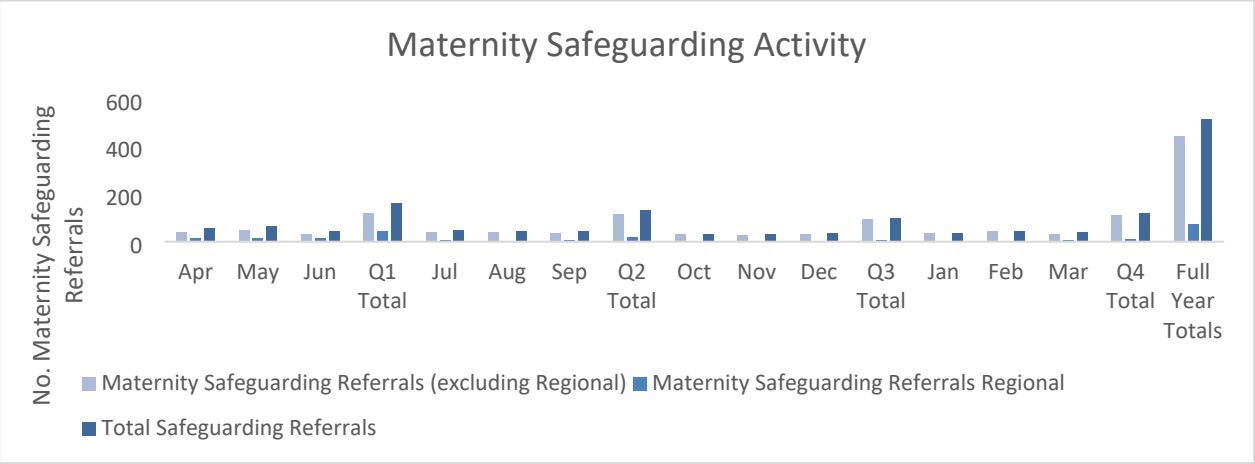
3.5 Patients who are identified as victims of Domestic Abuse has grown by **23% (n=1116)** this year

Figure 3. Referral to HIDSVA Team (all sources)



3.6 A change in data collection does not allow for yearly comparison of Safeguarding Maternity activity however end of year data identifies a total of **n=515** referrals to the Named Midwife Safeguarding via SCRF process.

Figure 4. Maternity Safeguarding Activity



3.7 Whilst the volume of individual safeguarding alerts is expected as a result of well evidenced impact of Covid 19 pandemic and the 'safeguarding surge', what isn't articulated via the numbers is the complexity of safeguarding cases.

3.8 It is acknowledged by the service that refined methods of data collection are required to ensure analysis of activity is fully reflective; it is noted that separate referrals per category of abuse or service practitioner have an element of duplication. In order to ensure a true 'Think Family' approach there is a requirement to better cross-reference existing data sets to extrapolate commonalities in relation to individuals; by understanding our high frequency patients and families, alongside developing an understanding of context such as impact of poverty, community and life experiences a preventative approach to safeguarding can be developed.

3.9 Utilising learning from reviews and grasping the opportunities arising from place-based care to support delivery the Think family Safeguarding Service aims to support all staff across the Trust in

positively influencing the health outcomes of those whereby risk of, or actual harm and abuse has been experienced.

3.10 There is limited ability to capture safeguarding activity within the Community Division however it is acknowledged that due to the nature of caseloads and provision of longer-term interventions community practitioners are highly skilled in the management of complex cases. Work is ongoing with Community Division colleagues and SystmOne analysists to support utilisation of Electronic Patient Record (EPR) to generate notifications to the Think family Safeguarding Service whilst establishing backend data reporting via SNOMED codes to capture safeguarding intervention and activity.

3.11 When considering the fundamental purpose of the Think Family Safeguarding Service it is useful to review data captured that presents an overview of referral source. Analysis of referral source assists in provision of assurance; it can evidence timeliness of identification i.e. Emergency Village are consistently the highest referral source for safeguarding adult and children alerts and additionally HIDSVA referral. This consistency reassures that the culture in terms of safeguarding being 'everybody's business' is embedded at the 'Front Door' of the Organisation with staff readily intervening to ensure children and adults at risk are protected from harm and abuse.

3.12 Safeguarding concerns that initiate contact with the Adult and Children Safeguarding Teams are reviewed in detail to ascertain area of abuse/concern. In keeping with the overall increase in notifications there is an associated rise in regard to most forms of abuse and harm. ***Appendices 3 and 4*** provide an overview of categories of notification in regard to safeguarding adults. Care and Support Needs **(38%)**, followed by Mental Health Issues **(22%)** and Alcohol/Substance Misuse Issues **(11%)** make up a significant proportion of all concerns. This data is reflective of the challenges highlighted locally and supports the narrative of increasing need and vulnerability for many members of our community.

3.13 Whilst the Acute notifications evidence emerging needs or often crisis episodes as a result of limited or unacknowledged requirement for support, the Community notifications frequently highlight the impact of uncoordinated or restricted offers of support and protection from all agencies, particularly for those with complex presentations who have a background of trauma. Regularly the 'safeguarding' element of this community cohort of patients is indicative of longstanding concerns; Self-Neglect is the highest notification category **(28%)** followed by Neglect/Acts of Omission **(25%).**

3.14 The service has now begun to collect data in relation to Unwitnessed Falls and Pressure Ulcers; further narrative has been provided within monthly reports to SEG however limited data over the year as a whole does not facilitate robust analysis.

3.15 It is a theme that a large number of patients accessing WWLTH Acute and Community services will have sustained a fall or pressure ulcer prior to contact. The Named Nurse Safeguarding Adults is supporting the improvement work internally and across the partnership in regard to these two areas to ensure concise review should harm have been caused by WWL whilst alerting to safeguarding concerns arising from care and provision afforded by other agencies. This work compliments the WWLTH Harm Free Care agenda.

3.16 When considering safeguarding concerns relating to children there has been a marked increase in terms of Neglect with a potential correlating statistic regarding Accidental Physical Injury ***(see Appendix 5).*** It is important however to consider children particularly in the context of family and the cumulative effect of harm as a result of witnessing Domestic Abuse or having a parent experiencing Mental Health or Substance Misuse issues. This situation can manifest in a presentation indicative of all types of abuse.

3.17 This year, and again reflective of national trends, there has been a significant increase in children presenting with Mental Health concerns; **25%** of all notifications. Home is not a safe place for some with children experiencing what has been described as 'Pressure Cooker environments'. The challenges for 'Lockdown babies' in terms of hindered development has also been well voiced giving rise to very real concerns regarding the new 'Mental Health Pandemic'.

3.18 Routes to safety have been limited and the opportunity for disclosures to be made where abuse has occurred restricted. Children and adults continue to experience loss and isolation further compounded by the impact of constrained access to a network of support previously readily available with stretched services unable to cope with ever increasing demand. National Child and Adolescent Mental Health Services (CAMHS) report a 300%+ increase in referrals, a trend reflected in Wigan with particular demand arising from children who are suffering with Eating Disorders (ED).

3.19 The impact of children with increasing mental health needs is felt across Acute and Community Children's Services. There continues to be high levels of inpatient activity on Rainbow Ward for children with ED; these are invariably long stay admissions requiring Section 85 *(Children Act 1989)* notifications to the Local Authority. The medical, clinical, social, and emotional complexity of these children mean that a robust package of care with clear multi-agency support plan is required. Often there is a requirement to detain children with ED under the Mental Health Act; this presents further challenge for both Paediatric staff however support and intervention by the Think Family Safeguarding Service is readily available and initiated.

3.20 Often presentations of Mental Health issues are a result of previous abuse and trauma; Children in Care feature heavily within the data set and similarly to ED patients will require admission to Rainbow Ward as a 'place of safety'. There have been a number of cases associated with complex admissions resulting in extended stay in hospital due to lack of provision within the community or specialist Tier 4 Mental Health Services. Again, this is not unique to Wigan or indeed Greater Manchester however work is underway to develop an urgent and responsive service for children who remain in hospital, or inappropriate placements, due to lack of specialist provision. The Safeguarding Children Team work closely with WWLTH staff, Mental Health colleagues from Greater Manchester Mental Health Foundation Trust (GMMH), and Wigan Children's Social Care (CSC) to expedite discharges once agreement of a safe plan is achieved. Escalation of such cases is completed as required utilising the established model as approved internally and by WSCP; WWLTH Senior Leaders and Executives are fully sighted on cases as appropriate with the need for support and intervention readily met.

3.21 In keeping with Adult notifications, the Emergency Village remains the highest 'referral' source ***(Appendix 6);*** again, this provides reassurance of early identification of safeguarding issues in terms of recognition and response. The Named Nurse Safeguarding Children has developed close working relationships with Emergency Village senior Nursing colleagues which has facilitated the implementation of additional safeguarding processes such as a 'Safeguarding Checklist' for use within Paediatric Emergency Care Centre (PECC). This is a new tool, currently being trialled, for which the outcome and impact will be detailed within subsequent Annual Reports.

3.22 CP-IS alerts (Child Protection Information Sharing Service) account for the most notifications via HiS **(28%).** The Child Protection - Information Sharing service (CP-IS) helps health and social care professionals share information securely to better protect children with looked after status, those who have a child protection plan and expectant women who have an unborn child protection plan. Whilst automatic alerts should be generated this is not a failsafe process and it is important that WWLTH staff recognise safeguarding concerns at the earliest opportunity. Monthly data reports into SEG provide assurance around this and consistently recognise that children open to Universal

Services are identified as being subject to potential abuse/neglect to enable referral to appropriate support and assessment by statutory services.

3.23 Domestic Abuse is one of the ten categories of abuse as legislated by the *Care Act 2014*; the Safeguarding Service hosts two HIDSVAs who are available on site to support victims of abuse, be they patients or staff. It is of note that the number of WWLTH staff accessing support from the HIDSVA service over the year was **53** highlighting the breadth of the service currently on offer within the Trust. A full breakdown of HIDSVA referral detail can be found in ***Appendix 7.***

3.24 Whilst an average of **25%** of referrals to the HIDVAs will be generated by the Emergency Village it is noted that the spread of other referral sources is wide and varied. Community practitioners such as Midwives and Health Visitors readily make contact for advice and support in regard to Domestic Abuse with joint visits to patient's homes or via clinic appointments facilitated.

3.25 Referrals to the HISDVA services predominantly relate to female victims **(935)** however in 2021/22 a total of **181** victims **(16%)** identified as male. The most prevalent age group identified sees victims aged between twenty and thirty-nine years of age, **46%** of all referrals to the service, however it can be noted that a more general spread in terms of age range was seen. With the exception of those aged sixteen to nineteen, all age groups saw an increase in victim presentation. **9** children under the age of sixteen were referred to the HIDSVA service which highlights the complexity of presentation. These children were victims of Domestic Abuse in the traditional sense however changes in legislation as a result of the recent Domestic Abuse Bill will see children now considered victims by virtue of witnessing and/or living in Domestic Abuse households. Domestic Abuse Act 2021 (legislation.gov.uk)

3.26 The most common form of Domestic Abuse being reported to the HIDSVA service is Physical Abuse **(27%)** however it is noted that often victims will be subject to more than one form of abuse. Assurance can be taken in terms of WWLTH staff ability to recognise and respond to all forms of Domestic Abuse. Routine Enquiry and Professional Curiosity assist in swift identification which enables referral and communication with professionals and services that are able to support the victim in maintaining their safety and/or exiting the abusive relationship.

3.27 Outcome data following referral to HIDSVA service can be found in ***Appendix 8***. Service users will often require a multiple offer of support relative to the complex presentations seen within referrals with interventions delivered recorded as 'outcomes.' A total of **2942** outcomes were noted against all cases with Safety Planning being required in **679** cases. **171** services users **(15%)** were uncontactable following referral however the HIDSVAs follow a strict protocol in terms of attempting engagement which is aligned to the Local Authority Community IDVA service. It must however be acknowledge that the total cohort of victims may include repeat referrals therefore it is entirely plausible that within the 171 victims not supported initially subsequent referrals may have resulted in a positive outcome of support after establishing contact.

3.28 Analysis of referrals per Midwifery Team following completion of Special Circumstances Referral Form to indicate safeguarding concern can demonstrate localities/teams which are impacted the most in relation to complex maternity cases. A significantly large proportion of cases are open to the Ashton Team, again noted being almost double the cases open to other locality teams. Comparative annual data is sadly unavailable, but analysis of residence can assist in ensuring allocation and provision of services.

3.29 The Named Midwife Safeguarding, whilst an established post, has seen a change in personnel in 2022. It is anticipated that subsequent reporting will capture new and refined data sets to assist the Director of Midwifery in ensuring delivery of safe maternity care as outlined within the Ockenden Report Final report of the Ockenden review - GOV.UK (www.gov.uk).

3.30 A breakdown of all safeguarding related activity highlights the numbers of unborn babies subject to new Child Protection **(n=80**) or Child in Need Plans **(n=89) *(Appendix 9)***. Associated activity in relation to attendance at Initial and Review Child Protection Conference is captured with the Maternity Service providing input to ensure an effective multi-agency plan to safeguard unborn children. Additionally, requests made to the Midwifery Service for Court Reports are collated with the Named Midwife Safeguarding and wider Think Family Safeguarding Service supporting on the completion and quality assurance of such.

3.31 A total of **110** Police referrals were received in relation to unborn babies considered to be at risk of harm. Pregnant women discussed at daily MARAC meetings (Multi Agency Risk Assessment Conference) due to risk of Domestic Abuse was **39**. Police referrals is a continuing trend not always relating to high risk from Domestic Abuse and is indicative of the additional complexities in relation to maternity safeguarding presentations and supportive of findings linked to increased presentation of mental health and alcohol/substance misuse concerns. A total of **16** Female Genital Mutilation cases were noted over the year however limited detail is available in terms of type and presentation to service. Future reporting will hopefully generate a deep dive into this area to provide additional assurance related to the muti-faceted response to this practice.

3.32 WWLTH fully complies with the *Mental Capacity Act 2005* and *Deprivation of Liberty Safeguards* that came into statue in *2008*. **2121** DoLS have been submitted to the Local Authority for the year 2021/22 with **90+%** evidencing a recorded Mental Capacity Assessment (MCA). The MCA/DoLS Lead for WWLTH, an integral team member within the Think Family Safeguarding Service, provides oversight on all DoLS supporting staff to rescind the application when it is no longer applicable.

3.33 Each patient on a DoLS is discussed jointly by the WWL MCA/DoLS Lead and the Local Authority DoLS lead on a weekly basis. Key areas considered include the level of enhanced care, use of covert medications and the use of sedations.

3.34 There continues to be an increase in MCA on the acute wards across the Trust, which indicates that staff are considering the patient's capacity throughout their journey providing evidence of good working practices. An increasing number of wards are now completing daily assessments for specific patients including those who are withdrawing from drugs/alcohol, post-surgery, and those with intermittent confusion. Areas of excellence can be noted within the surgical teams who are now holding regular Best Interest Meetings for their patients who are lacking capacity and who require investigations and treatments adopting a co-productive approach that utilises the skills and expertise of the multi-disciplinary team.

3.35 The Liberty Protection Safeguards (LPS) draft Code of Practice is currently under review following the end of the consultation period in mid-2022. It is suggested by legal experts that LPS will be delayed until at least March 2023 or even 2024. They also advise that the priority is to ensure that staff are fully cognisant and competent with the *Mental Capacity Act (2005)* with the Think Family Safeguarding Service already devising a detailed action plan and supportive audit programme to assist Trust readiness for implementation.

4 Training, Supervision and Support

4.1 A key priority for the Think Family Safeguarding Service throughout 2021/22 was to increase visibility across all Divisions, promote a culture of care, support and assistance for all staff whilst recognising the challenges faced on a day to day basis for those involved with caring for children, adults and families when a significant feature of concerns are of a safeguarding nature.

4.2 Despite the disruption as a result of 'covid waves' which at times limited opportunity to mobilise safeguarding practitioners to work alongside frontline staff, the service remained committed to extended support whenever possible. In early 2022 several members of the service offered additional clinical input to high demand areas via a 'flexible' redeployment model. Staff provided nursing input on A&E, Neonatal Unit, Midwifery, Rainbow Ward, and Children in Care Team with several team members assisting with the opening of an Escalation Ward (Ward A) at Wrightington Hospital on New Year's Day.

4.3 The advantage of having a visible safeguarding presence in clinical areas is two-fold; the obvious reactive, timely and productive point of care safeguarding support provided to staff in manging safeguarding concerns but a by-product for the Think Family Safeguarding Service of understanding the complexities of internal systems and an ability to target additional education and supervision sessions to assist in improvements in safeguarding skills, knowledge, and confidence.

4.4 Specialist Nurses for both Safeguarding Adult and Children focused heavily on supporting staff within the Emergency Village. As the highest 'referral' source safeguarding practitioner presence has meant immediate advice and support for staff which in turn reduces the requirement for HiS notifications which can often be resource and labour intensive for the Think Family Service due to the high volume of associated activity to review.

4.5 Patients can be seen in 'real time' as opposed to consideration of safeguarding need following review of patient records. Feedback from staff has been extremely positive; all forms of contact with the Think Family Safeguarding Service have increased and the improvements in regard to a 'duty' model ensure a more immediate and meaningful response to assist practitioners in managing what can be highly emotive and often distressing situations.

4.6 Safeguarding Children Specialist Practitioners are based in each locality within the Community Division once per month and are available for face to face reactive and responsive supervision, advice, support, and guidance. This proactive and visible approach is being adopted by the Named Midwife Safeguarding and the two HIDSVAs with the Adult Safeguarding Team mirroring a similar method of support by extending visibility to District Nursing Service, Jean Heyes Unit and Wrightington Hospital. The service has secured a 'Community hub' at Claire House and is the home of the Children in Care Team, the newest members of the Think Family Safeguarding Service.

4.7 The nature of safeguarding activity lends itself instinctively to a predominantly Adult Acute focus with Community Children's services such as Health Visiting and School Nursing requiring the most input and contact with the Think Family Safeguarding Service. The finite resource within the service requires prioritisation of support despite recognising all areas are equally deserving of input and focus.

4.8 The embedding of a 'Think Family' culture is therefore vitally important alongside the promotion of safeguarding as 'everyone's business' to ensure professional curiosity is the norm. Consideration of trauma and lived experience must remain at the forefront when supporting children and adults at risk of or suffering from harm and abuse.

4.9 Staff within the organisation are further supported and protected by ensuring robust safeguarding policies and procedures are in place. All outdated Policies and Standard Operating Procedures are under review with a clear tracker and action plan in place to ensure timely consideration of expiring

documents. Additional scoping to identify any gaps following changes in legislation or learning from internal audit/external reviews remains ongoing.

4.10 The safeguarding needs of children and adults within the Wigan Borough are becoming more complex and increasingly apparent. Safeguarding Supervision is key for all community and acute services staff during these very challenging and demanding times to support practitioners with the rising number of challenging cases.

4.11 The restorative aspect of supervision supports practitioners with the emotional challenge of addressing safeguarding demands whilst retaining a focus on the lived experience and needs of the child/adult. Revision of the Safeguarding Supervision Policy is underway and will clearly outline this offer with resultant data presentations to provide additional assurance.

4.12 Safeguarding Supervision is delivered in a mandated but also flexible format; the well-established model of supervision for 0-19s practitioners, following a period of suspension in early 2021 due to the pandemic, continues with an ambition to replicate a robust offer for other practitioners and services across the Trust. Midwives and Neonatal staff benefit from both one-to-one and group supervision with the Health Inclusion & Outreach Team being supported with regular opportunities to discuss individual cases or thematic issues.

4.13 Safeguarding Supervision is considered in a Signs of Safety context to allow a strength-based approach; consideration of what works well, what staff are worried about and what needs to happen is fundamental to eliciting change for children, adults and families whilst effectively managing risk. Supervision and escalation are intrinsically linked with adaptations to supervision templates and recordings reflecting discussions whereby drift and delay in multi-agency intervention and plans may result in lack of protection and increased incidence of harm.

4.14 The ability of health care staff to recognise and respond to safeguarding concerns is influenced heavily by the provision of high quality, up to date, relevant training. The Trust has a statutory and contractual requirement to demonstrate how it will educate and train its staff in the safeguarding agenda. The Think Family Safeguarding Service, supported by Learning and Development Colleagues, lead on developing and coordinating a comprehensive training offer to ensure all staff achieve the appropriate level of skill, knowledge, and competence commensurate with their role.

4.15 Safeguarding training is mapped against Intercollegiate Documents; *Roles and Competencies for Health Care Staff: The three Intercollegiate Documents for children, young people, looked after children, and adults (2018, 2019 and 2020)*. Thresholds for compliance are expected by NHS GM Wigan and outlined within the *Greater Manchester Clinical Commissioning Groups Safeguarding Children, Young People and Adults at Risk Contractual Standards 2021-2022*.

4.16 Mandatory training in relation to Safeguarding Adults was a relatively new introduction just prior to the Corona virus outbreak with NHS Trusts given a period of two years to demonstrate incremental gains in cohort compliance. The disruption as a result of the pandemic has seen a lack of traction against expected thresholds however WWLTH has maintained an ambitious focus on achieving against set metrics.

4.17 October 2021 saw the introduction of WWLTH Safeguarding Adult Level 3 Training via a new internally developed eLearning package. Difficulties in access with the previous package alongside cost implications encouraged alternative approaches to delivery of mandated content. Whilst well received the Think Family Safeguarding Service recognise the time elements associated and are striving to revise the offer across the whole suite of safeguarding training packages.

4.18 Safeguarding Children Level 3 training, after a period of virtual delivery, reverted back to face-to-face sessions in 2022. At the same time a significant review of content was completed with improvements and revisions a continual process to ensure staff remain updated against a backdrop

of ever-changing national legislation, guidance and initiatives alongside awareness of local themes and trends.

4.19 The end of year position in compliance relating to all levels of mandatory Safeguarding Adult and Children Training remained fairly stable with six out of eight Mandatory Training Levels for Adults and Children showing full compliance against the agreed set metrics as per GM Safeguarding Contractual Standards.

4.20 Compliance levels across all safeguarding training metrics is shown below. Thresholds for compliance against GM Standards is Level 1 = 95% and Levels 2 and 3 = 85%. Level 4 relates to Named Professionals with no explicit level set however there is a requirement against the Intercollegiate Standards to achieve this level within the first twelve months of taking up post. It is of note the GM compliance thresholds may differ from applied internal targets.

Figure 5. Overall Mandatory Safeguarding Training Compliance

Safeguarding Training	COMPLIANT	NON-COMPLIANT	Total Cohort	2020/21	2021/22
WWL Safeguarding Children Level 1	2193	46	2239	96%	↑98%
WWL Safeguarding Children Level 2	2789	163	2952	93%	↑94%
WWL Safeguarding Children Level 3	727	88	815	63%	↑89%
WWL Safeguarding Children Level 4	5	0	5	100%	↔100%
WWL Safeguarding Vulnerable Adults Level 1	1563	113	1676	95%	↓93%
WWL Safeguarding Vulnerable Adults Level 2	1526	29	1555	97%	↑98%
WWL Safeguarding Vulnerable Adults Level 3	2389	563	2952	63%	↑81%
WWL Safeguarding Vulnerable Adults Level 4	5	0	5	100%	↔100%

4.21 The impact of Covid and winter pressures remained significant when considering training compliance with increased challenges noted in relation to staff availability linked to annual leave and sickness. Despite national challenges associated with the continuing Covid-19 Pandemic, in particular the impact of the Omicron variant, there had been no direction to pause mandatory safeguarding training or review expected compliance levels. As such the Trust maintained monthly focus in this area via Safeguarding Effectiveness Group with additional scrutiny of themes and trends with consideration of associated risk.

4.22 The overall theme evidences a positive improvement journey for the Trust in relation to ensuring compliance with mandatory Safeguarding Training. Robust data review and open internal communication has succeeded in identifying challenges to achieving compliance whilst recognising significant commitment to progressing actions to assist in such. The demands on frontline practitioners must be considered to understand barriers to accessing mandated training with innovative methods of training delivery needing to be utilised to ensure completion of packages.

4.23 The wider remit of safeguarding interlinks with other areas of WWLTH mandatory training requirements. Below highlights such with a positive picture against set targets noted.

Figure 6. Additional Safeguarding Training Compliance

Training Course	COMPLIANT	NON-COMPLIANT	Grand Total	%
WWL Mental Capacity Act	2418	216	2634	**92%**
WWL Mental Capacity Act for HCAs	831	67	898	**85%**
WWL Prevent (BPAT)	5750	405	6155	**93%**
WWL Prevent Clinical (WRAP)	2842	201	3043	**93%**

4.24 It is recognised that there are challenges in reflecting a true picture of mandatory Safeguarding Training compliance which will be ongoing, with acknowledgement that robust data cleansing is a continuous process. Revision and implementation of a Safeguarding Training Needs Analysis and Strategy will likely see a further dip across all metrics whilst new an educational framework is implemented. This will however be closely monitored and managed.

4.25 The delivery model of Safeguarding Training is a key workstream for the Think Family Safeguarding Service; a proposal paper has already been tabled at SEG with initial approval received. A radical redesign of the approach should see compliance at all levels being maintained. A programme of exciting 'bitesize' sessions available for staff that capture the essence of local safeguarding and enable targeting of services/subjects has already commenced and will work alongside an approach that sets the tone of expectations from induction into the Trust. Senior Nursing Leaders have been welcoming and supportive of the vision which in turn promotes a shared mission to improve skills, knowledge, and confidence across all staff cohorts.

5 Contribution to Multi-Agency Safeguarding

5.1 Safeguarding children, young people and adults cannot be done in isolation; it is only truly effective via collaborative and restorative working with partner agencies to 'Think Family' and protect all those at risk of harm, abuse, or neglect.

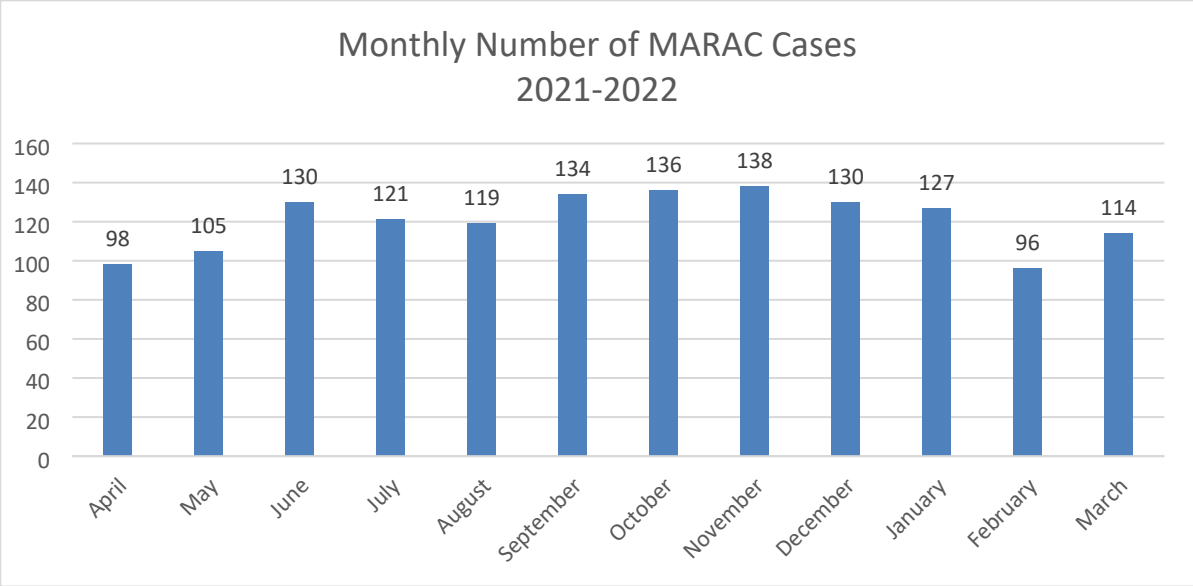
5.2 The Think Family Safeguarding Service and the Organisation contributes widely to the partnership via Wigan Safeguarding Adult Board (WSAB) and Wigan Safeguarding Children Partnership (WSCP) subgroups and workstreams. There is additional participation via the Domestic Abuse Strategic Oversight Board (this replaced the Domestic Abuse Steering Group) and the Community Safety Partnership (CSP) inclusive of all associated subgroups.

5.3 The Wigan Borough Place and Community Safety Partnership Domestic Abuse Strategy 2021 – 2024 aims at being '*aspirational and that Wigan as a Borough deem domestic abuse as being unacceptable in all its forms, and where we want people in our community to be able to live safely and have happy lives free from abuse'.* WWLTH as the major health provider within the Borough advocates and works as a key partner agency in fulfilling this strategy.

5.4 A Multi-Agency Risk Assessment Conference (MARAC) involves the sharing of information relating to the highest risk domestic abuse cases with representation inclusive of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from statutory and voluntary sectors. The primary focus of the MARAC is to safeguard the adult victim however actions to safeguard children and manage the behaviour of the perpetrator will also be considered. WWLTH's contribution to MARAC is co-ordinated by the Think Family Safeguarding Service, throughout 2021/22 daily MARACs continued with the number of cases heard per day averaging at around six.

5.5 A total of **1448** MARAC cases were heard within daily meetings in 2021/22.

Figure 7. Annual MARAC Data



5.6 ***Appendix 10*** details a breakdown of cases with data in relation to victims who have children. **75%** of all cases heard were noted to involve children, this remains a consistent metric. As there is often more than one child within a family data highlights that **2516** children were impacted by high-risk domestic abuse in the Wigan Borough throughout the course of the financial year.

5.7 The Think Family Safeguarding Service continues to complete a high number of checks **(5412)** to ensure timely, appropriate sharing of health information to inform safety and action planning for adults and children at risk.

5.8 A number of MARACs are repeat incidents involving previously discussed victims/perpetrators with **27%** of cases falling into this category. It could be concluded that the original MARAC action plan was inadequate in keeping the victim safe however it must also be considered that a review at MARAC is a result of a breach of a protective order by a perpetrator that has been appropriately reported by the victim.

5.9 The Think Family Safeguarding Service continues to host co-located 'Health' roles via the employment of a Complex Safeguarding Nurse based at Wigan Police Station with the Complex Safeguarding Team, and Specialist Nurse Safeguarding Children based within the newly named Children First Partnership Hub (formally MAST) at Wigan Life Centre. Whilst these post holders have a specific remit in terms of the multi-agency approach to exploitation of children and the 'Front Door' to Safeguarding, practice is embedded widely in terms of the 'Think Family' approach embraced by the service.

5.10 The prevalence of Sexual and Criminal Exploitation of children in Wigan remains an area of focus across the partnership. An average of **70** children are open to the Multi-Agency Complex Safeguarding team at any one time and there has been a recent revision of the model of social care input to facilitate the ACT (Achieving Change Together) Model of intervention.

5.11 This relational model of practice often characterised by assertive outreach approaches provides the perfect platform to revitalise the role of the Complex Safeguarding Nurse. There is a move to embed public health approaches into the health delivery model enabling effective and productive interventions that will assist in reducing risk alongside supporting overall holistic assessment of the needs of children subject to Criminal or Sexual Exploitation.

5.12 Further scoping and development of the health offer is necessary however a robust internal appraisal of intervention is already underway with the capturing of thematic data to better understand the specific health needs of this cohort. Disruption as a result of this post being subject to vacancy resulting from Maternity Leave has limited progress at this time.

5.13 It has already been established a link between prevalence of ADHD, more crucially that which is not managed by medication, and children who are at increased risk of criminal exploitation. Review of processes to capture and effectively analyse health data related to Contextual Safeguarding is ongoing however an overview of caseload numbers can be seen in ***Appendix 11***.

5.14 The role of the WWLTH Health Practitioner within the Children First Partnership Hub is to undertake the immediate health information sharing and attend Initial Strategy Meetings. ***Appendix 12*** provides a breakdown of 2021/22 activity in relation to attendance at Strategy Meetings **(n=691),** sharing of Health Information **(n=884)** and Health screenings **(n=3545).**

5.15 As can be established from the data this post is resource intensive with activity to ensure urgent and appropriate multi-agency responses time barred as per Statutory Processes outlined in *Working Together 2018*. Unfortunately, during 2021/22 significant IT issues resulted in co-location in the multi-agency hub being minimal, this was further compounded by the ongoing impact of the Covid-19 Pandemic and staff absence. There is an anecdotal direct correlation between presence and availability of the Specialist Nurse onsite to increased completion of requests for support and intervention.

5.16 As is well versed when considering 'what works well' in relation to safeguarding it is often the practice of informal communications and development of mutually supportive professional relationships. The Children First Partnership Hub Nurse role is a single person post therefore periods of high demand require a flexible and supportive response from the wider Safeguarding Children Team to ensure essential activity is maintained.

5.17 Discussions with Local Authority colleagues, Designated Professionals from NHS GM Wigan and ICS Commissioners is required to consider the level of current investment into both Multi-Agency posts with a particular focus on the changing face of safeguarding as indicated by recent high profile National Children Safeguarding Practice Reviews (CSPRs) National review into the murders of Arthur Labinjo-Hughes and Star Hobson - GOV.UK (www.gov.uk) and Local Child Safeguarding reviews Local Child Safeguarding Practice reviews (wiganlscb.com).

5.18 Work was ongoing in 2021/22 in relation to **13** Local CSPR's, **3** of which related to two children. A number of these included 'legacy' reviews whereby the completion of final report was hindered by the Pandemic; **3** CSPRs were signed off and published by the WSCP.

5.19 All reviews have active Action Plans to support Multi-Agency learning with WWLTH Think Family Safeguarding Service, via the Leadership of the Named Nurse Safeguarding Children, required to provide evidence of delivery against such. These include learning opportunities and implementation of practice changes across a number of WWLTH services with underpinning themes that relate to 'Voice of the Child and Lived Experience', 'Transition', 'Professional Curiosity and

Escalation', 'Trauma Informed Practice', 'Working with families where engagement is problematic or resistant', 'Information Sharing and Communication' and 'Use of Evidenced Based Tools'.

5.20 Validation visits for the CSPR's were undertaken by the NHS GM Wigan Designated Nurse Safeguarding Children to review the WWL evidence for the legacy Serious Case Reviews and recently published Child Safeguarding Practice Reviews; positive feedback was received against progress and onward innovation to embed lessons learned. The Named Nurse Safeguarding Children attends WSCP Case Review subgroup and meets with the Partnership monthly to update ongoing actions.

5.21 The process around child deaths is overseen by the Named Nurse Safeguarding Children supported by the Safeguarding Children Team who are responsible for the Child Death Overview Panel (CDOP) processes. Sadly **15** Child Deaths were reported during 2021/22, some of which were unexpected.

5.22 An updated Child Death Policy was presented for approval at the Safeguarding Effectiveness Group in March 2022 following additional input and review by the newly appointed Designated Doctor for Child Death. A robust action plan has been drafted to support internal Child Death processes and to ensure the Trust is compliant with statutory expectations in relation to practices introduced to ensure effective and responsive support to families following the loss of a child. Initial work on ensuring compliance and adherence to the guidance issued in 2018 had been significantly delayed however substantial progress has now been made under the direction of the new Named Nurse Safeguarding Children who commenced in post in September 2022. Child death review: statutory and operational guidance (England) - GOV.UK (www.gov.uk)

5.23 There is a requirement to establish a new post/workstream of Key Worker for Child Death, again as outlined in Statutory Guidance, with the Think family Safeguarding Service implementing this via utilisation of existing resources and recent income generating workstreams.

5.24 Partnership work streams associated with the Adult Safeguarding agenda are as demanding as those for children. The Adult Safeguarding Team contributed to **4** Safeguarding Adult Reviews (SAR) throughout 2021/22 alongside involvement in a number of Brief Learning Reviews (BLRs) and Domestic Homicide Reviews (DHRs).

5.25 In line with WSCP processes there is a requirement by the WSAB for WWLTH to be a key partner in contributing to reviews and the generation of associated action plans to ensure wider partnership learning. Similar themes to those found in Safeguarding Children Reviews are evident however there are noted trends in regard to 'Suicide', 'Self-Neglect and Neglect', 'Mental Health and Substance Misuse', 'High Level Complexity and Impact of previous Trauma' with additional consideration of the Care Experienced cohort and the long-term challenges faced by young adults who exit the 'looked after children' system.

5.26 The WWLTH Safeguarding Adult Team attend twice weekly WWLTH Pressure Ulcer Meetings to provide Safeguarding oversight of the multiple 2; category 3; category 4; unstageable and Deep Tissue Injury pressure ulcers recorded by the Trust. The Named Nurse Safeguarding Adult takes a lead in this work and is able to provide advice and assurance linked to Adult Social Care referral pathways upon identification of a pressure ulcer.

5.27 The internal work around the Pressure Ulcer and Harm Free Care agenda is significant from a partnership perspective. Any areas whereby the Trust is considered to have caused harm requires robust investigation and is considered via Strategy Meetings in line with Section 42 Safeguarding Adult processes.

5.28 Resource investment in terms of safeguarding service activity, time and capacity associated with Pressure Ulcers is significant however this has been embraced by the Think Family Safeguarding Service and support significantly by the Chief and Deputy Chief Nurse.

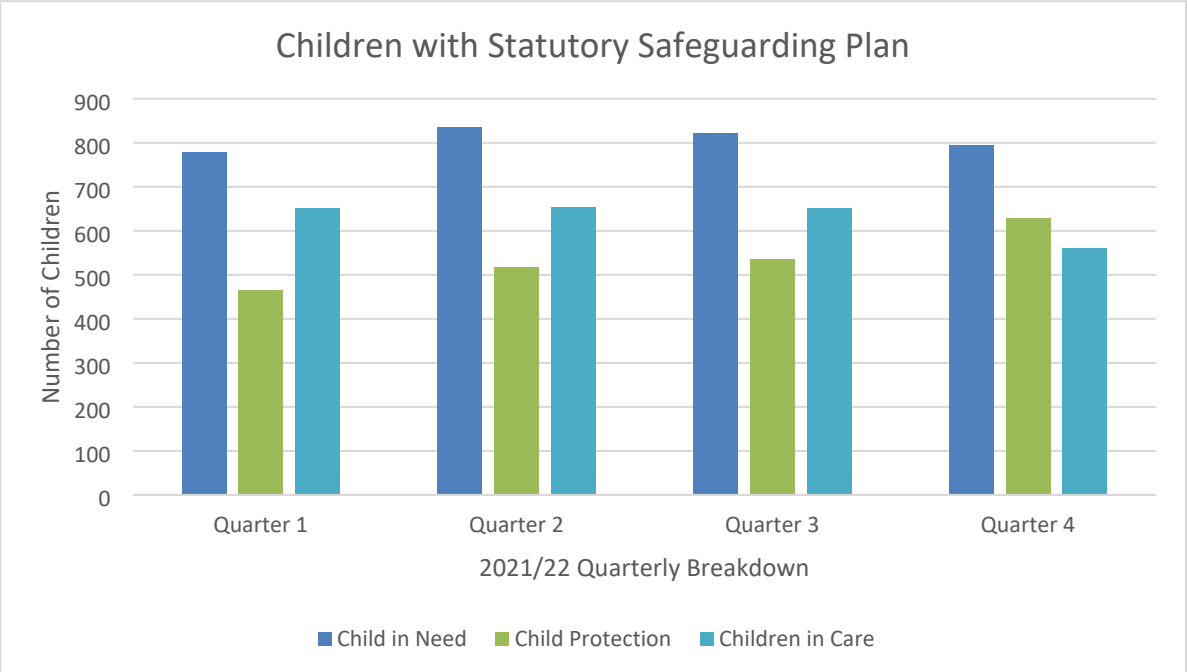
5.29 The Safeguarding Team have attended a high number of Strategy Meetings in relation to pressure ulcers during 2021/22; these Strategy Meetings were held in relation to both community and acute acquired pressure ulcers where Neglect or Acts of Omission could be a factor. Any cases deemed at Pressure Ulcer Panel to show lapses in care are referred to the Local Authority. Internal processes to consider STEIS reportable harm following Concise Investigation progress with ongoing input and support from a safeguarding perspective to ensure accuracy and objective consideration of concerns.

5.30 Internal assurance around this workstream has been demonstrated within monthly data reports sighted by SEG and show that the Trust is effectively responding to incidents of hospital and community acquired Pressure Ulcers. The introduction of the Pressure Ulcer Policy, SOP and Decision Tree reflects the commitment to ensure proportionate safeguarding responses alongside robust review of each incident to consider learning opportunities. This improvement work has been shared across the partnership with Adult Social Care, NHS GM Wigan and WSAB colleagues excited by the proactive and solution focused approaches being driven by WWLTH. Data collection to validate these improvements is in its infancy but it is hoped that the 2022/23 Annual Report will showcase this work explicitly and demonstrate significant improvements and WWLTH commitment to the wider Harm Free Care agenda.

5.31 Partnership working in a more subtle form is ongoing across WWLTH with the Think Family Safeguarding Service and a multitude of other professionals and services engaged in multi-agency workstreams, audits and meetings, be these at individual patient level or from a community or theme specific perspective.

5.32 Activity is generally more quantifiable from a safeguarding children viewpoint and can be linked to those that are subject to Child Protection Plans, requiring intervention from a Child in Need Plan or in Children in the care of the Local Authority.

Figure 8. Children subject to safeguarding plans



5.33 Children requiring the intervention of the Local Authority, whereby actual or risk of harm and abuse is evident, need health practitioners and services to fulfil their role to keep them safe within in the coordinated plan. The Think Family Safeguarding Service support both practitioner, and

children and families, within this process via direct contact or as a result of training, supervision and contribution to strategic developments and innovation.

5.34 Refined data collection over the coming year will allow quantifiable information in regard to WWLTH Safeguarding Adult activity. It is hoped that a clearer picture of the issues for our community can be presented which will assist in service delivery and care provision to improve health outcomes to support those most at risk.

5.35 The Adult Safeguarding Team link extensively with the Local Authority Quality and Performance Officers (QPO) in relation to adults in care home settings. The team is involved in the safeguarding of adults requiring residential or nursing care at point of contact with WWLTH services should safeguarding issues arise; this may be associated with acquired pressure ulcers, falls, medication errors or disclosures of abuse.

5.36 The Trust has a duty to cooperate with the Prevent agenda under the Counterterrorism and Security Act (2015) with the perceived threat to the United Kingdom remaining significant.

5.37 The Assistant Director for Safeguarding has ensured timely and accurate submission of the National PREVENT Duty Data Set following some initial challenges in data retrieval and coordination. Quarterly submission as required by NHS GM Wigan and NHS England are now completed. The Assistant Director of Safeguarding is the WWLTH PREVENT Lead and nominated representative on Channel Panel ensuring responses to requests for information to assist in management of risk for individuals susceptible to radicalisation are complied with.

5.38 The current PREVENT Policy is under review however training compliance across the organisation is good with appropriate referrals and discussions when individuals of concern are identified. Clear lines of communication and positive relationships with Human Resources and Information Governance colleagues have further supported robust responses to this agenda.

6 Achievements and Assurance

6.1 Key priorities set within the previous Annual Report (2020/21) outlined a number of objectives for the Think Family Safeguarding Service. Whilst focus on these has remained it is inevitable that additional or adapted workstreams have been developed as influenced by the political climate, social contexts, and local agendas.

6.2 The service has ensured prioritisation of statutory obligations therefore maintaining a clear focus via SEG on the multi-faceted nature of safeguarding. Reporting to internal and external groups, committees and boards has much improved providing assurance and reassurance to executives, governors, and key stakeholders in regard to performance.

6.3 The Quality and Safeguarding Group (QSG) is a subgroup of the NHS Wigan Borough Clinical Commissioning Group (now NHS GM Wigan) Clinical Governance Committee. The Group reviews and monitors compliance against statutory safeguarding responsibilities using the 'NHS Provider Safeguarding Audit Tool' included in the contract.

6.4 Sixty-seven Key lines of Enquiry (Standards) are reviewed by the Designated Nurses with WWLTH Think Family Safeguarding Service, and the Children in Care Team (at the time sitting within

Community Division 0-19s service), required to provide evidence to show compliance. Validation Visits were completed in November 2021 with final agreement in regard to rating detailed within January 2022 QSG.

6.5 In terms of Safeguarding Standards (11 are specific to Children in Care) **35** out of **56** standards were rated as GREEN and therefore fully compliant. For the remaining **21** standards a rating of AMBER, denoting *'Partial compliance, action plans in place to ensure full compliance and progress is being made within agreed timescales'* was agreed. No standards were deemed RED.

6.6 For the standards requiring additional work and provision of evidence to demonstrate assurance a comprehensive action plan was formulated. Thematic overview of this work included update of policies and supported SOPs (either outstanding or delayed review or requiring adjustment due to legislative/contractual changes) with particular focus areas in regard to 'Was Not Brought' and 'Least Restrictive Practices'.

6.7 None of the areas deemed AMBER were not already identified by the Think family Service as priority workstreams with activity well underway to confirm assurance could be obtained in the near future. The service has maintained work against this action plan and subsequent review against contractual standards has seen a further **4** standards now achieving full compliance. Remaining AMBER standards are progressing against agreed timescales with compounding factors outside of the control of the Think Family Safeguarding Service, and indeed WWLTH as a whole, limiting the ability to achieved a GREEN rating by the end of this reporting period (March 2022).

6.8 Compliance and assurance against Children in Care Contractual Standards will be discussed and highlighted within the 2021/2022 Children in Care Annual Report which is compulsory as a separate document due to statutory and contractual requirements.

6.9 The 'Think Family' approach to safeguarding has become further mainstreamed across the Trust. This has been achieved in part by staff being visible in clinical areas plus a duty system bolstered and refined to provide responsive and reactive support and guidance whilst responding to queries from external partners and agencies. Members of the service have worked positively and enthusiastically to embed this ethos reviewing internal processes and acting on staff and service user feedback.

6.10 Participation in a range of internal and multi-agency audits, shared and ratified via SEG, resulted in the implementation of policy and procedure whereby impact to improve outcomes alongside a willingness to share good practice and data to further support WWLTH and partnership developments can be seen. Collaboration with all has been embraced and a confident safeguarding workforce has been established.

Key Priorities for 2021/22	Demonstration of Achievements
Preparation and implementation Liberty Protection Safeguards	Draft Implementation Plan including resource review, Training Needs Analysis and Audit Programme devised with a number of actions already completed Engagement with WSAB LPS Sub-group Involvement with Regional and National LPS forums Review of current DoLS Workstreams and practice improvements Revision of current DoLS/MCA paperwork

Enhancing the utilisation of patient experience and staff feedback to supplement performance and outcome data and demonstrate "what we do well"	Responded to requests from service areas to deliver bespoke training packages Review of Safeguarding Supervision Policy Safeguarding Training Strategy and Associated TNA in draft Relaunch of Safeguarding Champions in Quarter 1 2022/23
Develop the WWL "Think Family model" within a contextual safeguarding framework	Consistent language and terminology embedded Review of Think family Safeguarding Service structure inclusive of revising Job Descriptions and Person Specification Improved Training Programme with updates to mandatory packages Integration of Safeguarding Practitioners and agendas within all areas of the Organisation via increased visibility and attendance at groups/forums/meetings Improved data capture and quality of reports to SEG
Assessing readiness for ICS transition	Ensuring all statutory functions maintained with clear action plan to achieve compliance against Contractual Standards Full participation in partnership activity inclusive of WSAB/WSCP/CSP/DASOB groups Regular and consistent review of new legislation, initiatives, partnership priorities and Trust objectives to ensure alignment with Think Family Safeguarding Service Workplan

6.11 The Think Family Safeguarding Service delivered against the 2021/22 Safeguarding Audit Calendar across both adults and children's agendas via completion of both planned and reactive audits. Areas for improvement have a schedule of re-audit and are included within the 2022/23 work plan.

6.12 Future development of the Think Family Safeguarding Agenda remains a priority; the service is keen to work in a different way to ensure staff are supported and patients are protected. Complex cases are increasing which continue to impact on workload whilst there remains specific and commissioned work, either via SEG or the partnership, that place demands on time and resource.

7 Looking Forward 2022/23

7.1 The WWLTH Think Family Safeguarding Service is ambitious for the year ahead and has a clear vision of ongoing innovation and improvement which is underpinned by the 'WWL Way 4wards'.

Key Priorities for 2022/23
➢ Development of WWLTH Think Family Safeguarding Strategy and associated Think Family Safeguarding Workplan linked to WWL Way 4wards and Trust Corporate objectives incorporating WSAB/WSCP priorities

➢ Completion of internal review of WWL Think Family Safeguarding Service with any proposed restructure/business case founded on contribution and collaboration of all team members following facilitation of Service Away Day
➢ Think Family Safeguarding Training Strategy and associated Training Needs Analysis implemented to support ongoing developments ensuring WWLTH effectively maintains compliance against mandated Safeguarding Training targets whilst establishing a confident and competent workforce able to safeguard children and adults at risk
➢ Develop improved Safeguarding Supervision offer across WWLTH ensuring all staff have personal resilience and professional motivation to support safeguarding issues
➢ Monitor and review Mental Capacity Act/Deprivation of Liberty Safeguard compliance against Quality Standards to support development of robust Trust wide Liberty Protection Safeguards Implementation Action Plan
➢ Review data collection and safeguarding notification processes implementing necessary changes utilising Business Intelligence support to improve data integrity and influence future service developments
The WWL Way

8 Conclusion

8.1 The Think Family Safeguarding Service has experienced a number of challenges throughout the year with significant changes in staffing, particularly in key leadership roles. A level of stability is now present, and this is creating and valuing a culture of respect and acceptance.

8.2 Whilst a review of the structure and business of the service is ongoing this does not impact the desire to improve and innovate across all safeguarding workstreams with practitioners eager to engage internally with a wide range of colleagues whilst embracing fully the benefits of multi-agency and partnership working.

8.3 The data and narrative provided within this report presents a summary of safeguarding activity across the service, and WWLTH as a whole, throughout 2021/22 culminating in a picture that demonstrates acceptable level of assurance in regard to the discharge of statutory safeguarding duties.

8.4 There is a sincere recognition of the work required in the year ahead but the ability to acknowledge gaps in provision or areas for service improvement motivate the WWL Think Family Safeguarding Service to ensure meaningful change that ultimately protects those with the greatest level of need.

8.5 The Safeguarding Service is focussed on promoting the best possible outcomes for children, adults and families using a purposeful shift in considering the value of impact and outcome from a patient centred perspective by analysing the 'So What?' of every possible contact.

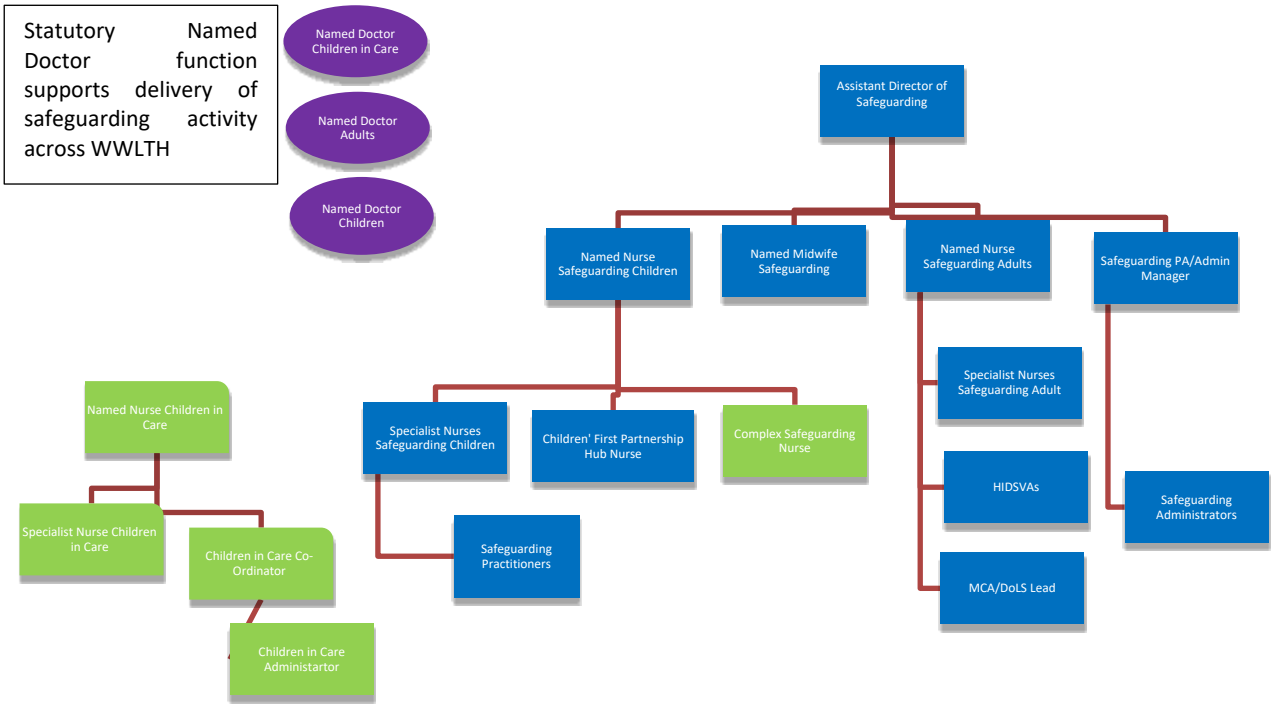
be the Difference

Appendices

Appendix 1.

Think Family Safeguarding Service Structure

Statutory Named Doctor function supports delivery of safeguarding activity across WWLTH



CiC Team previously in Community Division 0-19 Service. Transferred to Corporate Safeguarding Team July 2022

Full Staffing establishment: -
1 WTE AD of Safeguarding
4 x WTE Named Nurses/Midwife
7 x WTE Think Family Safeguarding Specialist Nurses
2 x WTE Safeguarding Practitioners
2 x HIDSVAs
1 x 0.8 WTE MCA/DoLS Lead
1 x WTE CFPH Nurse
1 x WTE Complex Safeguarding Nurse
4.8 WTE Specialist CiC Nurses
4.8 WTE Administrators (Safeguarding/CiC)

Appendix 2.
Safeguarding Effectiveness Group Terms of Reference

Leigh Teaching Hospita
NHS Foundation Tr

Safeguarding Effectiveness Group Terms of Reference	
Committee Name:	Safeguarding Effectiveness Group
Chairperson	Chief Nurse
Date:	May 2022
Version:	3
Reports to:	Quality and Safety Committee
Receives reports/minutes from:	**External** • Safeguarding Partnership Board Adults & Children minutes **Internal** • Divisional Quality Executive Group chair reports • Safeguarding Team reports to include Safeguarding Children, Adults, Learning Disabilities, Maternity, IDSVAs, MARAC.
Meeting and attendance Frequency:	Monthly
Definition of Quorum:	As a minimum the Group will be considered quorate providing the following members are present: Executive rep, SG rep, Divisional rep, Named Dr rep
Membership:	Executive Lead for Safeguarding - Chief Nurse Deputy Chief Nurse (Safeguarding Portfolio) Assistant Director of Safeguarding Named Nurse Adults Named Nurse Children Named Midwife Safeguarding Learning Disabilities Lead IDSVA Lead Named Doctor Children Named Doctor Adults Designated Nurse Children CCG (or deputy) Designated Nurse Adults CCG (or deputy) Non-Executive Director Divisional Directors of Nursing (or deputy HON) • Community • Specialist Services • Surgery • Medicine Director of Midwifery (or deputy) Chief Informatics Nurse Head of Emergency Care (or deputy Matron) Admiral Nurse

Appendix 3.

Acute Safeguarding Adult Notifications by Category

Category of Referral	Q1 2021-2022				Q2 2021-2022				Q3 2021-2022				Q4 2021-2022				Full Year Total
	Apr	May	Jun	Q1 Total	Jul	Aug	Sep	Q2 Total	Oct	Nov	Dec	Q3 Total	Jan	Feb	Mar	Q4 Total	
Physical Abuse	6	4	14	24	9	15	9	33	12	10	12	34	1	13	11	25	116
Sexual Abuse	1	1	0	2	1	3	0	4	0	1	1	2	1	0	1	2	10
Financial Abuse	1	2	1	4	2	4	1	7	1	0	3	4	5	1	2	8	23
Psychological / Emotional Abuse	0	2	0	2	1	3	1	5	2	0	1	3	2	4	3	9	19
Neglect & Acts of Omission	43	40	31	114	46	45	28	119	35	41	64	140	45	62	41	148	521
*Unwitnessed Fall (recorded from March 2022)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	82	82	82
Sexual Exploitation* (not recorded in March 2022)	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1
Organisational Abuse	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	2	2
Self-Neglect	13	13	13	39	21	17	7	45	13	13	15	41	16	18	18	52	177
Domestic Abuse	13	10	7	30	10	10	7	27	7	19	20	46	20	15	21	56	159
Modern Slavery	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	2	2
Discriminatory Abuse	0	1	0	1	2	0	0	2	1	1	0	2	2	1	1	4	9
Care and Support Needs	170	153	200	523	255	193	174	622	203	204	279	686	205	170	201	576	2407
*Pressure Ulcer (recorded from March 2022)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	32	32	32
Mental Health Issues	142	149	168	459	128	111	85	324	95	87	81	263	85	112	137	334	1380
Alcohol/Substance Misuse	83	72	20	175	75	64	47	186	41	56	62	159	47	61	77	185	705
Learning Disability* (recorded in outcomes in March 2022)	15	10	13	38	17	26	11	54	3	3	3	9	0	0	0	0	101
Other* (not recorded in March 2022)	74	65	90	229	70	68	44	182	28	21	39	88	8	0	0	8	507
Total	**561**	**522**	**557**	**1640**	**637**	**559**	**414**	**1610**	**441**	**456**	**581**	**1478**	**439**	**457**	**629**	**1525**	6253

Appendix 4.

Community Safeguarding Adult Notification by Category

Category of Referral	Q1 2021-2022				Q2 2021-2022				Q3 2021-2022				Q4 2021-2022				Full Year Total
	Apr	May	Jun	Q1 Total	Jul	Aug	Sep	Q2 Total	Oct	Nov	Dec	Q3 Total	Jan	Feb	Mar	Q4 Total	
Physical Abuse	0	1	0	1	0	0	0	0	0	1	0	1	0	0	0	0	2
Sexual Abuse	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Financial Abuse	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Psychological / Emotional Abuse	0	0	0	0	0	1	0	1	0	1	0	1	0	0	0	0	2
Neglect & Acts of Omission	4	1	3	8	0	2	0	2	0	3	0	3	0	2	0	2	15
*Unwitnessed Fall (recorded from March 2022)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sexual Exploitation* (not recorded in March 2022)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Organisational Abuse	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Self-Neglect	0	2	1	3	3	5	0	8	1	3	0	4	0	0	2	2	17
Domestic Abuse	0	1	0	1	2	0	0	2	0	0	0	0	1	0	2	3	6
Modern Slavery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Discriminatory Abuse	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Care and Support Needs	0	1	0	1	1	1	0	2	0	2	0	2	0	0	0	0	5
*Pressure Ulcer (recorded from March 2022)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1
Mental Health Issues	0	0	2	2	0	1	1	2	0	0	0	0	0	0	0	0	4
Alcohol/Substance Misuse	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1
Learning Disability* (recorded in outcomes in March 2022)	0	0	0	0	1	0	0	1	0	1	0	1	0	0	0	0	2
Other* (not recorded in March 2022)	1	0	0	1	1	0	1	2	0	0	0	0	0	2	0	2	5
Total	**6**	**6**	**6**	**18**	**8**	**11**	**2**	**21**	**1**	**11**	**0**	**12**	**1**	**4**	**5**	**10**	61

Appendix 5.
Acute Safeguarding Children Notifications by Category

Category of Referral	Q1 2021-2022				Q2 2021-2022				Q3 2021-2022				Q4 2021-2022				Full Year Total
	Apr	May	Jun	Q1 Total	Jul	Aug	Sep	Q2 Total	Oct	Nov	Dec	Q3 Total	Jan	Feb	Mar	Q4 Total	
Neglect	1	4	4	9	7	5	7	19	9	1	6	16	2	3	1	6	50
Physical Injury - Non-accidental	5	8	6	19	3	3	2	8	7	6	2	15	6	6	8	20	62
Physical Injury - Non-mobile Child	3	6	8	17	5	4	14	23	5	4	9	18	10	9	10	29	87
Physical Injury - Accidential	27	12	20	59	25	10	15	50	11	24	16	51	23	18	21	62	222
Emotional Abuse	1	1	0	2	3	2	1	6	0	1	1	2	1	0	0	1	11
Sexual Abuse	0	1	0	1	0	0	1	1	0	1	1	2	0	2	1	3	7
Sexual Abuse - CSE	0	0	2	2	1	0	2	3	0	0	0	0	0	1	0	1	6
Sexual Abuse - Trafficking	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Domestic Abuse	4	0	8	12	4	5	3	12	1	4	5	10	8	3	4	15	49
Substance Misuse - Child	10	6	10	26	4	7	6	17	1	3	8	12	8	10	4	22	77
Substance Misuse - Parent/Carer	3	4	4	11	4	1	3	8	2	4	11	17	4	10	12	26	62
Mental Health - Child	48	57	54	159	27	29	37	93	29	48	45	122	49	52	69	170	544
Mental Health - Parent/Carer	1	9	15	25	4	12	16	32	11	9	9	29	12	21	16	49	135
Dog Bite	4	8	4	16	4	4	8	16	4	3	8	15	8	7	8	23	70
Other	13	9	7	29	3	13	15	31	8	10	20	38	22	16	34	72	170
CIPS General	51	66	51	168	48	45	51	144	46	58	63	167	50	32	50	132	611
16 & 17 year olds (Safeguarding)				0				0				0	9	9	4	22	22
16 & 17 year olds (Not Safeguarding)				0				0				0		3	0	3	3
Total	**171**	**191**	**193**	**555**	**142**	**140**	**181**	**463**	**134**	**176**	**204**	**514**	**203**	**190**	**238**	**631**	**2163**

Appendix 6.
Children Safeguarding Notifications by source

Referrals by Departments	Q1 2021-2022				Q2 2021-2022				Q3 2021-2022				Q4 2021-2022				Full Year Total
	Apr	May	Jun	Q1 Total	Jul	Aug	Sep	Q2 Total	Oct	Nov	Dec	Q3 Total	Jan	Feb	Mar	Q4 Total	
Children's A&E	171	191	193	555	142	140	181	463	134	121	141	396	126	109	175	410	1824
Rainbow				0				0		4	4	8	5	4	2	11	19
Leigh WIC				0				0		21	14	35	21	16	18	55	90
Minor Injuries Unit				0				0		3	6	9	10	6	2	18	27
Adult A&E				0				0		23	18	41	20	20	24	64	105
Adult Ward				0				0		3	2	5	2	1	4	7	12
Adult Safeguarding Nurses				0				0		0	16	16	16	33	12	61	77
Other				0				0		1	3	4	3	1	1	5	9
Total	**171**	**191**	**193**	**555**	**142**	**140**	**181**	**463**	**134**	**176**	**204**	**514**	**203**	**190**	**238**	**631**	**2163**

Appendix 7.
HIDSVA Referral Breakdown

Referral Breakdown	Mar	Q1 2021-22				Q2 2021-22				Q3 2021-22				Q4 2021-22				Full Year Total
		Apr	May	Jun	Q1 Total	Jul	Aug	Sep	Q2 Total	Oct	Nov	Dec	Q3 Total	Jan	Feb	Mar	Q4 Total	
Gender																		
Male	16	17	12	17	**46**	11	19	15	**45**	16	14	7	**37**	13	24	16	**53**	**181**
Female	64	71	82	73	**226**	69	74	78	**221**	79	79	88	**246**	81	74	87	**242**	**935**
Transgender	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**
Monthly Total	**80**	**88**	**94**	**90**		**80**	**93**	**93**		**95**	**93**	**95**		**94**	**98**	**103**		
Age Range																		
Under 16	0	0	1	1	**2**	0	0	1	**1**	0	1	0	**1**	2	1	2	**5**	**9**
Age 16-19	3	2	11	6	**19**	9	4	9	**22**	5	4	8	**17**	3	4	5	**12**	**70**
Age 20-39	35	39	45	44	**128**	36	40	38	**114**	47	49	48	**144**	42	36	46	**124**	**510**
Age 40-59	20	27	24	26	**77**	10	21	20	**51**	31	19	19	**69**	27	35	25	**87**	**284**
Age 60 +	21	20	13	13	**46**	25	28	25	**78**	12	20	20	**52**	20	22	25	**67**	**243**
Monthly Total	**79**	**88**	**94**	**90**		**80**	**93**	**93**		**95**	**93**	**95**		**94**	**98**	**103**		
Breakdown																		
Staff	1	0	2	1	**3**	3	4	5	**12**	10	5	4	**19**	1	7	11	**19**	**53**
LGBT	0	0	2	1	**3**	0	0	1	**1**	1	1	0	**2**	0	1	2	**3**	**9**
Learning Disabilities	1	2	1	1	**4**	0	1	0	**1**	0	2	1	**3**	1	1	3	**5**	**13**
BAME	1	0	0	0	**0**	0	0	1	**1**	0	2	0	**2**	1	0	1	**2**	**5**
Pregnant	3	2	4	3	**9**	2	2	5	**9**	2	6	11	**19**	6	8	8	**22**	**59**
Repeat Referral to the HIDSVA Service	1	6	3	0	**9**	10	11	6	**27**	8	4	11	**23**	9	12	10	**31**	**90**
Out of Area	3	2	3	4	**9**	2	4	8	**14**	4	5	4	**13**	6	3	1	**10**	**46**
Victim of Patient	0	0	0	0	**0**	0	0	1	**1**	2	3	0	**5**	0	1	5	**6**	**12**
Mental Health	1	31	35	36	**102**	14	25	12	**51**	12	17	14	**43**	15	8	11	**34**	**230**
Type of Abuse																		
Verbal	NR	NR	NR	NR	**NR**	11	25	30	**66**	32	18	43	**93**	31	40	33	**104**	**263**
Physical	NR	NR	NR	NR	**NR**	16	40	32	**88**	31	37	47	**115**	38	40	33	**111**	**314**
Emotional	NR	NR	NR	NR	**NR**	6	14	22	**42**	27	17	43	**87**	27	29	33	**89**	**218**
Financial	NR	NR	NR	NR	**NR**	8	16	14	**38**	16	8	11	**35**	13	12	8	**33**	**106**
Sexual	7	6	9	5	**20**	6	9	8	**23**	10	6	8	**24**	11	7	15	**33**	**100**
Coercion & Control	NR	NR	NR	NR	**NR**	4	16	15	**35**	20	20	27	**67**	21	27	16	**64**	**166**
Mental Health Breakdown																		
MH Issues	NR	NR	NR	NR	**NR**	10	12	10	**32**	14	10	19	**43**	14	18	9	**41**	**116**
Self Harm	NR	NR	NR	NR	**NR**	1	2	3	**6**	3	3	0	**6**	2	9	2	**13**	**25**
Suicidal	NR	NR	NR	NR	**NR**	8	15	12	**35**	11	16	8	**35**	5	14	9	**28**	**98**
Perpetrator																		
Partner	NR	NR	NR	NR	**NR**	19	36	30	**85**	18	36	20	**74**	26	24	39	**89**	**248**
Ex-partner	NR	NR	NR	NR	**NR**	2	9	18	**29**	20	14	24	**58**	13	23	11	**47**	**134**
Sibling	NR	NR	NR	NR	**NR**	0	1	1	**2**	1	0	0	**1**	0	0	2	**2**	**5**
Other	NR	NR	NR	NR	**NR**	6	19	15	**40**	15	14	12	**41**	14	13	7	**34**	**115**
Sexual Assault																		
Partner	NR	NR	NR	NR	**NR**	0	1	1	**2**	1	0	3	**4**	0	3	1	**4**	**10**
Stranger	NR	NR	NR	NR	**NR**	0	2	2	**4**	2	4	4	**10**	5	1	1	**7**	**21**

Appendix 8.
HIDSVA Outcome Data

Outcome	Mar	Q1 2021-22			Q1 Total	Q2 2021-22			Q2 Total	Q3 2021-22			Q3 Total	Q4 2021-22			Q4 Total	Full Year Total
		Apr	May	Jun		Jul	Aug	Sep		Oct	Nov	Dec		Jan	Feb	March		
Referral to Refuge	3	2	2	6	10	1	2	6	9	3	1	1	5	1	0	3	4	28
Referral Out of Area	1	2	2	4	8	2	1	2	5	2	0	1	3	1	0	1	2	18
CSC Referral	2	0	0	4	4	3	4	5	12	1	2	4	7	5	2	2	9	32
ASC Referral	1	1	5	2	8	5	8	6	19	7	7	7	21	7	7	8	22	70
Application for civil order	1	1	1	0	2	0	1	1	2	2	0	0	2	0	0	0	0	6
Declined Support	4	5	1	3	9	1	1	9	11	3	4	5	12	7	3	5	15	47
Ongoing contact attempts	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	12	12	12
Unable to establish contact	4	11	11	14	36	8	24	14	46	18	16	8	42	19	20	8	47	171
MARAC Referral by WWL	6	1	11	8	20	6	5	6	17	12	5	7	24	2	4	2	8	69
MARAC Referral by other agency	NR	NR	NR	NR	0	5	6	8	19	7	12	8	27	6	5	1	12	58
Support from Community IDVA	8	7	11	9	27	7	11	6	24	5	5	8	18	10	9	4	23	92
Safety Planning	71	72	82	43	197	39	48	55	142	60	53	59	172	55	56	57	168	679
Criminal Options Discussed	0	10	5	7	22	9	12	24	45	24	18	23	65	17	16	20	53	185
Welfare Checks	0	0	0	0	0	0	2	0	2	1	0	0	1	1	0	1	2	5
Housing/Refuge Discussed	0	21	17	18	56	16	31	36	83	36	43	50	129	41	33	24	98	366
Civil Orders Discussed	0	7	5	3	15	9	14	20	43	22	11	10	43	12	17	12	41	142
Liaise with Other Agencies	0	23	19	18	60	25	35	33	93	40	42	51	133	41	29	29	99	385
One off Advice	0	15	19	11	45	13	15	9	37	13	16	26	55	19	18	25	62	199
Appropriate Contact Numbers Provided	0	1	13	5	19	9	33	54	96	32	22	20	74	14	9	11	34	223
Perpetrator	NR	NR	NR	NR	0	5	4	1	10	1	7	4	12	1	3	7	11	33
Not DA	NR	NR	NR	NR	0	2	8	10	20	7	7	3	17	4	18	11	33	70
Other	0	11	8	9	28	1	1	3	5	2	3	4	9	4	2	4	10	52
Monthly Totals	**101**	**190**	**212**	**164**	**566**	**166**	**266**	**308**	**740**	**298**	**274**	**299**	**871**	**267**	**251**	**247**	**765**	**2942**
Quarter Totals			**566**				**740**				**871**				**765**			

Appendix 9.
Maternity SCRF data

Maternity	Q1 2021-2022				Q2 2021-2022				Q3 2021-2022				Q4 2021-2022				Full Year Totals
	Apr	May	Jun	Q1 Total	Jul	Aug	Sep	Q2 Total	Oct	Nov	Dec	Q3 Total	Jan	Feb	Mar	Q4 Total	
Maternity Safeguarding Referrals (excluding Regional)	41	50	30	121	38	40	37	115	32	29	33	94	35	42	33	110	440
Maternity Safeguarding Referrals Regional	14	13	15	42	8	4	5	17	1	1	4	6	2	2	5	9	74
Total Safeguarding Referrals	**55**	**63**	**45**	**163**	**46**	**44**	**42**	**132**	**33**	**30**	**37**	**100**	**37**	**44**	**38**	**119**	**514**
No. of Unborns new to CP Plan during month	4	9	4	17	7	6	6	19	5	11	8	24	3	8	9	20	80
No. of Unborns on CP Plan during month	11	17	14	*25	17	18	17	*29	21	21	18	*26	17	17	21	*55	
No. of Unborns new to CIN Plan during month	12	3	3	18	9	13	5	27	5	14	4	23	14	5	2	21	89
No. of Unborns on CIN Plan during month	31	31	18	*37	22	29	24	*37	22	27	21	*41	25	20	11	*56	

Appendix 10.
MARAC Overview Data

Period during 2021-22	Month	No. of MARAC Cases	No. of Repeat Cases	% of Cases that are Repeat	No. of Cases with no children listed	% of Cases with no children listed	No. of Cases with children	% of Cases with children	No. of children discussed / Health Information provided	Total MARAC checks completed including Victim, Perpetrator and children linked
Q1	April	98	31	32%	31	32%	67	68%	141	337
	May	105	16	15%	27	26%	78	74%	186	396
	June	130	20	15%	31	24%	99	76%	209	469
	Q1 Total	**333**	**67**	20%	**89**	27%	**244**	73%	**536**	**1202**
Q2	July	121	30	25%	20	17%	101	83%	239	481
	August	119	38	32%	34	29%	85	71%	214	452
	September	134	25	19%	36	27%	98	73%	228	496
	Q2 Total	**374**	**93**	25%	**90**	24%	**284**	76%	**681**	**1429**
Q3	October	136	23	17%	29	21%	107	79%	266	538
	November	138	40	29%	32	23%	106	77%	232	508
	December	130	46	35%	37	28%	93	72%	224	484
	Q3 Total	**404**	**109**	27%	**98**	24%	**306**	76%	**722**	**1530**
Q4	January	127	49	39%	35	28%	92	72%	220	474
	February	96	30	31%	24	25%	72	75%	161	353
	March	114	39	34%	31	27%	83	73%	196	424
	Q4 Total	**337**	**118**	35%	**90**	27%	**247**	73%	**577**	**1251**
2021-2022 Total		**1448**	**387**	**27%**	**367**	**25%**	**1081**	**75%**	**2516**	**5412**

Appendix 11.
Complex Safeguarding Caseload Overview

Complex Safeguarding Caseloads (Monthly average)	Quarter 1 2021-22 (Apr, May, Jun)		Quarter 2 2021-22 (Jul, Aug, Sep)		Quarter 3 2021-22 (Oct, Nov, Dec)		Quarter 4 2021-22 (Jan, Feb, Mar)
Open Complex Safeguarding Cases (monthly average)	60	↑	76	↑	81	↓	72

Appendix 12.
Children First Partnership Hub Health Data Overview

Children First Partnership Hub	Quarter 1 2021-22 (Apr, May, Jun)		Quarter 2 2021-22 (Jul, Aug, Sep)		Quarter 3 2021-22 (Oct, Nov, Dec)		Quarter 4 2021-22 (Jan, Feb, Mar)
Strategy Meeting Attendance by MAST Specialist Nurse	182	↓	138	↑	208	↓	163
Health Records Researched for Strategy Meetings	902	↓	741	↑	1078	↓	824
Health Information Requests to MAST Specialist Nurse	226	↓	153	↑	269	↓	236
Health Records Researched for Health Information Requests	929	↓	730	↑	1486	↓	1157

Title of report:	Winter Planning Briefing
Presented to:	Board of Directors
On:	5th October 2022
Presented by:	Deputy Chief Executive
Prepared by:	Deputy Chief Executive and Head of Resilience & Operations.
Contact details:	Ext 3080

Executive summary

The winter of 2022/2023 is predicted to be particularly challenging with longer waiting times for emergency and elective care already impacting on delivery of care, along with it being the first winter where both flu and covid are likely to increase demand for services. Unscheduled care and planned care services are of equal importance and many actions are in place to protect both to provide safe patient care using a combination of traditional and new models. Ultimately, demand may be such that some services must be stepped back but this will be done based on clinical advice, noting Accident & Emergency, critical care, emergency surgery, trauma. d maternity must be maintained as core services. Emergency activation plans to enable this to be done safely are being tested to ensure the organisation is as resilient as possible heading into the period.

Risks associated with this report and proposed mitigations

Demand continues to increase
No Right to Reside do not reduce
Unfunded Escalated areas remain open
Occupancy levels remain over 90%
Impact on the elective recovery

Financial implications

Penalties linked to non-delivery of elective recovery plan
Unfunded escalation areas remain open

People implications

Sickness absence
Increase in temporary spend

Wider implications

Greater Manchester ICS failure to achieve Elective recovery times and associated funding.
Impact on NWAS in responding to those most in need in a timely way.

Recommendation

This year there has not seen the usual slight easing of pressure during the summer months and even during July and August the situation was very demanding. This paper will outline a summary of the current position and then provides an overview of the plans for the winter period. The Board is asked to note the work being undertaken to mitigate the impact but also to prepare for the worst should this be necessary.

Report

The current position

The current position in relation to several key areas is set out below

Elective recovery

Greater Manchester re-commenced elective recovery in a more challenged position than other areas. More patients have been added to the Trust's planned care waiting list every month, however recent weeks has not seen the same level of growth compared with previous months. Many of these patients have waited significant length of time and therefore protecting planned care is a key priority over the winter period. Different models, such as patient initiated follow up and increased use of advice and guidance to help patients and primary care colleagues, have been rapidly implemented and expanded and we continue to seek and provide mutual aid where it makes sense to do so. The Greater Manchester surgical hub theatre at Wrightington is now operational and therefore the continuation of activity throughout the winter will be key as part of this partnership working.

Bed occupancy

Bed occupancy on the RAEI site is circa 99%, September 2019 saw occupancy rates around 91% which provided the much-needed head room to respond to demand and maintain flow through the hospital. This is made more significant because, compared to September 2019, capacity has been increased by the opening of three ward additional areas, Bryn Ward North, the Jean Heyes

Reablement Unit, and the Community Assessment Unit (all of which are unfunded). The increasing occupancy levels, despite additional beds is likely to make 2022/2023 winter period even more challenging.

No Right to Reside

Currently a third of Adult General and Acute beds on the Royal Albert Edward Infirmary site are occupied by patients who are no longer receiving any medical care, but they cannot be discharged due to pressures outside of the hospital. The worst-case scenario planned for is that this doubles over the coming months.

Staffing

Staff absence remains high and is starting to increase; intelligence tells us this is likely linked to anxiety as staff coming through the covid experience are now looking forward to the forthcoming winter period after an exhausting summer without the traditional easing of pressure. In addition, agency use continues to be higher than planned due to both sickness and vacancies.

Ambulance pressures

Delays in ambulance handover poses one of the most significant patient safety issues facing the NHS. Despite all the work being done to improve the position there is currently very little headway being made.

Winter plan – Key Components

As outlined above, all efforts are being made to maximise capacity for elective patients through a combination of productivity and efficiency gains internally, utilising capacity in the independent sector and accepting and providing mutual aid. Partnership working across the Greater Manchester Integrated Care System is embedded within Wrightington, Wigan and Leigh so that as many patients as possible can get the care they need.

With regards to the number of people in beds who fall within the No Right to Reside Criteria, a joint locality bid has been submitted to Greater Manchester to secure funding allocated for winter pressures to procure additional short term care home beds within the Wigan Borough The target is to reduce the number of patients who are no longer receiving medical care from approximately 100 to 50 , modelling shows this is the number required to support A&E by increasing flow. 24 Partnership working locally continues to try to identify more capacity while fully utilising existing community beds to support safe patient flow.

In addition to extra care home beds. A business case is developed to support the expansion of ‘Same Day Emergency Care’ which is expected to provide significant benefits as the current service cannot take patients at the most pressured period of the da y. Similarly, the virtual ward project is currently funded for 40 beds, equipped for 80 with a sequential increase in capacity to expand to 150 virtual beds with clinical pathways in Frailty, Falls, Respiratory and Cardiology being the focus. This will enable significantly more patients to be managed safely either through admission avoidance or earlier discharge.

The winter plan is currently being finalised for 2022/23 and this will provide a flexible escalation system like that used during the covid-19 surges which will sit alongside a portfolio of actions available to the identified decision-making group (depending on the stage of escalation). This should promote effective decision making through authority and pre-determined actions.
It should be noted that all mitigations being taken may not be sufficient and therefore at the same time emergency plans are being reviewed, updated, and tested. These describe the way in which services would be stepped down. Medical Directors across Greater Manchester are defining what services must be protected and the order in which others can be reduced or stopped and this will be mirrored in local plans. Despite the commitment to protect planned and unscheduled care services equally there may come a point whereby the requirements to provide emergency care (A&E, trauma, emergency surgery, critical care, and maternity services) overwhelm the former. In this case capacity will be created by stepping down elements, or all the elective programmes. The procedures to take these actions to keep patients and staff safe are currently being tested to ensure a high state of readiness throughout the winter period and are expected to be ready to release into the organisation by October.

Conclusion

It is likely that the 2022/23 winter period will be another huge challenge for the NHS as a whole and WWL will experience sustained pressure especially when the current position in mid-September is considered. However, many actions have been and continue to be put in place to protect service delivery with a focus on both planned and unscheduled care as equal priorities. To ensure the Trust is prepared for the worst, emergency plans are being updated and tested to provide as much resilience as possible for the benefit of both patients and staff.

Agenda item: [20]

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	WWL M5 Balanced Scorecard
Presented to:	Board of Directors
On:	5 October 2022
Presented by:	Director of Strategy & Planning
Prepared by:	Data, Analytics and Assurance Team
Contact details:	BI.Performance.Report@wwl.nhs.uk

The WWL Way

Executive summary
As promised at the last Board away day, the first iteration of the Trusts New Balanced Scorecard is now complete and presented to Trust Board.
This version is largely still manually populated on a monthly basis and therefore not real-time or available to view at Divisional or Speciality levels.

As the Data Warehouse (DW) continues to migrate to the cloud, Key Performance Indicators (KPI)s will be developed using the new DW and will replace the need to populate them manually.
With that said the interactive version on the Balanced Scorecard is available and allows you to view trend,

Statistical Process Control (SPC) and year on year comparison (where data available) charts for each KPI. This functionality will also be expanded and refined over the next few months.

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

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

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

Link to strategy
Patient
Partnership
Workforce
Site and Service

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

Financial implications
None currently highlighted.

Legal implications
None identified.

People implications
None identified.

Wider implications

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

Report: M5 WWL Balanced Scorecard: August 2022

Quality & Safety (Chief Nurse & Medical Director)

ID	KPI Title	Period Covered	Total	Target	On Target	Trend
1	Never Events	Aug-22	0	0	●	▷
2	Number of Serious Incidents	Aug-22	4	0	●	▼
3	Sepsis - Screening and Antibiotic Treatment (IN DEV)	Apr-22	0	IN DEV		-
4	Serious Pressure Ulcers (Lapses in Care)	Aug-22	0	0	●	▼
5	Serious Falls	Aug-22	0	0	●	▼
7	Complaints Responses	Aug-22	47.83%	90%	●	▼
8	Improved Discharge (Grouped) (IN DEV)	Apr-22	0	IN DEV		-
9	Patient Experience (FFT)	Aug-22	86.85%	TBC		▲
52	Methicillin-Resistant Staphylococcus Aureus (MRSA)	Aug-22	0	0	●	▷
53	Methicillin-Susceptible Staphylococcus Aureus (MSSA)	Aug-22	6	0	●	▲
54	Clostridium Difficile (CDT)	Aug-22	12	0	●	▲
55	Escherichia Coli	Aug-22	13	0	●	▼
56	Klebsiella	Aug-22	2	0	●	▷
57	Pseudomonas Aeruginosa	Aug-22	0	0	●	▷
69	Improved Discharge: % Discharge Letters sent	Aug-22	80.00%	100%	●	▼

People (Chief People Officer)

ID	KPI Title	Period Covered	Total	Target	On Target	Trend
10	Vacancy rate	Aug-22	9.10%	5%	●	▼
13	Rate card adherence (Medical)	Aug-22	45.60%	80%	●	▼
14	Rostering timeliness	Aug-22	23.91%	75%	●	▼
15	% Turnover Rate	Aug-22	10.41%	10%	●	▲
16	Your Voice Score (QTR) - Engagement score	Jun-22	3.94	4	●	▼
18	Your Voice Score (QTR) - Well-being score	Jun-22	3.35	3.5	●	▼
19	Mandatory training compliance	Aug-22	89.42%	95%	●	▲
21	Sickness - %age time lost	Aug-22	5.83%	4%	●	▼
50	Usefulness of Trust wide communication	Apr-22	82.00%	70%	●	▼
51	Leaders Forum Reach	Aug-22	120	110	●	▼
62	Number of outputs per month (LF, ASTB, Executive Vlogs, CEO Vlog / Blog)	Aug-22	6	6	●	▼
63	FTSU contacts	Aug-22	8	n/a		-
64	Your Voice Score (QTR) - Psychological Safety	Jun-22	3.71	3.75	●	▼
65	Appraisal	Aug-22	75.69%	90%	●	▲
66	Empactis coverage (% of staff)	Aug-22	30.10%	50%	●	▷

Performance (Deputy Chief Executive)

ID	KPI Title	Period Covered	Total	Target	On Target	Trend
23	Elective Theatre Utilisation	Aug-22	77.81%	85%	●	▼
24	Patients waiting over 104+ weeks (except patient choice)	Aug-22	2	0	●	▼
25	G&A Bed Occupancy - Acute Adult Inpatient Wards	Aug-22	100.00%	93%	●	▲
28	Outpatient Utilisation (IN DEV)	Apr-22	0	IN DEV		-
30	RTT clock stops	Aug-22	7,938	9260	●	▲
31	Cancer - waits longer than 62 days	Aug-22	133	100	●	▲
32	Reduce 12-hour waits in EDs towards zero and no more than 2%	Aug-22	12.48%	2%	●	▲
33	No Right to Reside Patients (excluding Discharges)	Aug-22	136	50	●	▼
41	Elective Recovery Plan	Aug-22	90.86%	100%	●	▲
42	Patients waiting over 78 weeks (except patient choice)	Aug-22	140	TBC		▼
58	Ambulance handovers under 15 minutes	Aug-22	48.17%	65%	●	▲
59	Ambulance handovers under 30 minutes	Aug-22	70.41%	95%	●	▲
60	Ambulance handovers 60+ minutes delay	Aug-22	211	0	●	▼
67	Virtual Outpatient Consultations	Aug-22	28.10%	25%	●	▼
68	Outpatient DNA Rates	Aug-22	10.71%	6%	●	▲
75	Cancer Referrals - 115% of pre -covid averages	Aug-22	1,780	1310	●	▲

Finance & Investment (Chief Finance Officer)

ID	KPI Title	Period Covered	Total	Target	On Target	Trend
34	Surplus / Deficit	Aug-22	-43	-422	●	▼
35	Capital Spend (CDEL)	Aug-22	-549	1485	●	▲
36	Cash	Aug-22	-3,079	35755	●	▼
39	Temp Spend/Agency Spend	Aug-22	-1,077	692	●	▼
47	CIP	Aug-22	-324	1992	●	▼
48	BPCC target 95%	Aug-22	89.77%	95%	●	▼

M5 WWL Balanced Scorecard Commentary: August 22

Quality & Safety (Chief Nurse & Medical Director)

Latest Commentary - **Aug-22**

Patient Safety
There were 4 serious incidents reported within this period. It should be noted that none of these incidents related to pressure ulcers. These incidents related to missed opportunities to treat whilst in care and treatment delays. This theme has been identified within a recent thematic analysis and further work is being done to reduce the risk of incidents., including a review of clinical speciality follow-up lists to provide assurances that there have been no further patients lost to follow-up

Clinical Effectiveness
Although Complaints responses had started to increase, there was a slight decrease within August, although the overall trend is increasing. There has been an end to end review of complaints management and a comprehensive plan has commenced to support the efficiency of the complaints process overall.
FFT has seen an increase in responses as further work continues to improve returns from patients.

People (Chief People Officer)

Latest Commentary - **Aug-22**

Vacancy rate: As at June 2022, WWL had 582 vacancies, approximately 8% compared to our staff in post figure. Based on our current recruitment, turnover and retirement projections, we anticipate this will drop to 429 vacancies by June 2023. Our assumptions, based on known plans and historic activity, have been fed into a workforce trajectory waterfall diagramme, monitored and updated through People Committee and the Workforce Transformation Board.
Rate Card Adherence: The Medical Locum LPV adherence for August was 45.6 against a target of 85%. Adherence has declined in surgery and specialist services and improved slightly in medicine. Shifts and rate breaches are documented and have been shared with all divisions. Divisions have been tasked with developing improvement plans and acute medicine will be apply the Trust rate card from October.
Turnover: Our overall level of staff turnover, on a rolling 12-month basis and as of Aug 2022, is at 10.41%. Of this, 25.49% of turnover is amongst colleagues with less than 12 months service. Whilst our overall level of turnover has increased in the last 6 months, this was expected given the agreed GM projection of a 0.5% turnover increase by March 2023. Each division has, in different forms, established a Divisional Our Family, Our Future, Our Focus taskforce. Reps from each division have joined the strategic retention group, which now feeds into the FFF steering group.
Mandatory Training compliance: Divisions have been set improvement trajectories to achieve 95% by the end of March 2023. Our lowest compliance tends to be across medical staff groups. Plans are in discussion to ensure doctors are 100% compliant before their appraisal. Enforcement options are being explored. Mandatory training has now been linked back to pay progression, having been relaxed during the pandemic.
Rostering timeliness: 75% compliance with nursing rosters had been achieved but dropped back in August due to system management issues. Forecasted to improved for September onwards. An improvement programme is being led by the DCNO regarding roster management – 3 areas of focus are issuing in line with expected weeks' notice, management of owed hours and annual leave profiling.
Appraisal: Appraisal compliance for all staff groups is picked up through the monthly divisional performance review process.
Empactis Coverage: Significant rollout progress in August with domestics, SSDU, endoscopy leigh and wigan, COPD & 5 community childrens teams live totalling 700 staff.

Performance (Deputy Chief Executive)

Latest Commentary - **Aug-22**

Whilst the Trust successfully eradicated 104 week waits by the end of June 2022 (excluding patient choice delays), two patients waited beyond 104-week in August, a late return from the independent sector and a data error following which a validation exercise was undertaken. Delivery against 78 weeks and 52 week remains on track. The number of Urgent (P2) patients waiting reduced within Surgery but remained static within Specialist Services and Medicine.
Cancer referrals continue to increase adding pressure to achievement of cancer targets and impacting on routine elective patients cancelled to accommodate. Cancer performance in August was behind plan driven by colorectal and breast tumour sites. Business case to expand one stop breast services is making good progress.
Elective activity was higher than 19/20 baseline, but planned activity was not achieved largely driven by a deficit in new patient attendances across all divisions, and day case due to workforce issues. The overall 18-week Referral to Treatment waiting list continues to increase, however, growth has slowed over the last two months. People not attending their appointment remains higher than pre-covid levels although improvement should be seen in November following approval of the text reminder business case.
WWL remains number one in Greater Manchester for A&E performance against the four-hour standard. However, we continue to experience two interdependent challenges impacting on delivery of urgent and emergency care. Increased demand at the front door although August saw reduced attendances, the Trust still experience days where demand exceeds the planned capacity. The second area is Flow and Discharge, the Trust averaged 100 patients per day over the past 9 months of people meeting the No right to reside criteria impacting ability to allocate beds for those patients awaiting admission in a timely manner, this is a significant increase when compared with pre-covid levels, September 2019 saw on average 9 medically optimised patients per day. The impact of the demand and flow is demonstrated in the number of patients who reside in A&E for 12 hours or more and the ability to off load ambulances in a timely manner.
WWL continues to build upon the progress made with the Acute Hospital Discharge programme, now extended to the '100 Day Challenge', committed to investing resource to extend Same Day Emergency Care and Virtual Ward offer. We also continue to work with, and support, system partners to promote alternatives to A&E, seek immediate solutions and additional capacity to reduce the number of patients who no longer have a right to reside, including short term commissioning of additional beds.
It should be noted by the Board that the operational reality is still not in line with the key assumptions to support delivery of the elective recovery plan significant pressures are still seen in urgent care demand, cancer referral rates and bed occupancy levels. The Trust continues to work with system partners both at locality and Integrated care system levels to safely manage both urgent and planned care.

Finance & Investment (Chief Finance Officer)

Latest Commentary - **Aug-22**

The Trust has reported an actual deficit of £0.5m for August 2022 (month 5), which is approximately on plan. Year to date, the Trust is reporting an actual deficit of £6.4m against the planned deficit of £3.1m, creating an adverse variance of £3.3m.
An overall total CIP of £1.7m was transacted in month 4, against a target of £2.0m which is an adverse variance of £0.3m. Year to date, CIP is £3.5m adverse to plan.
At the end of month 5, the cash balance is £32.7m which is £3.1m below plan
Total capital expenditure is £0.5m below plan in month and £2.1m below plan year to date.
Please see the monthly finance report for further commentary.

Title of report:	University Hospital Status Update
Presented to:	Trust Board
On:	05 October 2022
Presented by:	Richard Mundon, Director of Strategy and Planning
Prepared by:	Madeleine Jackson, Service Development Manager
Contact details:	T: 07464652520 E: Madeleine.Jackson@wwl.nhs.uk

Executive summary

Achieving University Hospital status is a key priority within Our Strategy 2030 and is also included within the corporate objectives for 2021/22 and 2022/23.

To achieve University Hospital status organisations must meet the membership criteria set out by the University Hospital Association (UHA).

Work began on developing a plan to achieve University Hospital status in line with our corporate objective 2021/22. However, part way through this process the UHA changed the membership criteria for achieving University Hospital status, increasing some targets.

A University Hospitals Group was established in December 2021 to review each criterion, appraise the Trust's current compliance against each and assess what would be required to meet all the criteria in future years.

Since University Hospitals Group was established, the group has assessed the UHA's new criteria and WWL's ability to achieve each one. Through this activity the group have identified one criterion which, given the recent changes, will be extremely challenging for WWL to achieve. The criterion is:-

1c i) A core number of university principal investigators. There must be a minimum of twenty consultant staff with substantive contracts of employment with the university with a medical or dental school which provides a non-executive director to the Trust Board. These individuals must have an honorary contract with the Trust in question.

This paper outlines:

- The changes to criterion *1c i)*
- Why it will be difficult for WWL to achieve
- The work and information gathered by the University Hospital Group
- Recommendations for next steps

Link to strategy

Achieving University Hospital Status is a key priority within Our Strategy 2030 and one of the corporate objectives for 2021/22 and 2022/23.

Achieving University Hospital Status is also an objective in our Research Strategy.

Risks associated with this report and proposed mitigations

None

Financial implications

None

Legal implications

None

People implications

None

Wider implications

None

Recommendation(s)

The Board is asked to:

- Note the changes to criterion *1c i)*
- Note why it will be difficult for WWL to achieve
- Note the work and information that the University Hospitals Group has undertaken and gathered so far
- Note the recommendations
- Agree next course of action based on recommendations and information contained in this paper

Report

1.0 Introduction

Achieving University Hospital status is a key priority within Our Strategy 2030 and is also included within the corporate objectives for 2021/22 and 2022/23.

To achieve University Hospital Status organisations must meet the membership criteria set out by the University Hospital Association (UHA).

The key characteristics of being a University Hospital is a commitment to teaching and research, shown through partnerships with university staff, which includes collaboration in research activity and delivering a high standard of education for clinical and health professionals. (A full set of criteria is in appendix 1)

The benefits of being a University Hospital include improved ability to recruit and retain staff and from a patient perspective better access to available treatments and in some cases improved delivery of services due to the learning staff and teams gain from participating in education, research, and clinical trials.

Whilst work commenced in 2021/22 to create a plan to achieve University Hospital status in line with our corporate objective, the UHA changed the membership criteria in 2021, increasing some targets. This may significantly impact on our ability to achieve University Hospital status and/or the timescales we initially proposed in Our Strategy 2030.

The University Hospitals Group was established in December 2021 to review the new criteria and assess WWL's ability to achieve University Hospital Status in the future.

When the group met in December 2021 there was unanimous agreement from members that the Trust should continue to pursue our aim to become a University Hospital Trust. This aim is reflected in our corporate objective for 2022/23 'To make progress towards our ambitions to be a University Teaching Hospitals' with a continuation of the three-to-five-year timescale.

Since University Hospitals Group was established, the group has assessed the UHA's new criteria and WWL's ability to achieve each one. Through this activity the group have identified one criterion which, given the recent changes, will be extremely challenging for WWL to achieve. The criterion is: -

1c i) A core number of university principal investigators. There must be a minimum of twenty consultant staff with substantive contracts of employment with the university with a medical or dental school which provides a non-executive director to the Trust Board. These individuals must have an honorary contract with the Trust in question.

Previously the number was ten, which was already an area of challenge to achieving University Hospital status, due to the size of the Edge Hill University Medical School, which is currently smaller than some of the larger Universities in the UK.

2.0 Why is achieving Criterion *1c i)* Difficult for WWL?

We currently have one consultant member of staff with a substantive contract of employment with a university (Edge Hill University) with medical or dental school which provides a non-executive director to the Trust Board (with an honorary contract). However, there are around three or four other consultants that could potentially meet this criterion, dependent on a change to their contractual status. Therefore, achieving ten, as per the original criterion would have been a challenge, now the figure is twenty it is even more so.

3.0 University Hospital Group Activity and Information to Date

As a group we have worked through the criteria.

Where we have met the criteria, we are collating evidence to demonstrate this.

Where we have not yet met the criteria, but we know that we can achieve it, we have instigated programs of work with WWL and Edge Hill University colleagues to progress e.g., 1 a) "The Trust shall have in place with the University a Memorandum of Understanding on Joint Working for Effective Research Governance; it will actively investigate joint Research Offices to foster more efficient working;"

In regard to *1c i)* we have consulted HR colleagues at WWL and Edge Hill to understand more fully contracting arrangements. In addition, we are exploring the possibility of including nurse, midwife, and allied health care professionals. These groups of staff are increasingly taking on consultant roles, research, and clinical trials, which reflects our evolving health care environment and includes the community element of healthcare.

The University Hospital Group are unclear on the reasons and process that was undertaken by the UHA to make the changes to the criteria. In addition, more information is required on the application process to become a University Hospital and how University Hospital status is monitored once granted, to ensure that Trusts continue to meet the criteria. It has been suggested that members of the University Hospital Group contact the UHA to request further information and potentially meet with the UHA to discuss elements of the criteria further.

4.0 Conclusion and Recommendations

The UHA criteria has recently changed. Whilst WWL can meet most of the new criteria and is working towards that aim, Criterion *1ci)* remains the area of greatest challenge to achieve, with the number of consultant staff with substantive contracts of employment with the university with a medical or dental school which provides a non-executive director to the Trust Board increasing from ten to twenty.

Given the scale of the difficulty in achieving Criterion 1c, it is proposed that the Trust Board now consider how best to respond to this situation, and, specifically, the merits and implications of lobbying the University Hospitals Association to influence flexibility around this Criterion. It is considered that there are limited options available to the Trust and Edge Hill at the current time to achieve the criteria and hence taking an intentional approach to see the criteria change put forward for discussion and a decision by Trust Board.

The Board is asked to:

- Note the changes to criterion *1c i)*
- Note why it will be difficult for WWL to achieve in the timescale set out in Our Strategy 2030 and our corporate objectives 2021/22 and 2022/23
- Note the work and information that the University Hospitals Group has undertaken and gathered so far
- Note the recommendation of lobbying the UHA to see a change in the current Criterion
- Agree next course of action based on recommendations and information contained in this paper

Appendix 1

University Hospital Association Membership Criteria and WWL's 'Rag' rated progress against each Criterion

	Rag
1. In Terms of Research	
a. The Trust shall have in place with the University a Memorandum of Understanding on Joint Working for Effective Research Governance; it will actively investigate joint Research Offices to foster more efficient working;	
b. The Trust shall demonstrate that it is working collaboratively with the university to develop an agreed joint research strategy;	
c. There shall be evidence of significant research activity within the Trust, much of which will involve collaboration with university staff. This will include:	
i. A core number of university principal investigators. There must be a minimum of twenty consultant staff with substantive contracts of employment with the university with a medical or dental school which provides a non-executive director to the Trust Board. These individuals must have an honorary contract with the Trust in question.	
ii. The research output to be REF returnable;	
iii. For Trusts in England, an average Research Capability Funding allocation of at least £200k average p.a. over the previous two years.	
Further details of RCF allocations can be found here	
2. The Faculty and University Hospital shall maintain strategic links and a close working relationship, which shall include:	
1. University representation on the Trust's Local Awards Committee for considering nominations for Clinical Excellence Awards;	
2. University representation on the Trust's Advisory Appointments Committees for Consultant posts;	
3. Board membership of a non-Executive Director from the Faculty;	
4. The Trust's Chief Executive attending formal meetings with the Faculty Dean's Advisory Committee.	
3. The Trust shall provide for the University practice placements for undergraduate medical students and for students from at least one other healthcare profession (dentistry, nursing, or one or more of the allied health professions).	
4. The Trust shall provide for undergraduate students appropriate library facilities, IT facilities with Internet access, and teaching facilities. There may be integrated provision for postgraduate and undergraduate education.	
5. The Trust shall have a Lead Placement Contact approved by the Faculty of Medicine, to be responsible for undergraduate education, for each of the professions for which it provides placements.	
6. The Trust must be able to demonstrate to the University that it promotes a culture of excellence in medical education and provides high quality clinical training. This will require evidence of the following:	
a. Flexibility:	
i. Flexibility in light of any changing needs of the University in respect of undergraduate education;	
b. Appropriate human resources:	
i. Ability on part of Trust staff to deliver the curriculum and assessments determined by the university;	
ii. Provision by Trust staff of appropriate student supervision as agreed with the University. This may involve staff from a range of professions and grades;	
iii. The participation by core Trust teaching staff in appropriate training;	
c. A collaborative working partnership:	
i. The availability of Trust staff to provide teaching and supervision and to respond to student queries and problems in a timely manner;	
ii. Collaboration between Trust staff and University staff, for example, regarding curriculum development and ED&I arrangements;	
iii. Full cooperation by Trust staff in monitoring and evaluating the quality of education provision, and in facilitating student evaluation;	
iv. The readiness of Trust staff to respond to feedback from students and the Faculty;	
v. Evidence of action by trust on Faculty quality assurance measures;	
d. Resources:	
i. Provision of appropriate support staff, equipment and accommodation for Lead Placement Contracts;	
ii. Provision for students of access to lockers and appropriate facilitates;	
e. For Trusts in England, evidence of compliance with:	
i. HEE's Education Contract and the schedule on the Tri-Partite Agreement.	

Agenda item: [22]

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Monthly Trust Financial Report – Month 5 (August 2022)
Presented to:	Board of Directors
On:	05 October 2022
Presented by:	Ian Boyle [Chief Finance Officer]
Prepared by:	Senior Finance Team
Contact details:	E: Kelly.Knowles@wwl.nhs.uk

Executive summary

Description	Performance Target	Performance	Explanation
Revenue financial plan	Achieve the financial plan for 2022/23.	Amber	Year to date, the Trust is reporting an actual deficit of £6.4m against the planned deficit of £3.1m, creating an adverse variance of £3.3m. The Trust is currently forecasting to achieve the full year financial plan based on a deficit of £8.4m but this is predicated on delivery of the CIP plan and management of operational financial pressures. Additional bold mitigating actions are likely to be required in order to achieve the forecast if significant improvement is not seen in quarter 3.
Activity	Achieve the elective activity plan for 2022/23.	Red	The month 5 activity data highlights that the Trust has not achieved the elective activity plan that was submitted to NHSE. There is a risk of a clawback of the elective recovery funding (ERF) within the financial position. NHSE have advised not to make a provision for a penalty as at month 5 indicating this is unlikely to be applied.
Cash & liquidity	Effective cash management ensuring financial obligations can be met as they become due.	Green	Cash is £32.7m at the end of month 5 which is £3.1m below the plan.
Capital expenditure (CDEL)	Achieve CDEL for 2022/23.	Amber	Expenditure against CDEL is £0.4m below plan in month 5 and £2.1m below plan year to date.
Cost Improvement Programme (CIP)	Deliver a 5% efficiency in 2022/23 as per the mandate from the GM ICS.	Red	In month 5, £1.7m was transacted against the target of £2.0m, creating an adverse variance of £0.3m. The year to date variance is adverse by £3.5m to the CIP target and this is one of the key drivers behind the Trust financial position and variance to plan.
Agency expenditure	To remain within the agency ceiling set by NHSE.	Red	Agency expenditure was £1.8m in month 5 and £6.0m year to date. WWL is currently £2.5m above the ceiling year to date. Agency expenditure is £2.2m (58%) higher year to date than for the same time last financial year with high sickness a contributing factor.

COVID-19 expenditure	To reduce COVID-19 expenditure by 57% in line with the reduction in system funding.	Amber	COVID-19 expenditure was £0.5m in month which was an increase of £0.1m on last month. The Trust has yet to see a significant reduction in COVID-19 expenditure to match the reduction in funding, which is a risk to the delivery of Corporate CIP. The executive team have committed to a review of divisional forecasts for the second half of the year to assess ongoing COVID-19 expenditure.
Business conduct	Comply with the Better Payments Practices Code (BPPC) of paying 95% of invoices within 30 days.	Red	BPPC as at month 5 is 90.6% by volume and 88.7% by value. This is due to problems with invoices being matched against purchase orders incorrectly by the SBS team. This issue is affecting all organisations and SBS have put in place actions to address this. The finance team are working with SBS to clear the backlog and are monitoring the issue.
Financial Risk	Report the financial risks through the Board Assurance Framework.	Amber	There are multiple risks to delivery of the plan associated with operational pressures, workforce shortages, COVID-19 expenditure, and the elective recovery. These are reflected within the year to date variance to plan.

Link to strategy

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

Risks associated with this report and proposed mitigations

There is a significant financial challenge associated with the delivery of the final plan, as well as the sustainability risk of operating at a deficit. The Trust has a year to date deficit of £6.4m and is currently maintaining the forecast to deliver the full year deficit of £8.4m. To achieve the forecast, the deficit in month 6 to 12 could not exceed a further £2.0m. A range of bold mitigating actions will need to be considered by the executive team if there is not a turnaround in the financial position in quarter 3.

The cash balance has reduced by £21.4m since 31st March 2022 (from £54.1m to £32.7m at the end of August 2022). As it stands, the Trust has sufficient cash to service this planned deficit and the planned capital program. However, that assumes that the full value of the efficiency programme is cash releasing and at present the expenditure run rate is not reducing.

There are increasing levels of national scrutiny on the financial position of the Greater Manchester Integrated Care System (GM ICS) which in turn leads to greater scrutiny within the system. There is a view from the national team that the North-West has an increased cost base, with an increase in workforce numbers, against reduced levels of productivity when compared to 2019/20.

The planning guidance assumed low levels of COVID-19 but this is not the current reality. There is uncertainty about the ongoing level of admissions and staff absence. This has inhibited the ability to de-escalate COVID-19 expenditure safely, which forms part of the Corporate CIP planned efficiency. A revised approach to budgeting has been agreed for the second half of the year to evaluate all ongoing COVID-19 expenditure in the light of the latest infection, prevention, and control (IPC) guidance.

There are underlying cost pressures, particularly within the clinical divisions of Medicine and Surgery, which are complex and challenging to address. The RAPID (Recovery, Action, Planning, Implementation and Delivery) meetings will need to facilitate swift decisions to ensure actions are taken to manage these pressures within the remainder of the financial year.

Financial implications

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

Legal implications

There are no direct legal implications in this report.

People implications

There are no direct people implications in this report.

Wider implications

There are no wider implications in this report.

Recommendation(s)

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

Financial Performance

Key Messages

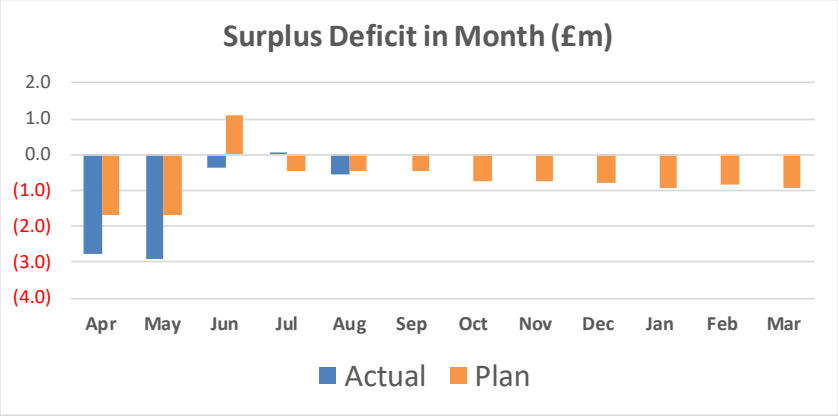
- In month, the Trust has reported an actual deficit of £0.5m, which is approximately on plan.
- Year to date, the Trust has reported an actual deficit of £6.4m, which is £3.3m adverse to the planned deficit of £3.1m.
- The Trust is forecasting to deliver the full year planned deficit of £8.4m.

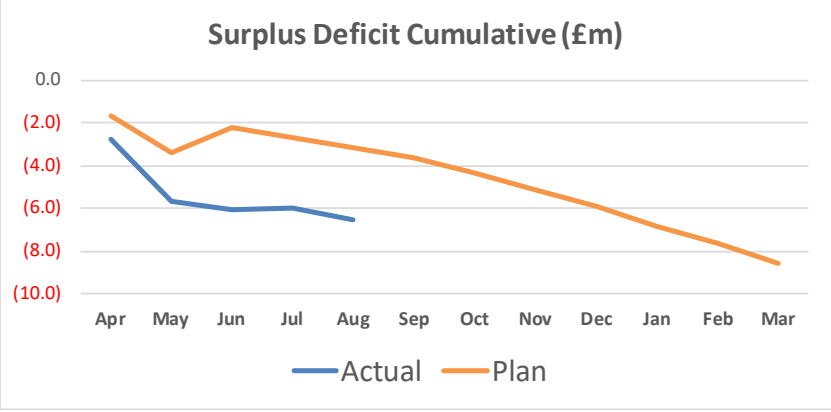
The Trust has reported an actual deficit of £0.5m for August 2022 (month 5), which is in line with the planned deficit of £0.5m.

Year to date, the Trust is reporting an actual deficit of £6.4m against the planned deficit of £3.1m, creating an adverse variance of £3.3m. The variance remains the same as at month 4.

There was minimal change in the underlying run-rate in month 5, which has remained fairly static since April. There is actual expenditure of £38.0m in month 5 (month 4 £38.2m), which is £1.1m adverse to plan. This includes an adverse variance of £0.3m associated with unachieved CIP. There are also significant pressures within the divisions with Medicine £1.1m adverse and Surgery £0.3m adverse to plan in month.

There is actual income of £39.3m in month 5, which is £1.2m favourable to plan. This is a decrease of £0.7m compared to month 4 (£40.0m).





Key Financial Indicators

Key Financial Indicators	In Month (£000)			Year to Date (£000)			Full Year (£000)
	Actual	Plan	Var	Actual	Plan	Var	Plan
Financial Performance							
Income	39,283	38,109	1,174	194,368	190,418	3,950	457,218
Expenditure	(37,939)	(36,800)	(1,139)	(192,096)	(184,795)	(7,301)	(444,814)
Financing / Technical	(1,823)	(1,752)	(72)	(8,725)	(8,758)	33	(21,018)
Surplus / Deficit	(543)	(443)	(100)	(6,516)	(3,135)	(3,381)	(8,615)
Adjusted Financial Performance *	(470)	(427)	(43)	(6,399)	(3,054)	(3,345)	(8,426)
Other							
CIP	1,668	1,992	(324)	6,466	9,958	(3,492)	23,900
COVID-19 Expenditure	456	713	258	2,515	3,568	1,053	8,524
Agency Spend	1,768	311	(1,457)	5,979	1,555	(4,424)	3,731
Cash Balance	32,676	35,755	(3,079)	32,676	35,755	(3,079)	38,123
Capital Spend - CDEL	401	450	49	2,245	3,087	842	11,107
Capital Spend - PDC	0	500	500	19	1,300	1,281	17,025

CIP

- £1.7m transacted in month 5 and £6.3m YTD.
- Split in month: Divisional £0.7m; Corporate CIP £1.0m.
- Corporate CIP includes £0.8m in month (£1.6m YTD) accrued from Wigan Council associated with support for no right to reside patients.

COVID Expenditure

- £0.5m expenditure in month – a small increase on last month (£0.4m)
- £0.3m less than plan in month, but plan still based on 21/22 H2 run rate (plan to be adjusted once divisional forecasts agreed).

Agency

- Expenditure of £1.8m in month 5 and £6.0m YTD.
- Includes £0.5m of recoded agency in month.

Cash

- £32.7m cash balance; £3.1m below plan.
- Decrease of £2.7m from previous month due to payment of capital and creditor invoices.

Capital

- £0.4m spend in month £.05m behind plan
- £2.3m YTD spend, £2.1m behind plan
- £1.2m variance is due to delay in PDC approval nationally, remaining £1.1m relating to delay in commencement of schemes.

Divisional Performance

Medicine

- £1.0m adverse to plan in month
- Nursing including 1:1 (£0.4m)
- A&E escalation (£0.3m)
- Medical staffing (£0.2m)
- Unachieved CIP (£0.1m)

Surgery

- £0.3m adverse to plan in month
- Medical staffing cost pressures in general surgery and paediatrics (£0.1m)
- Wards and theatre staffing cost pressures (£0.1m)
- Unachieved CIP (£0.1m)

Specialist Services

- £0.4m favourable to plan in month
- Private patient income £0.1m
- CIP £0.1m
- Orthopaedic hub £0.1m
- Other smaller items £0.1m
- Prosthesis on plan

Community

- On plan in month
- Nursing including temporary spend on CAU, Jean Hayes and district nursing (£0.1m) reduced from last month
- Unachieved CIP (£0.1m)
- Vacancies £0.2m

Estates & Facilities

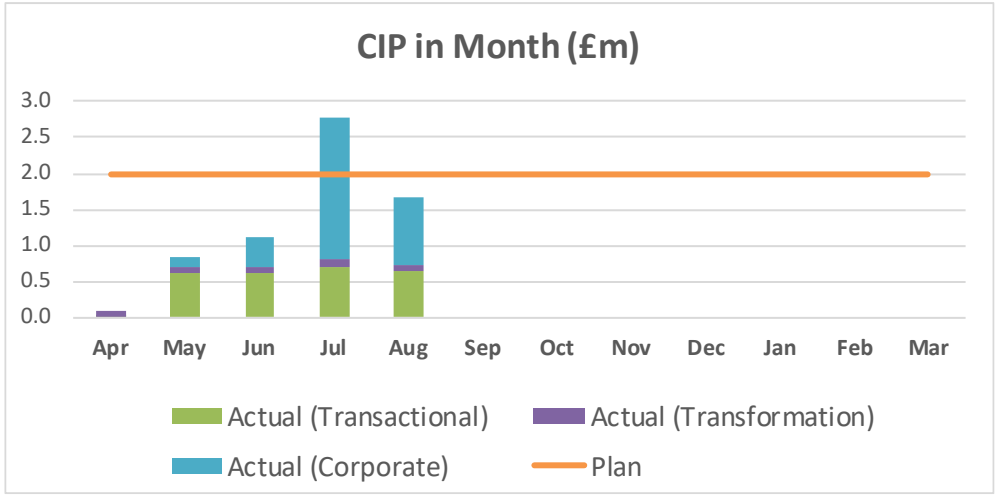
- £0.3m adverse to plan in month
- Rental charges RPI increase (£0.4m)
- Energy expenditure (£0.1m)
- Income for community premises £0.1m
- CIP £0.1m

Corporate Divisions

- £0.4m favourable to plan in month in aggregate
- IM&T £0.2m capitalised posts
- GTEC £0.1m
- HR £0.1m
- CIP on plan

An action plan has been developed for both Medicine and Surgery. This is being monitored via the Divisional Assurance Meetings and RAPID process. Based on the RAPID metrics for month 5, it was agreed that Medicine, Surgery and Specialist Divisions would be asked to provide additional assurance through the RAPID meetings. Each division has completed a detailed forecast and scenario planning to the end of the financial year which itemises the actions within the recovery plan, when these are expected to take effect, and the impact on the financial position.

Cost Improvement Programme



£1.7m of CIP was transacted in month which was £0.3m adverse from the £2.0m plan. Year to date, £6.5m has been transacted, which is £3.5m adverse to the plan of £10.0m.

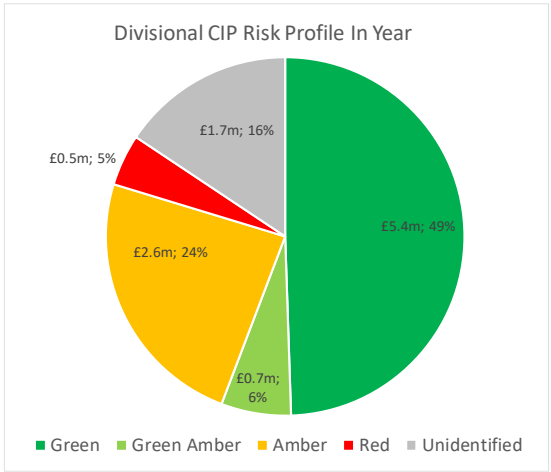
Of the £1.7m transacted in month, £0.7m related to divisional CIP and £1.0m related to Corporate CIP.

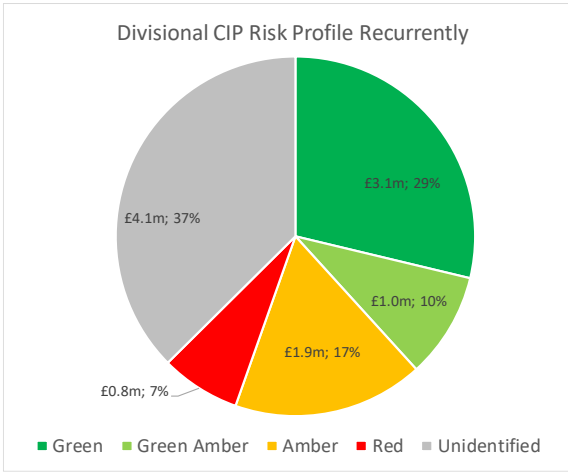
The divisional CIP transacted year to date of £3.0m can be split £0.4m for transformational schemes and £2.6m for transactional schemes. The transformational CIP relates predominantly to the clinical services collaboration scheme and private patient income for Trauma and Orthopaedics.

Corporate CIP of £3.5m has been transacted year to date. There is a forecast to deliver c.8.0m of corporate CIP non-recurrently in year, with the year to date position now reflecting this proportionately. This would leave a shortfall of £5.0m against the full year target of £13.0m.

Reductions in Covid expenditure and changes in IPC guidance were expected to contribute towards the Corporate CIP. The executive team will be undertaking a full review of divisional Covid forecasts for the remainder of the year to ensure that all ongoing expenditure is appropriate.

The risk profile of the divisional CIP forecast for 2022/23 and recurrently is shown on the right. In year, 16% of the target remains unidentified and 5% is red rated. The risk profile increases recurrently, reflecting the non-recurrent nature for a significant proportion of schemes.





Forward Look

The GM system has a scrutiny meeting with the national team on September 15th 2022. The North West has been flagged as having disproportionate levels of financial risk. This includes data flows on bed numbers, WTE increases, cash, liabilities and provisions and agency usage. There has been a particular focus on WTE growth, with an increase of c.10,500 WTE (14%) across GM since March 2020. The Trust has an increase of 15% in WTE since March 2020 (March 2020, 5,816 WTE; June 2022, 6,672 WTE) which is above the GM average growth. There has been a particular focus on growth in managerial posts with an increase of 416 WTE (23%) over the same period within GM. The growth at WWL is 27 WTE (25%). A detailed analysis of WTE movements by division is underway to support the wider triangulation of the change in the financial position of the Trust over the last few years.

The pay award has been announced for 2022/23 with arrears to be paid in September, estimated at £6.4m (full year £12.8m). There is a risk of a financial pressure however this cannot be confirmed until the GM ICS allocation of additional income is finalised. This relates to the additional funding above the 2% within baseline budgets.

It has been confirmed that there will be a two year national planning round for 2023/24 and 2024/25, with guidance expected to be issued in December 2022. Early communication suggests that the GM ICB will be required to submit a high level 5 year plan.

As part of the drive for continual improvement, the finance team are introducing a faster closedown of the month end position from month 6 (September 2022). This may lead to some one-off changes in the financial position for month 6, which will be detailed in next month's report. The faster closedown will support system reporting and ensure that information is provided in a timely manner. More focus will be created on divisional forecasting and value adding activities.

The finance user survey for 2022 has closed with 112 responses from service users. The feedback is being analysed so that service improvements can be identified, and an action plan developed. This will be shared in a 'you said, we did format'.

Title of report:	Well-led action plan
Presented to:	Board of Directors
On:	5 October 2022
Presented by:	Director of Corporate Affairs
Prepared by:	Paul Howard, Director of Corporate Affairs
Contact details:	E: paul.howard@wwl.nhs.uk

Executive summary

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

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

At today's meeting, the board is asked to:

- Agree a short extension to the deadline associated with recommendation 5;
- Approve the closure of the actions associated with recommendation 9; and
- Approve the closure of the actions associated with recommendation 12.

Link to strategy

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

Risks associated with this report and proposed mitigations

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

Financial implications

There are no financial implications associated with this report.

Legal implications

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

People implications

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

Wider implications

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

Recommendation(s)

The Board of Directors is recommended to review the updates provided and approve the changes set out in the executive summary.

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

Open actions

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

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

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
4 High	The CEO should consider including senior divisional leaders in some executive team development activities to help further build cohesion between the executive and divisional leadership levels, as well as exploring ways in which leaders can further demonstrate the values and behaviours expected within the organisation.	As part of the executive development programme referenced at recommendation 1 above, divisional leaders will be invited to participate in at least 2 sessions in H2 2022/23.* *(Original intention to provide 1 session in H1 2022/23 and a second session in H2 2022/23 was amended by the Board in August 2022 to reflect the narrative above).*	Chief Executive	This has been shared with the programme facilitator and is being built into session plans.	
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 developed an 'Accountability Framework' incorporating the existing trust behaviours and we will have implemented this by the end of Q3 2022/23.	Deputy Chief Executive	We have an accountability framework in place, in direct response to the divisional assurance meetings, which includes clear financial escalation processes via a RAPID framework. The intention is to expand these frameworks into the organisation. A task and finish group has been established to consider the development of a wider accountability framework. The intention is to include this in the just culture formal launch in January 2023**. An extension to the deadline of 31 December 2022 is therefore requested.**	

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

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
9 High	The Trust should revisit engagement and communications around changes to the quality governance structure to ensure that there is greater understanding of the rationale for change and the intended impact of this, and to ensure that all involved across the organisation are clear regarding the purpose, timing and sequencing of the changes.	By the end of Q2 2022/23, we will have approved an updated quality governance meeting structure and shared this within the organisation. We will have shared the structure at a meeting of Leaders' Forum and our intranet site.	Chief Nurse	The review of the quality governance meeting structure has commenced and a first draft was circulated for review and comment on 29 Mar 2022. It was shared with the Quality and Safety Committee on 10 Aug 2022 and is scheduled for Leaders' Forum in October 2022.	
10 High	The Board should consider more detailed oversight of the digital agenda through the introduction of tailored board seminars in this area and by building this agenda item into the board and committee annual plans. This could involve assigning responsibility for the digital strategy to one of the existing committees, for example the Finance and Performance Committee, which is already responsible for the oversight of material business cases.	By the end of Q4 2021/22, we will have agreed where oversight of the digital agenda will take place. At least one board seminar session in H2 2021/22 as well as H1 and H2 2022/23 will include an aspect of the digital agenda.	Chair	The board has agreed that oversight of the digital agenda will take place via the Finance and Performance Committee and this has been incorporated into the revised terms of reference. The H2 2021/22 board seminar session was held on 23 Feb 2022 and focused on cybersecurity. The H1 2022/23 seminar session took place on 20 July 2022 and focused on the digital strategy in action. The H2 2022/23 has been provisionally scheduled to take place on 18 Jan 2023.	

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

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

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

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
12 Medium	The Chair should introduce a range of virtual forums aimed at providing additional organisational oversight for Non-Executive Directors (NEDs), whilst also raising NED visibility with staff. Initiatives could include NED divisional alignment, NED-led staff focus groups, 1:1 staff meetings and Chair webinars.	By the end of Q1 2022/23, NED walkabouts will have recommenced. By the end of Q2 2022/23, we will have introduced appropriate publicity materials on all main trust sites.	Chair	NED walkabouts have commenced and these will cover all parts of the Trust to ensure visibility amongst clinical and non-clinical teams. NEDs will be invited to undertake a walkabout at least once per quarter, accompanied by an Executive Director who they do not usually work with, to facilitate an additional networking opportunity. Non-Executive Directors will also be providing mentorship support to the Shadow Board programme which will help in increasing visibility with senior leaders. Publicity materials for all main sites are currently being printed and will be installed on receipt.	

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

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

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

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
15 High	At the time of fieldwork, a number of changes were underway to strengthen leadership development, including identifying and supporting future talent. This should take into account opportunities for a multidisciplinary approach (both within the trust and across system partners where appropriate) and should also consider the skills required both as a leader within the trust as well as those which will be needed as a result of greater levels of integrated system working.	By the end of April 2022, we will have relaunched the Leadership Development Framework within the organisation. The talent programme will be prioritised for development from April 2022, which will include identification of talent, assessment of potential, talent pathways and development programmes. The design element of the programme will be completed by the end of Q1 2022/23 and phased implementation for organisational tiers will commence from Q2 2022/23.	Director of Workforce	The Leadership Development Framework has been agreed and relaunch took place during March and April 2022. Work is underway to scope and develop the talent programme. Feedback has been obtained from key stakeholders and a survey has been distributed to leaders to gain insight on talent identification and talent management, coupled with the skills required for future leaders. The initial draft of the programme is being shared in August for consultation, input and feedback. The design element of the programme is in final stage of review and subject to ETM approval, pilot launch will commence Q3 2022/23.	

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

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

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

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

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

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

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

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

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

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

Title of report:	Equality, Diversity and Inclusion Annual Monitoring Report – April 2021 to March 2022
Presented to:	Trust Board
On:	05 October 2022
Presented by:	Chief People Officer
Prepared by:	EDI Leads
Contact details:	E: [2217] M: 07786522871

Executive summary

The EDI annual report for 2021/22 was considered at the People Committee in September and was approved for publication.

The Committee noted that the report content was reduced due to covid associated issues, but all statutory requirements are included. The timeline for the 2022/23 annual report has been brought forwards to ensure that it is submitted to the relevant sub-committees, as set out in the new EDI governance arrangements, and to Board in a timelier manner following year end. Content will also be collated in real time, aligned to the shadow running of the EDS3 during 2022/23. This will also improve the content and style of the report.

Link to strategy

Equality, Diversity and Inclusion Strategy 2022-2026 was approved by Trust Board with three overarching aims:

- To increase diversity and accessibility
- To eliminate inequality
- To improve experience for protected groups

Risks associated with this report and proposed mitigations

The report illustrates that health and employment inequalities are present. Our patient experience, staff diversity networks and EDI champions will help with identifying priority areas for action and will raise awareness through sharing of lived experience.

Some actions identified under the Equality Delivery System (EDS) were delayed because of the Covid pandemic. These are now being progressed and clear timelines in place.

Accessible Information Standard compliance remains fragmented due to the number of systems used. Interim arrangements are in place, but it cannot be guaranteed that all communication will be provided in the appropriate format because of interoperability issues with some of the systems used.

Financial implications

There are no direct financial implications associated with this report.

Legal implications

The Trust s required to comply with the Equality Act 2010 and the public sector equality duty. This annual report is one component of required reporting.

People implications

The report highlights the workforce equality standards and demographic comparison with the local population.

Wider implications

Failure to actively promote equality across all protected characteristics could see the Trust receive challenge from the local community and loss of reputation and public confidence could arise as a subsequence. Non-compliance / failure to address national requirements could impact on our Care Quality Commission Scores. The key risks to the Trust therefore in terms of service delivery are non-completion of equality impact assessments, failure to provide accessible information in a patient's preferred format and the limited availability of equality information against some of the protected characteristics.

Recommendation(s)

The Trust Board is asked to approve the streamlined 2021/22 EDI annual report for publication on the website and note the proposed changes for the 2022/23 report and reporting cycle.

Report

This report provides a summary update of the main achievements, progress and developments in relation to the Equality, Diversity and Inclusion (EDI) agenda at WWL during 2021/2022.

2021/2022 was a very challenging 12 months for the Trust. A year which was dominated by the impact of and response to the Covid-19 global pandemic. WWL remained committed to providing an environment where all staff, service users and carers have equality of opportunity.

In July 2021, our new Workforce EDI Lead joined the Trust. This gave us the opportunity to revaluate our EDI agenda and the structures in place to support this. During 2021/2022 we reviewed the Trust's strategic approach to EDI and developed new equality objectives for 2022-2026, which reflected our learning from the COVID Pandemic. Following a consultation with stakeholders and staff, we developed a new EDI Strategy, which was launched in January 2022.

In October 2021, WWL was lucky enough to secure a funded place on the LGBTQIA+ Rainbow Badge Phase 2 Scheme and have since commenced the assessment process for this, which included a policy review, workforce assessment and staff, patients and services review surveys. This review will help us to identify and celebrate the work that is already being done, while also understanding what next steps need to be taken to make our services a safer and more inclusive environment for LGBT+ people.

During 2021/22, WWL also commenced the Race Equality Code Accreditation process and recently received feedback to be shared with the Board along with key themes and actions in the November 2022 workshop. Feedback from the Rainbow Badge Assessment and the Race Equality Code Accreditation will be invaluable, whilst the frameworks relate to specific protected characteristics, the recommendations and actions taken will be beneficial for people beyond the specific protected characteristic of the framework.

A review of the staff networks available at WWL was undertaken and by the end of 2021, WWL were recruiting to the newly formed LGBTQIA+ and Disability Staff Networks. These networks are now operational. In addition, work has been undertaken to review the Focus on All Minority Ethnic (FAME) Staff Network. The role of the EDI champion is being reviewed and strengthened. EDI Champions, in alliance with the Staff Networks will play a vital role in the EDI Structure at WWL.

WWL has continued to enhance patient experience, by engaging and involving patients, and their families. During 2021/22 WWL sourced and implemented transparent face masks, to help improve communication; a focus group was established to involve patients living with disabilities in the design and implementation of the new Trust website; and funding was sourced for a further 5 year contract with AccessAble for the provision of our on-line hospital accessibility checker.

The table in Appendix 1 summarises our EDI Objectives and key progress during 2021-22.

Our Staff / Our Patients

Having a clear profile of our staff and patients helps to advance equality of opportunity and meet the needs of our patients and staff in designing our services and employment practice. The following workforce data is collected routinely by the Trust:

- Age
- Disability
- Ethnicity
- Sex
- Marital Status
- Maternity

- Religion & Belief
- Sexual Orientation

For the purposes of this report, we have reviewed the data which is available to us in terms of the above protected characteristics. The Trust does not hold data on gender reassignment for its workforce profile although it does for statistics in relation to Recruitment and Selection.

The Trust has historically only had very limited information on the protected characteristics of the people who use our services. As a consequence, it can be difficult for us to determine the extent to which we are providing services which are responsive to individual needs. The following patient demographics are collected routinely by the Trust:

- Age
- Sex
- Ethnicity
- Religion and Belief

For the purposes of this report, we have reviewed the data which is available to us in terms of age, sex, ethnicity and religion and belief, along with local data and reports. Where we do not have sufficient data in terms of disability, sexual orientation, marriage and civil partnership and transgender, we have used regional or national data as an estimate.

Our People (Workforce)

Age

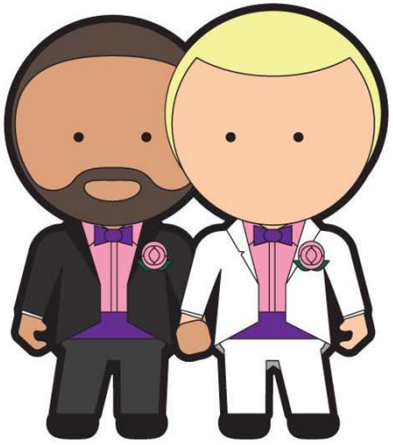
The proportion of staff in each age bracket has stayed relatively static compared to 2021.

As at 31 March 2022 WWL Trust staff breakdown was:

61.5% Aged 50 or under **38.5%** Aged 51 and over

Performance management cases split by age were 20% for aged 50 or under and 80% for aged 51 and over which is not in proportion to the workforce representation.

Marriage and Civil Partnership



As at 31 March 2022

54% of staff were **Married**

1% were in a **Civil Partnership**

33% single, 8% divorced / legally separated, 1% widowed, 3% unknown.

Figure has remained relatively static over a period of several years.

Disability

As at 31 March 2022

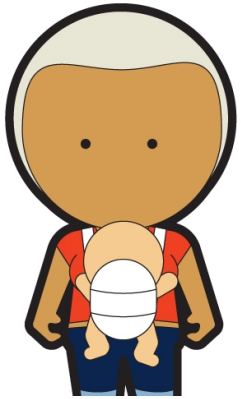
3.1% of the Workforce have declared that they are living with a disability. This has not significantly changed compared to the 2021 figure (2.6%).

Although there is still a large amount of undeclared data **21.7%** this has decreased over the previous years: 2021 = 26.6%, 2020 & 2019 = 29% & 2018 was 32%)

For Non-Clinical Staff there is an under representation of disabled staff in Band 7 and 8c and above.

For Clinical Staff there is an under representation of disabled staff particularly in Bands 8b and 8c, in addition to Medical & Dental.

Pregnancy and Maternity



As at 31 March 2021, a snap shot from the Electronic Staff Record indicated that:

1.85% of staff were on **Maternity Leave**

This is comparable to the previous two years.

Religion and Belief

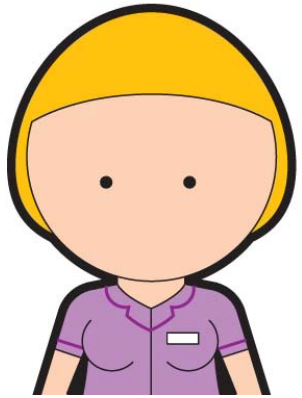
As at 31 March 2022

58.2% of staff were Christian. The remaining staff are split across a range of religions and beliefs with the highest number being in Atheism category (7.6%) and then Other Religion (6.9%).

A significant proportion of staff have not declared their religion and belief (22.9%).

(2011 Census, The Wigan borough figure for Christianity is 77.8%)

Sexual Orientation



Workforce as at 31 March 2022:

77.6% Heterosexual

1.3% Gay or Lesbian

0.7% Bisexual

20.3% did not wish to disclose.

There is under representation of gay, lesbian or bisexual staff in AFC bands from 8c and above.

Ethnicity

As at 31 March 2022:

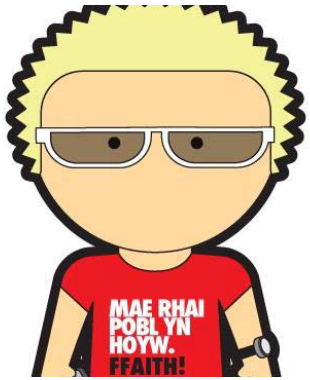
87.8% of Staff of White Ethnicity
(2011 Census, Wigan Borough White representation is 97.3%)

11.1% of Staff from Black & Minority Ethnic Groups
1% Not Stated

11.8% of the Trust Board membership is BME.

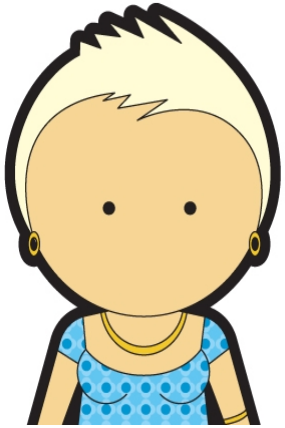
21.7% of **Disciplinary** cases were in respect of BME staff members which was above the proportionate workforce profile.

Gender Reassignment



Transgender information for current staff is not recorded on ESR so we cannot therefore undertake workforce profile monitoring at present.

Sex



Workforce as at 31 March 2022:
81% Female
19% Male
(2011 Census, 50.3% female / 49.7% male within Wigan population)

48.1% of **Disciplinary** cases were in respect of male staff members which is over representative of the workforce profile. This is a slight increase from the previous year's data at 47% of disciplinary cases in respect of male staff members.

Our Service Users (Patients)

Ethnicity (Out-Patients & In-Patients)

During 2021/22

91% of Patients of British White Ethnicity

4.7% of Patients from Black & Minority Ethnic Groups (BME)

During last 12 months, 0.4% decrease in patients of BME Origin. Patients of British White Ethnicity remains the same. 4.3% not stated.

Over last 12 years steady increase in BME activity 2010/11: 2.9% / 2021/22: 4.7%.

Ethnicity (Accident & Emergency)

During 2021/22

90.3% of Patients of British White Ethnicity

7.5% of Patients from Black & Minority Ethnic Groups (BME)

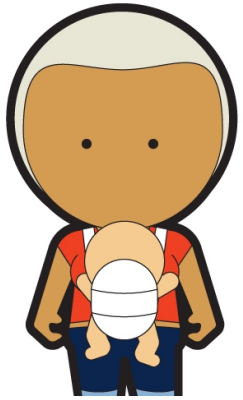
2.2% Not Known

During last 12 months, 1% decrease in patients of British White Ethnicity. 1.3% increase in patients of BME Origin.

Over last 12 years steady increase in BME activity in A&E. 2010/11: 3.5% / 2021/22: 7.5%

Ethnicity overall reflective of local population – Latest census (2011) reported that 95% of the local population were of British White Ethnicity. In 2001 it was estimated that 97.6% of Wigan's Population was "White: British". However, since 2001 the number of residents from Black, Asian and other Minority Ethnicities has more than doubled to 7,062 (2.2% of the population).

Ethnicity (Maternity Admissions)



During 2021/22

86.8% of Patients of British White Ethnicity

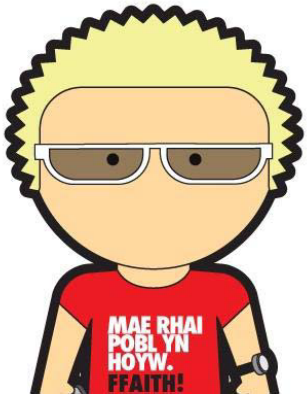
12.3% of Patients from Black & Minority Ethnic Groups

0.9% Not Known

During last 12 months, data mirrors previous year's data. During last 7 years 3.2% decrease in patients of British White Ethnicity. 2.5% increase in patients of Black and Minority Ethnic Backgrounds

Higher % of Black and Minority Ethnic Groups using maternity services than overall out-patient / in-patient activity. No statistically significant difference noted – data historical. Data in line with significant growth in Wigan Borough migrant worker population and numbers of refugees / asylum seekers.

Interpreter & Translation Services



During 2021/22
Top Languages Requested

Polish, Farsi, Arabic, Kurdish Sorani, Romanian, Russian, Portuguese, Urdu

Trends show the similar top languages as 2020/21 with an increase in Portuguese interpreters this year.

During 2021/22:

48 Translations into other languages
14 Other formats - 6 Large Print / 6 Braille / 2 Audio Translations requested
This will continue to increase with the implementation of the Accessible Information Standard.

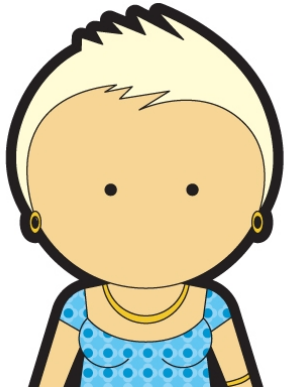
Ethnic Population in Greater Manchester

As of the 2011 Census, over 95% of the population was White British. This compares to just under 80% in England as a whole. However, Wigan Borough has received a sizeable number of refugees and migrants over the last decade and it is likely that the population will become more diverse over the coming years. Migration has significantly changed the wealth of diversity in Wigan since the last census and there has been significant demographic change within Wigan Borough.

Ethnic minority populations living in Wigan are:
Long-term resident ethnic minority population and asylum seekers
And refugees, migrants, Gypsies and Travellers,
European Roma and Overseas students. Although the numbers are small compared to the size of the total population and some only stay for a short period of time, some will have specific health needs that need to be addressed.

Local Authority	White British	Mixed	Asian or Asian British	Black or Black British	Chinese
Wigan	95%	0.8%	1.3%	0.7%	0.3%
Bolton	84%	1.4%	9.6%	1.2%	0.5%
Salford	86%	1.6%	3.3%	1.7%	0.6%

Sex (Out-Patients)



During 2021/22
57% Female
43% Male

Latest census reported that 50.3% of the local population is female

As with most healthcare services in the UK, women are more likely to use hospital services than men.

Age

During 2021/22
% of patients accessing hospitals services

9.5% Under 18 **11%** 18-30 Years
42% 31-64 Years **37.5%** 65+ Years

1 in 6 residents in Wigan are now aged over 65 years.

Set to increase by 30,000 over the next 20 years

Age overall reflective of local population – Latest census reported that the % of the population aged 65 and over in the Wigan Borough was the highest seen in any census. **There has been a steady increase in the number of people aged 65+ within Wigan Borough as a result of increasing life expectancy . The proportion of people aged 65+ in 2017 was 18.8%. This is projected to rise to 20.9% by 2025, to 23.0% by 2030, and to 26.2% by 2040.**

Maintaining the health and resilience of older people is important both for the individuals themselves and in ensuring the sustainability of local health and adult social care services.

The age of patients accessing hospital services is bias towards the older population, reflecting greater healthcare needs. Trends show a 3% increase in patients aged 65+ years over the last 2 years and 4% decrease in those aged 18-30 years. This needs to be monitored over longer period to establish if any statistical significant difference.

Religion and Belief

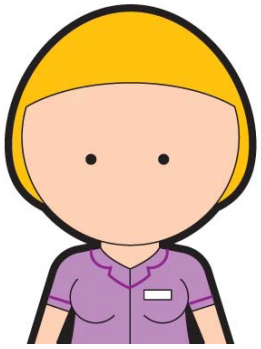
During 2021/22
% of patients accessing out-patient services

67% Christian	**18%** Unknown
14% None	**0.2%** Hindu
0.6% Muslim	**0.2%** Atheist
0.1% Buddhist	**0.1%** Islam
0.1% Jewish	**0.1%** Unitarian
0.1% Spiritualist	

Religion overall reflective of local population – Latest census reported that 78% of the population were of Christian Belief

Trust Data affected by the high proportion of religion not known (114,328 patients).

Sexual Orientation and Transgender



Based on recent research and LGBT inequalities data it is estimated that there are

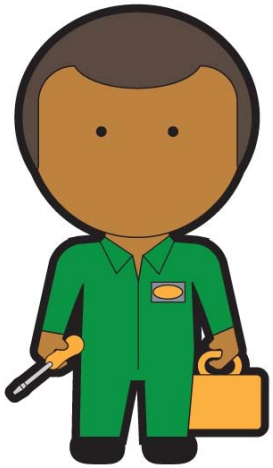
15,000 Lesbian, Gay or Bisexual Wigan Residents

2,500 People who identify as trans in Wigan

Despite the relatively small numbers, the impact that gender re-assignment can have on people's outcomes is extreme.

In response to national research, NHS England is spearheading a collective drive to improve the experience of trans and non-binary people when accessing health and care services.

Disability



Latest Census reported

21.5% of Wigan Residents living with a limiting long-term illness, health problems or disability which limits daily activities at work.

Higher than national average 17.9%

The 5 most common conditions which account for 54% of DLA Claims

Arthritis; Learning Disabilities; Heart Disease; Disease of muscles, bones & joints; Hyperkinetic syndromes

Action on Hearing Loss estimate that

1 in 6 (16%) of the population are living with hearing loss.

53,000 of Wigan Residents.

Royal National Institute for Blind People estimates that

8,680 of Wigan Residents are living with sight loss (**990** are living with severe sight loss)

By 2020, figures are expected to rise to

10,500 of Wigan Residents living with sight loss (1,250 living with severe sight loss)

1 in 4 people experience a mental health problem during their life. Having a long-term condition increases the risk that an individual will have a mental health.

The number of people who are at risk of having poor mental wellbeing in Wigan is high because of the high levels of deprivation.

Improving Health & Lives (IHAL) estimate that

1.9% (6,170 residents) have learning disabilities.

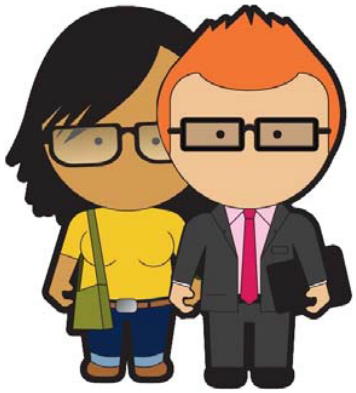
The Accessible Information Standard

A law to ensure that people who have a disability, impairment or sensory loss are given information they can easily read or understand. **Making information easier to understand for people living with communication and information needs.**

WWL is committed to working towards meeting the core requirements of the Standard for everyone we serve.

Patients with disabilities often report barriers to using health services, in terms of transport difficulties, distance and needing someone to accompany them. Poor communication leads to non-attendance for appointments. These are issues currently being reviewed within Wigan Borough Locality Plan.

Marriage and Civil Partnership



Latest Census reported

47.4% Wigan Residents are **Married**

0.2% (482) Wigan Residents in a Registered **Same-Sex Civil Partnership**

Complaints

441 Complaints Received during 2021/22

249 Female **189** Male

419 British White Ethnicity

10 Black & Minority Ethnic Background

12 Not Stated

5 Main Subject Complaints

- Clinical treatment
- Communications
- Patient Care
- Admissions and Discharges
- Value and Behaviour

No trends in relation to protected characteristics noted

63% Aged 50 years or above

Conclusion

WWL has strengthened its commitment to change and to reviewing, evaluating and improving equality, diversity and inclusion. WWL has continued to make good progress on EDI work and remains focussed on our equality duties. Particularly in the area of workforce EDI, 2021-22 has been a year to understand our baselines and where our gaps are to establish areas of focus for the coming years.

Of all the many achievements in 2021-2022, the primary highlights of the year have been:

- Continuing our significant equality, diversity and inclusion focused response to the COVID-19 pandemic for patients, service users, our communities and our staff.
- Reviewing our strategic approach to EDI, setting new overarching equality objectives for 2022-2026 and subsequently launching our new EDI Strategy 2022-2026.
- Setting up new governance structures to weave EDI into business-as-usual in the Trust.
- Ongoing FAME Network events and recruiting for the new LGBTQIA+ and Disability Staff Networks.
- Securing a funded place on the LGBTQIA+ Rainbow Badges Phase 2 and commencing the assessment process. This will help us to understand LGBTQIA+ inclusion in the Trust for our people and patients and where our areas of strength are, along with where we need to focus.
- Securing funding to train EDI Champions across the Trust, which will begin in Sep 2022.
- Secured funding to enter WWL into the Race Equality Code, which involves looking at how our organisation can be more anti-racist and inclusive.
- Redesigning the Annual EDI Calendar and promoting the team inclusion challenge.
- Continuing to raise awareness of protected characteristics throughout the year for example Wigan Pride which returned for a sixth year in August 2021, with a smaller scale format that allowed attendees to enjoy a mixture of in-person and online events.
- Implementation of transparent face masks to support communication between not only those who have hearing difficulties or are deaf, but patients with cognitive problems such as dementia, learning disabilities, autism etc. sourced.
- Establishing a focus group on-line to involve patients living with disabilities in the design and implementation of the new Trust Website. Accessibility functionality reviewed, stakeholders involved in the tender process and design.
- Securing funding for an additional 5 year contract with AccessAble (provider of WWL's on-line accessibility checker).
- Changes made to incorporate the capture of accessible information requirements in PAS for elective in-patients and out-patients.
- Continuing to undertake 3 yearly reviews of existing Equality Impact Assessments (EIAs) for all divisions.

WWL has met its statutory obligations to monitor and report on workforce and patient equality and diversity issues and provides assurance that action is being taken to address issues of note.

Under current practice, there continues to be gaps within the Trust's information gathering and analysis of patient data. Only equality information in relation to a patient's ethnicity, age, sex and religion is collected routinely via out-patients and admissions. Although postal patient experience surveys collect data across all 9 protected characteristics, the implementation of more robust

equality monitoring and data analysis within service delivery continues to be addressed and is being actioned as a key priority within the Trust's Equality Objectives.

For the purposes of this report, we have reviewed the patient data which is available to us in terms of age, sex, ethnicity and religion and belief, along with local data and reports. Where we do not have sufficient data we have used regional or national data as an estimate. The overall picture of access, using the best available data, continues to reflect broad similarity to local demographics.

In terms of workforce data, we have reviewed the data which is available to us with regards to age, disability, ethnicity, sex, marital status, maternity, religion & belief and sexual orientation. Other than in respect of Recruitment and Selection statistics, the Trust does not hold workforce data on gender reassignment.

The Trust recognises the importance of equality and human rights and the value that it adds. We will continue to build on the progress we have made to date.

Over the past few years, Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust have made substantial progress in understanding diversity within the local population and ensuring the knowledge, skills and competencies in our staff meet the needs of service users with protected characteristics. We will continue to make progress by ensuring these values are mainstreamed through all aspects of our service provision, and in how we work in partnership with our employees and our local communities.

The Year Ahead

EDI Strategy

Equality, diversity and inclusion objectives must be set every 4 years and the Trust must regularly monitor and demonstrate progress against these objectives. In January 2022, the new EDI Strategy 2022-26 was published. Our strategy focuses on three key themes:

- To increase diversity and accessibility
- To eliminate inequality
- To improve experience for protected groups

Discussions are currently taking place to agree the patient objectives we will be focussing on during the year ahead. People objectives have been approved at the People Committee ready for publication.

EDS2022

WWL will be implementing the new EDS 2022 framework which consists of 3 domains and 11 outcomes. Compared to EDS2 some of the key differences of the EDS3 include:

- Collaborative approach for the patient related domain instead of a single organisation approach.
- Focus on inequalities in workforce health and well-being, encouraging organisations to use data generated from tools such as WRES and WDES, rather than repeating their purpose
- Focus on the accountability of leaders and now requires leaders and board members to show evidence of how they personally commit and contribute to the EDI and health inequalities agenda within their organisations, and the use of relevant tools.

The EDS 2022 will be in pilot form until Quarter 4 of 2023, an exact date has not yet been published. It is not compulsory for Trusts to implement the EDS 2022 until the final version has been released and we will be applying some flexibility in the framework during the year ahead. The trust will report on the new domains and outcomes, however there may be some data gaps and additionally there may be flexibility in the proposed timescales for each domain. To support the Trust in working to the

EDS 2022 framework, a paper will be presented at an executive team meeting to the highlight key differences, details of what will be reported on, responsibilities, risks and mitigations, and any actions required in order to successfully implement this framework at WWL.

Maintaining Compliance with the Public Sector Equality Duty

The Trust has and will continue to monitor compliance with the equality agenda and ensure that staff and service users are consulted with and updated on any changes and progress. This will include ensuring that there is equality for all and eliminating discrimination.

WRES and WDES

The Equality Delivery System (EDS2), Workforce Race Equality Standard (WRES) and the Workforce Disability Standard (WDES) are published on our Trust Website and help us to focus, highlight concerns and keep on track with making improvements in what we do and how we do it – for the benefit of all our service users, carers and staff.

Engagement

We recognise the need to continue to work in partnership with staff and patients. For staff, this means continuing to raise awareness of initiatives and engaging with protected groups to ensure that all staff feel valued, respected and able to progress through the organisation. It also means the opportunity to share and build on areas of good practice whilst addressing areas for development. For patients and carers, this means being able to access our services, receive care and support and be treated as individuals with dignity.

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

Improving Representation and Access

We fully recognise that people access services in a range of different ways and may encounter different barriers in doing so. Our aim is to effectively engage with our local communities and organisation representing protected groups to understand their diverse needs, and then to provide services which meet these local needs.

The feedback from the Rainbow Badges Phase 2 assessment will be a very valuable tool to allow WWL to increase representation of the LGBTQIA+ community and improve patient access.

Census day was on 21st March 2021. Phase one results were published at the end of June 2022 These are estimates of the number of people and households in England and Wales. They show the number of people by sex and age at local authority level. Main results will be released within two years of the census. After a period of living with the coronavirus, there has never been a more important time to have a census. This data will be essential to our long-term understanding of the health, social and economic impacts on the people and households of England and Wales. The census will highlight the needs of different groups and communities, and the inequalities people are experiencing.

During 2021/22, the Trust continued to undertake equality analysis on all policies and practices (to ensure that any new or existing policies and practices do not disadvantage any group or individual). Equality impact assessments are embedded as part of Trust Policy Protocol. We need to review our

approach to service redesign, ensuring that equality, diversity and inclusion are central to community engagement, consultation and decision making to ensure the patient voice is heard.

The **Accessible Information Standard** came into force for all NHS organisations in July 2016**.** It stipulates that we have a duty to ensure that people with a disability, impairment or sensory loss are given information in a way that they can understand. Patients must be asked if they have any communication needs. These must be recorded, highlighted and acted upon.

WWL is continuing to make progress in relation to meeting the core requirements of the Accessible Information Standard. In March 2021 changes were made to incorporate the capture of accessible information requirements in PAS for elective in-patients and out-patients.

Although many controls have now been implemented to demonstrate compliance with the AIS, currently there is no consistent approach Trust wide (across all standalone systems). Patients could have their information and communication needs met for some services, but not for others. As we enter 2022-2023, we look forward to continued integration of the AIS in the Trust's IT systems to support patients and service users in accessing care services appropriate to their communication requirements.

Improving Experience

Developing a culture where patient experience considerations are at the heart of any key service change or development is fundamental. WWL is very keen to embed the philosophy of 'nothing about me, without me'. We will ensure that patients from all protected characteristics have assurance that their voices have been heard and informed the provision and development of health care services through patient informed design.

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

Staff Networks

Our newly formed LGTBQIA+ and Disability staff networks in addition to our FAME staff network will hold regular events during the year ahead. The staff networks will each own a project and be consulted in HR policy development.

Promotional Events

We will continue to help publicise and promote events that highlight best practice in equality and diversity within the organisation. This will focus on national campaigns that are linked to the protected characteristics as well as all the various initiatives that are being undertaken at a local level.

Employment Practice

We aim to further develop the support available to staff, with regard to equality, diversity and inclusion and look to develop more local resources and training. We also aim to further reduce

inequalities experienced by staff and applicants from a protected groups by means of staff network events.

Wrightington, Wigan and Leigh NHS Foundation Trust's
Equality Objectives & EDS2 Action Plan 2021/22

Governance

1.	Action(s)	Outcome	How Measured	Progress	Target Date
1.1 National	Produce 2020-21 Annual I&D Monitoring Report. To be approved by I&D Steering Group and tabled for information and sign off at People Meeting and Trust Board in November 2021.	Regular monitoring of staff & patient equality data. Reference to data signposted in Equality Impact Assessment (EIA) Guidance. Compliance with Public Sector Equality Duty.	Annual review of patient and staff activity by protected groups. Evidenced within Annual Report / Annual EDS Assessment / Equality Impact Assessments.	EDI Report produced Approved by People Committee Dec 21. Published on Trust website Jan 22.	Sep 21
1.2 National	Annual I&D Monitoring Report published on Trust Website in line with Public Sector Equality Duty Requirements to publish equality information. Trust website to be updated accordingly.				Jan 22
1.3 National	Produce Annual Equality Objectives Review and EDS2 Assessment 2021 Scores Report.	Report summarising progress against Equality Objectives during last 12 months and EDS Grades for 2020/21.	Progress monitored by I&D Steering Group. Shared with People Committee & Trust Board.	EDS Outcome Scores not reviewed during 2020/21 due to COVID. EHRC suspended PSED reporting obligations in England for 2020.	Sep 21
1.4 National	To review the Trust's strategic approach to EDI. To develop new equality objectives for 2021-2025 which reflect the learning from the COVID Pandemic - National media coverage has demonstrated that Covid has disproportionately affected some protected groups and exacerbated health inequalities. To develop a new EDI Strategy 2021-2025 that effectively addresses these issues.	Refreshed strategic approach to EDI, including how WWL monitors and provides assurance and how WWL can work not only within the Trust, but across the local borough. New EDI Strategy and Equality Objectives 2021-25 which reflects the learning from the COVID Pandemic.	EDI Strategy and Equality Objectives Action Plan. Progress monitored by I&D Steering Group. Shared with People Committee & Trust Board.	WWL's current equality objectives and EDI Strategy rolled over to 2021. Update given to staff in WWL News 12/05/21 in conjunction with ED&HR Week 10-14 May. Overall themes and aims proposed for 2022-26 Consultation undertaken with stakeholders & staff during October 2021. Feedback collated into themes. Strategy approved by Trust Board Nov 21. Strategy launched Jan 22.	Mar 22

1.5 National	Annual Workforce Race Equality Standard (WRES) assessment to be compiled and published.	Compliance with WRES requirements.	WRES Assessment completed & published by August 2021.	WRES report submitted and published on Trust website.	Aug 2021
Governance					
1.	**Action(s)**	**Outcome**	**How Measured**	**Progress**	**Target Date**
1.6 National	Review of requirements of forthcoming Workforce Disability Equality Standard (WDES)	Compliance with WDES requirements. To be mandated via the NHS Standard Contract in England from April 2019.	WDES Assessment to be complete by August 2021	WDES report submitted and published on Trust website.	Aug 2021
1.7 National	Gender Pay Gap Report to be published.	Compliance with Government Gender Pay Gap reporting requirements.	Gender Pay Gap Report to be completed & published by 30 March 2022	Report completed and published on Trust website. Actions to be built into Action Plan.	March 2022
1.8 CCG	E&D evidence requirements for QSSG Quality Monitoring Schedule 2021/22 to be compiled and submitted to Trust Governance Lead.	Compliance with Quality and Safety Standards as specified in Wigan CCG General Contract.	QSSG Self- Assessment Return.	Annual EDI Report submitted as evidence Jan 22.	Jan 22
1.9 National	Update flexible working policy following change in Agenda for Change terms and conditions effective from 13/09/2021. Review flexible working guidance available to managers and staff. Review how flexible working requests are monitored.	Flexible working policy to reflect Agenda for Change terms and conditions. Support managers to deal with requests confidentially and correctly. More detailed flexible working. reporting to allow us to assess any inequalities.	Improvement in Staff Survey results 'the opportunities for flexible working patterns.	Agenda For Change amends made to policy and flexible working request form updated. Flexible working guidance document being drafted, planned first draft by end of April. Then to be taken to policy development group with flexible working policy.	June 22

Organisational and Cultural Development					
2.	**Action(s)**	**Outcome**	**How Measured**	**Progress**	**Target Date**
2.1	Implement Schedule of Events for 2021/22 and promote / hold supporting events.	Increased staff and patient engagement. WWL seen as fully inclusive employer and service provider.	Monitored by I&D Operational Group/ I&D Champions. Annual Schedule of Events Summary Report.	Schedule of Events 2021/22 reviewed. Calendar implemented. On-going.	Apr 21
2.2	To continue 3 yearly reviews of existing Equality Impact Assessments (EIAs) for all divisions.	Review of all existing Equality Impact Assessments. Quality Assurance implemented. EIAs are embedded within Theme 3 Modelling of GM Improving Specialist Services. EIAs to be embedded within Quality Priorities 20/21 'Care' Proposal.	Robust review system implemented to ensure EIAs are monitored and reviewed Any negative impacts identified within Equality Impact Assessments. Assessors have a requirement to report on what actions will be implemented to reduce any negative impact.	Review commenced March 2021. EIAs on-going.	Mar 22
2.3	To develop training programme for Equality Impact Assessments for staff.	Staff have a more in depth understanding of how to complete an Equality Impact Assessment.	Staff feedback	EIA Training delivered for HR Staff during June 2021. One to one training provided as and when required.	Mar 22
2.4	To develop a new Equality Impact Assessment template for organisational change projects	The template will allow for an understanding of the demographics of the staff involved with the organisational change project compared to the overall Trust, allowing managers to identify impacts towards protected groups.	Any negative impacts identified within Equality Impact Assessments and what actions will be implemented to reduce any negative impact.	EIA template for organisational change projects paused so it can be considered as a wider EIA reform project. Existing EIA documentation to be used in the meantime	Jun 23
2.5	Cultural integration of international nurses. Identify areas where the Trust can improve its support of the international nurse community at WWL Identify areas where the Trust can streamline the	Standardise the support offer for international nurses to ensure a consistent high-quality level of support is in place across the Trust. Quicker team integration maintained dignity and respect.	Feedback via FAME network forum Feedback from ward leaders	Action not complete but actions already taken include: Identified common barriers to integration. Manager guide/WWL welcome pack in progress.	March 2022 and beyond

	integration of international nurses into their roles at WWL. Raise awareness of the cultural differences that exist between our international nurses so that we can celebrate our diversity and learn from one another	More inclusive behaviour within teams. Integration of colleagues from all backgrounds and cultures.	Improved Your Voice survey results and BHDV results	Working with FAME Network to establish cultural competence lived experience awareness programme.	
2.6	Race Equality Code	Complete Race Equality Code assessment and produce action plan to improve	Compliance against the 4 overarching principles of the code which includes 55 outcomes.	EDI Calendar/Teams Inclusion Challenge to support cultural competence. Relaunched FAME staff network, given committee formalised time and budget, including international nurses representative, employed EDI administrator to support. MS Teams backgrounds created for Black History Month, South Asian Heritage Month, Delivering microaggression training to students, FY1/2 doctors, Staff Engagement Associates, Wellbeing Champions, council of governors, apprenticeship inductions. Trust commenced Race Equality Code to ensure race equality is designed into governance structures. The process is completed, and key findings will be shared with the Trust Board in its November workshop	Mar 2022
2.7	Rainbow Badges Awards Scheme	Join first cohort of NHS Trusts to audit ourselves against LGBTQIA+ inclusion in the Trust and produce an action plan to improve.	Improved LGBTQIA+ declaration rates Improved Your Voice survey results from LGBTQIA+ colleagues	LGBTQ+ Exec Sponsor appointed. Induction attended Nov 21. Met with NHS Rainbow Badges in Jan 2022 to confirm timescales and requirements. Policy submission actioned Jan 22. Services / Patient & Staff Surveys commenced. Feedback and action plans should be received by July 2022.	July 2022

2.8	To complete the Disability Confident Employer reassessment by 8th December 2021. To complete ongoing yearly reviews of the self-assessment.	To keep our Disability Confident Employer Status active and demonstrate our commitment to this, identifying any associated actions required.	Disability Confident Employer Status Recruitment data for disabled applicants WDES	Reassessment completed.	Dec 2021
				Procurement will be one of key stakeholders to train on EIA's to encourage them to think more about the impact our suppliers have on disabled people. This will be picked up as part of the wider EIA project.	Jun 23

Equality Delivery System (EDS2) Annual Assessment & Scores

3.	Action(s)	Outcome	How Measured	Progress	Target Date
3.1	EDS2 Outcomes for 2021/22 Assessment for Goals 1 and 2 to be agreed. Action Plan for evidence collection to be agreed.	Action plan for evidence collection implemented.	EDS Action Plan 2021/22.	EDS Outcomes for Goals 1 and 2 confirmed.	Jul 2022
3.2	EDS2 Outcomes for 2021/22 Assessment for Goals 3 and 4 to be agreed. Action Plan for to be agreed.	Action Plan implemented.	EDS Action Plan 2021/22.	EDS Outcomes for Goals 3 and 4 confirmed.	Nov 2021
3.3	Evidence and proposed grades in relation to Goals 1 and 2 to be shared with local stakeholders for feedback and review.	Grades agreed by local Stakeholders through engagement / equality monitoring / improved patient access & experience during 2021/22. EDS 2022 Assessment Report summarising overall scores for 2021/22.	Patient Engagement Review of available services Equality Impact Assessments 2022/23 EDS Action Plan drafted to enable plans to be formulated to progress EDS scores.	Wigan Healthwatch agreed with proposed scores of 'achieving' for Outcomes 1.4 and 2.2	Mar 22
3.4	Evidence in relation to Goals 3 and 4 to be submitted to another Trust for peer review	Grades agreed via peer review.	2021/22 EDS Action Plan drafted to enable plans to be formulated to progress EDS scores.	EDS report for employment related goals delayed due to staff survey results not being available. Draft report sent for peer review w/c 11/04	May 22

Equality Objective 1 - Better Health Outcomes for All

To work together with the local LGBT Community to increase the quality of the information, knowledge and understanding we have about our LGBT service users.

4.	Action(s)	Outcome	How Measured	Progress	Target date
4.1	Wigan PRIDE 2021 Launch Event to be arranged and held.	WWL seen as an LGBT friendly employer and service provider. Increased staff awareness. Increased publicity.	Follow-Up Staff LGBT Awareness Survey shows improvement in baseline scores recorded.	Article featured in WWL News 19/05/21. Article for Pride Stewards featured in newsletter on 21/07/21.	May 21 Jul 21
4.2	To fully support and participate within Wigan PRIDE 2021.	Working collaboratively with Wigan Borough CCG & Bridgewater.		Wigan PRIDE took place on 14th August 2021. New format this year with return of a live audience. On a smaller scale to pre-covid events (No Parade).	Aug 21
4.3	Protocol for patient's changing gender identity and requests for medical records to be updated to be reviewed and formalised	Robust SOP Increased staff awareness	Audit Trail.	Draft SOP Produced. 7 patient requests received. Divisional responsibility and ownership to be confirmed.	Mar 22
4.4	To promote national trans awareness events	WWL seen as an LGBT friendly employer and service provider. Increased staff awareness.	Follow-Up Staff LGBT Awareness Survey shows improvement in baseline scores recorded.	Article featured in WWL News ED&HR Week 10-14th May. IDAHO 17th May 21 – Article featured in WWL. Rainbow Flag flown. Transgender Day of Remembrance 2021 featured in WWL and Rainbow Flag flown. Pronouns event advertised to staff Oct 21	On-going

Equality Objective 2 - Improved Patient Access & Experience

To ensure patients are communicated with in a manner that is appropriate to their specific need or requirement.

5.	Action(s)	Outcome	How Measured	Issues / Concerns / Progress	Target Date
Interpreter & Translation Services					
5.1	Raise staff awareness of interpreter and translation services protocol.	Increased staff awareness of how to access interpreter and translation services. Improved patient experience.	Follow-Up Staff Interpreter Awareness Survey shows improvement in baseline scores recorded.	Communications issued. On-going promotion of interpreter and translation services	Aug 21
5.2	Review and Update Staff Interpreter Handbooks.	Increased staff awareness of how to access interpreter and translation services. Improved patient experience.	Follow-Up Staff Interpreter Awareness Survey shows improvement in baseline scores recorded.	Handbooks updated and uploaded on Intranet.	Jul 21
5.3	Replace current video remote BSL interpreting provision in A&E and Maternity services with current F2F service provider DA Languages. During COVID service BSL Health Access was launched free of charge - SignHealth were optimistic that NHS England or another government body would pay for the service in due course. This is now not the case. Service ceased from 1st April 2021.	Access to BSL Signers in emergencies / unplanned hospital attendances.	Patient and Staff feedback. Activity Reports	Specification and configuration requirements requested from DA Languages – delayed due to GM Interpreter Services Tender. New agreement will include video remote interpreting.	Nov 21 On-going
5.4	VRI BSL Interpreting to be rolled out to other areas, when fully implemented in A&E and Maternity – funding to be sourced for dedicated IPADS.	Instant access to BSL VRI Interpreting	Patient and Staff feedback. Activity Reports	Potential for funding to be sourced from PLACE Funds for IPADs. New GM Interpreter Services Tender to include video remote interpreting.	Mar 22 On-going
5.5	VRI Interpreting for BSL and other languages to be embedded within Attend Anywhere Patient Clinics	Provision of Face to Face Interpreters available within Attend Anywhere practice.	Patient and Staff feedback. Activity Reports	New GM Interpreter Services Tender to include video remote interpreting.	Mar 22 On-going

5.6	Dual Sensory Awareness Training to be re-launched.	Increased staff awareness. Improved patient experience.	Patient feedback	Been on-hold due to COVID and staff redeployment.	Mar 22
5.7	Review the feasibility of developing an autism friendly kit on each hospital site (including A&E).	Improved patient experience for patients with autism.	Patient Feedback.	Been on-hold due to COVID 19 and staff redeployment.	Mar 22
5.8	Progress Implementation of **Accessible Information Standard.**	Increased progress in working towards meeting the requirements of the Accessible Information Standard (published by NHS England).	AIS Action Plan	Although controls implemented to demonstrate compliance with some aspects of AIS, no consistent approach Trust wide. Patients could have their information and communication needs met for some services, but not for others. Requirement for standalone systems to be reviewed recorded. In March 2021 changes made to incorporate the capture of accessible information requirements in PAS for elective in-patients and out-patients - Risk Assessment Score reviewed and reduced.	Mar 22 On-going
5.9	Annual Review of AccessAble (On-line Information Guides). To promote accordingly and raise patient & staff awareness further.	Increased public awareness of AccessAble and provision of WWL on-line information access guides. Patient feedback / improved patient access and experience. Increased provision of accessible information.	Activity Reports	AccessAble Surveys undertaken March 22. Estates Lead identified to co-ordinate future surveys. Funding secured for a further 5 year contract with AccessAble.	Mar 22
5.10	To provide PPI and E&D input and support for the implementation of the Project In-touch – supporting safe out-patient face to face services	Reduction in overcrowding of waiting areas and clinical rooms. Unsafe social distancing minimised. Reduction in cleaning of waiting areas. Helps to improve infection prevention and control measures	Patient feedback	workstream dedicated to PPI and E&D. Patient focus group set up. Feedback obtained.	Mar 22

Equality Objective 3 – A Representative & Supported Workforce

3.3 Training & Development Opportunities are taken up and positively evaluated by Staff

6.	Action(s)	Outcome	How Measured	Issues / Concerns / Progress	Target Date
6.1	To research into barriers and develop inclusive management programmes, enabling staff from protected groups to have equal access to career progression and progression to senior bandings. Potentially Springboard – VSM Training BME Leadership Module within WWL Leadership Programme	More reflective representation of BME & Female VSM staff across the workforce.	Improvement in WRES assessment scores Metric 4. Improved Staff Survey Results	Research into barriers for career progression needed before deciding most appropriate programmes. Could be discussed at staff network when set up. BME Leadership Modules – Leadership Academy Programme paused during Covid. Once open raise awareness and monitor take up. 27/10: provider that they hope to restart programme early 2022. Emailed for an update 05/04. Talent programme in final phase of design and scrutiny ready for pilot launch in Q3 2022-23	Mar 22
6.2	Review and develop current Training Evaluation System incorporating 3 step approach.	Robust meaningful evaluation process which will guide future development of training within the Trust.	Improved Staff Survey Results Improve EDS score for objective 3.	Learning Needs Analysis completed	Mar 22

Equality Objective 4 - Inclusive Leadership at all levels

4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations

7.	Action(s)	Outcome	How Measured	Issues / Concerns / Progress	Target Date
7.1	Regular Video blogs from executive leaders covering a range of EDI initiatives including encouraging colleagues to contribute to the draft EDI strategy, to take part in Wigan Pride etc.	Staff feel more connected to the executive team and the importance of EDI issues are demonstrated by senior leaders	Staff engagement with EDI initiatives will increase.	Regular	March 22

7.2	Executive sponsors appointed for FAME network (network for ethnic minority colleagues and their allies), Disability/LT Health Conditions network and LGBTQIA+ Network	Diverse voices are amplified and escalation routes are clearer	Improved Your Voice survey results Improved influence of colleague diversity networks	Appointed FAME, LGBTQIA and Disability exec sponsors and all started on training programmes	March 22
7.3	Weekly wellbeing walkabouts by WWL executive colleagues to encourage a listening culture.	Senior leaders will listen to colleagues at all levels about the culture in their work areas and highlight to relevant colleagues when issues are highlighted.	Improved Your Voice survey results	Regular	Dec 21
7.4	Appoint an EDI lead for workforce	New EDI Strategy will be written, to incorporate EDI Objectives for the next 4 years	Appointed to role EDI Strategy written	In post from July 2021	July 21
7.5	Execs working with Healthy Wigan Partnerships	Partnership working across the GM footprint on EDI issues	Improved connections across GM	Picked up as part of community wealth building and anchor inst prog.	Ongoing

Actions carried over from 2018/19 Action Plan

Equality Objective 3 – A Representative & Supported Workforce To reduce inequalities experienced by staff and applicants from a BME background						
8.	**Action(s)**	**Outcome**	**How Measured**		**Issues / Concerns / Progress**	**Target Date**
8.1	In collaboration with Staff Engagement, to implement a programme of focused BME Listening Events so as to provide opportunities for people to share, learn and contribute to improving the Trust. To progress actions developed from 2018 BME Focus Group 1. Prayer/Ablution Room at Buckingham Row 2. Time off for religious events 3. Lack of Training Opps	To enable BME staff to have an ongoing forum to have suggestions, comments and concerns listened to and acted upon.	Improvement for EDS Objective 3 assessment score. Improvement in WRES assessment scores Metric 4 Improvement in Staff. Engagement Scores.		Reviewing overall accommodation in Buckingham Row –further review to be made due to impact of Covid and staff working from home. Given time passed since issue raised and impact of covid / agile working, item to be revisited at future FAME event to understand if still required. Policy reviewed-comments going to Policy Development Group however feel flexibility already built into policy. Action completed in previous year. Training Data Triangulated with Staff Survey data, information does not correlate as more BME staff received training & dev than White staff groups. Action completed in previous year. Talent progression work will aim to identify barriers such as these and will be tackled if it comes out as a theme. FAME network now embedded	March 2022

Local Objectives - Linked to People Strategy Objective No.3 Go Engage (People)

I&D - WWL is an employer that values diversity and inclusion demonstrated by our workforce at all levels being representative of the community we serve:

- Reducing the gender pay gap by 5% / Improvement in WRES
- Improvement in the WDES
- Talent & succession plans aligned to ED&I ambitions

9.	Action(s)	Outcome	How Measured		Issues / Concerns / Progress	Target Date
9.1	Analyse Gender Pay Gap information by division and develop action plan to facilitate reduction in gender pay gap in 2019/20. 1. VSM Female Focus Group 2. Publicising Stories of VSMs 3. Springboard (Women's Development Programme) 4. Review EDS Survey format to include questions around Gender pay gap issues.	Reduce Gender Pay Gap by 5% in line with objective developed within Interim Plan	Improvement in % of Gender Pay Gap 2020 report		VSM Focus Group - met to discuss. develop format and agree dates – delayed due to Covid Stories – one story published in Focus Jan 19. One not published due to covid. See 6.1 – delayed for further research Work paused due to prioritising other EDI areas (EDI Strategy and Staff Networks)	March 2022
9.2	Drill down BME and Disability Shortlist to appointed ratios 2020/21 in order to identify any potential issues.	To identify any specific issues and develop any potential actions.	WRES % improvement in Indicator 2 and improvement in WWL recruitment stats.		Recruitment data for 2020-2021 is not reliable. Reports can't be re-run due to months dropping off system. To be built into ongoing analysis going forwards	Mar 20
9.3	Review current Recruitment Training to include prejudice and bias for Consultant Interviews	Ensure interview panel members undertake I & D related training with regards to bias and prejudice	WRES % improvement in indicator 2 and improvements in WWL Recruitment stats.		reviewed current training programme for Recruitment revised to include prejudice and unconscious bias. to escalate for approval. On hold due to Covid. Postpone as will be picked up during 2022-2023 recruitment project.	Mar 23

9.4	Development of I & D Leadership Masterclass	I & D Leadership Masterclass to be run as part of overall Masterclass Programme	Improvements in Staff Survey Results		Delayed due to Covid. Training programme commencing with Board and Shadow Board in November 2022. Senior leaders workshop delayed (period of national mourning). Rescheduled October 2022. Staff diversity network events – raising awareness through lived experience	Mar 22
9.6	1. Drill down staff survey 2020 Bullying & Harassment % figures to identify any specific issues around BME & Disability characteristics. 2. Launch of just culture programme. This will include a focus on any bullying / harassment, civility saves lives, embedding within performance management frameworks and a zero tolerance programme in relation to physical and verbal abuse of employees.	To identify any issues and develop any potential actions. Raise awareness of bullying and harassment within the Trust.	Improvements in Staff Survey results 2021. Improvements in Staff Survey results 2021 and WRES Metrics 5, 6 7 & 8 and WDES Metric 4. Reduction in dignity at work cases for 21-22, Corporate had high amount during 20-21.		Delayed due to Covid. Drilled down 2020 survey figures and discussed at FAME network 21/06/21. No negative experiences shared during the event Continue to explore this via staff networks. Launched in March 2020 but ongoing work during 2020-2021 around just and learning culture, toolkit and behaviour framework published.	June 2021 Mar 2021
9.7	Review of current Disciplinary Process following NHSE/I of recommendations made to Trusts in Dec 2020 following the review into the death of Mr Amin Abdullah.	Person centred disciplinary policy including support proforma EDI Work Plan - We are open and honest and staff have a voice.	Improvements in Staff Survey results 2021.		New policy ratified and support proforma being used. All cases go through exec review panel.	Mar 21
9.8	Strengthen the existing FAME network and launch Disability and long term health condition and LGBTQIA+ networks	To have influence over the changes that are required to enable WWL to become a more inclusive workplace.	Rainbow Badges Awards Scheme Disability Confident / WDES score improvements		Trust Management Committee agreed on 03/11/21 to new structure and remit of staff networks, plus protected time for	Nov 21

		Enable colleagues to work in partnership with senior management and the board to make decisions that affect them. To help to raise awareness of the lived experience of those from minority groups. To act as a safe space to network with others who share the same protected characteristic.	Race Equality Code / WRES score improvements More robust EIAs Your Voice survey results		network committee members	

Appendix 2 - Compliance against National Standards - Dashboard

Equality National Standards	Requirements	Update	RAG Rating
Equality Act 2010: **Public Sector Equality Duty - General Duty**	Must provide evidence that we have given 'due regard' to the three aims of the General Duty across all 9 protected characteristics: • Eliminate unlawful discrimination, harassment & victimisation • Advance equality of opportunity • Foster good relations	Equality Impact Assessments provide evidence-based assurance of how the Trust is identifying and addressing any existing or potential inequalities across all 9 protected characteristics.	
		Evidenced within Annual EDS Action Plan.	
Equality Act 2010: **Public Sector Equality Duty - Specific Duties**	Must publish relevant, proportionate information demonstrating compliance with the Equality Duty by 31st January of each year. Must set four-year equality objectives, based on key local equality priorities. Must analyse the effect of policies and practices on equality.	EDI Annual Monitoring Report 2020/21 drafted and reviewed at Workforce Committee in November 2021. Has been published on the Trust Website by the deadline of 31/01/22.	
		EDI Strategy 2022-2026 developed and was published in January 2022. Discussions are currently taking place to agree the patient and people objectives we will be focussing on during the year ahead.	
		Equality Impact Assessments provide evidence-based assurance of how the Trust is identifying and addressing any existing or potential inequalities across all 9 protected characteristics.	
Equality Delivery System (EDS2) NHS Standard Contract Requirement	Must comply with the Mandatory Equalities Reporting Framework for the NHS. Must undertake in partnership with local stakeholders, to review and improve performance for people from protected groups.	**When assessing and grading performance against 18 EDS Outcomes, guidance now stipulates that NHS organisations can choose to look at just one or a few aspects of their work, rather than looking across the entirety of all they do**. Given the number of services provided by the Trust and the 18 outcomes within EDS2, a phased implementation of EDS2 was agreed. 4 outcomes reviewed each year. One for each of the four goals. In March 2022 the Trust undertook its 10th assessment of performance against the EDS. From the evidence reviewed, it was proposed that Outcomes 1.4 and	

Embedded within CCG Assurance Framework & CQC Inspection regime.		2.2 be graded as **'achieving'**. Evidence can be provided for 6 to 8 protected characteristics for these outcomes. There is little evidence from the data of any groups of patients who fare less well. Healthwatch Wigan and Leigh agreed with our scores. Staff related assessment delayed due to staff survey results not being available. Sent for peer review April 2022.	
Equality National Standards	**Requirements**	**Update**	**RAG Rating**
Work Force Race Equality Standard (WRES)	Must demonstrate through the 9 Point Work Force Race Equality Standard (WRES) metric how we are addressing race equality issues in a range of staffing areas. Must demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of BME Board representation.	Completed and submitted August 2021. The report has been published on Trust's internet web page. Indications show: BAME staff were more likely to enter the formal disciplinary process compared to White staff. An improved percentage of BAME staff that believe the Trust provide equal opportunities for career progression or promotion. Indications show: More White staff reported experiencing harassment, bullying or abuse from patients, relatives, the public, or staff in last 12 months, the position had improved for BAME staff. BAME staff experience higher levels of bullying, harassment and abuse from other staff compared to White staff.	
Disability Work Force Equality Standard (WDES)	• A set of specific measures to enable us to compare the experiences of disabled and non-disabled staff. • Research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety. • Will form part of NHS Standard Contract. • WDES will enable us to better understand the experiences of disabled staff. It will support positive change for existing employees, and enable a more inclusive environment for disabled people working in the NHS. • August 2019 publication date for Trusts. • April / May 2020 publication of first national annual WDES report.	Completed and submitted August 2021. The report has been published on Trust's internet web page. Indications show: Disabled staff were more likely to enter the formal capability process compared to non-disabled staff, as measured by entry into the formal capability procedure (excluding ill health capability). A decrease in the percentage of disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. An increase in the number of disabled staff stating that their employer has made adequate adjustment(s) to enable them to carry out their work. Indications show: Disabled staff experience higher levels of bullying, harassment and abuse from patients/service users, their relatives or other members of the public, managers, and colleagues. Compared to the previous year, the percentage had slightly improved in relation to colleagues and patients/service users, their relatives or other members of the public.	
Gender Pay Gap Reporting	In line with the Gender Pay Gap regulations, the Trust published its gender pay gap data by the 31st March 2022.	Completed and published on Trust's internet web page. The Trust data has highlighted there is a gender pay gap within the Trust with women across the	

	The information is published on the Government website and on the Trust`s own website so that it is openly available for review. All organisations with 250+ employees are required to publish their data and there has been national press interest in the gender pay gap issue as the deadline approaches.	average, median and bonus gap being paid less than males. There has been an improvement to the average hourly rate gap and the median hourly pay gap is comparable to the previous year. The Trust has analysed its data and produced a supporting report which outlines the factors which contribute to the gender pay gap and this was discussed at Workforce Committee in March 2021.	
Equality National Standards	**Requirements**	**Update**	**RAG Rating**
Accessible Information Standard (SCCI1605) **(for people with a disability, impairment or sensory loss)** By law (Section 250 of the Health and Social Care Act 2012), all organisations that provide NHS care or adult social care must follow the Standard in full from 1st August 2016 onwards.	The Accessible Information Standard aims to ensure that disabled people have access to information that they can understand and any communication support they might need. The standard tells organisations how to make information accessible to patients, service users and their carers and parents. The standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss. **<u>Existing controls implemented to date:</u>** **Functionality identified on PAS to enable the recording of patient's needs (RPN).** AIS Codes developed and added to RPN. **IT Solution identified for one aspect of AIS - Ensuring all letters which are routed via Synertec are printed in the patient's preferred format.** WWL worked with Synertec to implement 'capture and share' system which facilitates the capture and acting upon information needs for all letters that are routed through synertec. Appointment Centre staff ask patients if they have any communication needs and record accordingly. **On-line Appointment Booking webpage** amended to include reference to communication / information needs. **Communication difficulties / impairments captured within nursing admission documentation.** Recorded on HIS System under 'activities of daily living assessment'. Visible to clinical staff during in-patient stay. **Access to Face to Face British Sign Language Interpreters available.** Services recently reviewed and new provider sourced and implemented from January 2020. **We now have video remote access to British Sign Language**	WWL is continuing to make progress in relation to meeting the core requirements of the Accessible Information Standard. • In March 2021 changes were made to incorporate the capture of accessible information requirements in PAS for elective in-patients and out-patients. • In April 2022 - A&E registration amended to provide ability to collect patient's needs (*Action addressed within a number of other required updates and scheduled into current resources, so no additional costs incurred (£12,000 projected not required).* Although many controls have now been implemented to demonstrate compliance with the AIS, currently there is no consistent approach Trust wide (across all 140 standalone systems). Patients could have their information and communication needs met for some services, but not for others. **Risk Assessment Score reviewed in March 2021. Due to new controls put in place, Score reduced from 15 to 20. At Patient experience Improvement committee in March 2021, agreed should be added to Corporate Risk register. Reviewed by Associate Director of Governance in July 2021, risk need to be rearticulated using new scoring matrix and include list of existing controls. Assigned score of 9. Risk Reduction Action Plan updated.** Future IM&T application submissions for system requirements to ensure AIS requirements are considered at WWL.	

	Interpreters in A&E & Maternity Services. A dedicated IPAD can be accessed from Reception Staff. **Capture of accessible information requirements now incorporated in PAS for elective in-patients and out-patients**. This information passes into HIS and is visible in the patient's information tab.		

Equality National Standards	Requirements	Update
Sexual Orientation Monitoring Standard Published 5th October 2017.	The Sexual Orientation Monitoring Information Standard provides the mechanism for recording the sexual orientation of all patients/ service users aged 16 years and over across all health services and Local Authorities with responsibilities for Adult social care in England in all service areas where it may be relevant to collect this data. The standard acts as an enabler for the Equality Act 2010, supporting good practice and reducing the mitigation risk for organisations required to comply with the Act. All public sector bodies have a legal obligation to pay due regard to the needs of (LGB) people in the design and delivery of services, and to ensure that people are not discriminated against based upon their sexual orientation. Health and Care Organisations must review the impact of this information standard and make appropriate changes to local health IT Systems from 5/10/17 and before 31/03/19.	**This standard provides the categories for recording sexual orientation but does not mandate a collection.** All new data sets with a business requirement to collect sexual orientation data will be expected to adopt this sexual orientation monitoring (SOM) fundamental standard, and existing data sets already reporting SEXUAL ORIENTATION CODE will be required to change to the new values at their next iteration. This Change Request adds the supporting definitions and values for Person Stated Sexual Orientation to the NHS Data Model and Dictionary to support the Sexual Orientation Monitoring Information Standard. PAS Update (Patient Centre) includes a field in which sexual orientation can be recorded. **As data not already recorded routinely within the Trust, guidance stipulates not a mandatory requirement. Standard requirements to be embedded within any changes to future operational protocol.**