Board of Directors - Public Meeting

Wed 02 February 2022, 13:15 - 16:15

MS Teams

Agenda

15. Declarations of Interest

Information *Mark Jones*

16. Minutes of Previous Meeting

Decision *Mark Jones*

16. Minutes - Public Board - Nov 2021.pdf (9 pages)

17. Ratification of use of emergency powers

Information *Mark Jones*

18. Chairs opening remarks

Information *Mark Jones*

Verbal item

19. Staff story

Discussion *Alison Balson*

Verbal item

20. Chief Executive's report

Information *Silas Nicholls*

21. Committee chairs' reports

Information *NEDs*

Verbal item

22. Board assurance framework

Discussion *Paul Howard*

22. Report - Board - BAF Feb 2022.pdf (37 pages)

People

23. Safe nursing staffing report

Discussion *Rabina Tindale*

23a. Safe Staffing Report for Feb board_final.pdf (12 pages)
23. Safe Staffing Report for December 2021 TB version.pdf (13 pages)

24. Safe medical staffing report

Discussion *Sanjay Arya*

24. Medical Safe Staffing report Jan 22 Updated .pdf (6 pages)

25. Biannual nurse staffing review

Discussion *Rabina Tindale*

25. Bi-annual Staffing Review for Feb Board_ (002).pdf (18 pages)

Patients

26. Maternity dashboard report

Discussion *Rabina Tindale*

26.Maternity Dashboard report Dec 2021.pdf (5 pages)
26c. Materity Dashboard Data Sheet December 2021.pdf (1 pages)
26. Dec 2021 Maternity Dashboard 2021.pdf (2 pages)
26b. Regional Dashboard December 2021.pdf (2 pages)
26a. Dec 21 Board Provider report.pdf (3 pages)
26.Maternity Board Provider Report December 2021.pdf (5 pages)
26. Mat CoC Building Blocks Plan.pdf (15 pages)

27. IPC board assurance framework

Discussion *Rabina Tindale*

Paper to follow

28. Q3 2021/22 Learning from deaths report

Discussion *Sanjay Arya*

28. Mortality Report Q3 2021_2022 Final2.pdf (9 pages)

Performance

29. Performance Scorecard

Discussion *Rabina Tindale/Sanjay Arya/Mary Fleming*

29. Board of Directors M9 2021 Scorecard.pdf (4 pages)

30. Finance report

Information *Ian Boyle*

30. Board Report 21-22 December month 9 Public.pdf (2 pages)

Consent agenda

31. Freedom to Speak Up Guardians report

Information

31.GSL Q3 report Oct -Dec 21.pdf (6 pages)

32. Close

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

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

HELD ON 24 NOVEMBER 2021, 12.00 NOON

BY VIDEOCONFERENCE

Present:	Mr M Jones	Chair (in the Chair)
	Mr S Nicholls	Chief Executive
	Prof C Austin	Non-Executive Director
	Mrs A Balson	Director of Workforce
	Mr I Boyle	Chief Finance Officer
	Lady R Bradley DL	Non-Executive Director
	Ms M Fleming	Deputy Chief Executive
	Mr I Haythornthwaite	Non-Executive Director
	Mr P Howard	Director of Corporate Affairs (minutes)
	Mrs L Lobley	Non-Executive Director
	Mrs A-M Miller	Director of Communications
	Mr R Mundon	Director of Strategy and Planning
	Ms R Tindale	Chief Nurse
	Mrs F Thorpe	Non-Executive Director
	Mrs A Tumilty	Non-Executive Director
In attendance:	Dr M Farrier	Associate Medical Director
	Mrs L Sykes	Public Governor (observer)

The Board reconvened following an adjournment.

137/21 Declarations of interest

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

138/21 Minutes of the previous meeting

The minutes of the previous meeting held on 29 September 2021 were **APPROVED** as a true and accurate record.

With regard to minute reference 117/21 and the intention to present a medical safe staffing report in a similar way to the safe nurse staffing report, the Director of Workforce noted the importance of the roll-out of the e-roster system to provide data in a timely and accurate way. She therefore noted the proposal to delay reporting until this is fully rolled out and noted that this had already commenced in a number of areas across the foundation trust. In response to a question from the Chair, the Director of Workforce suggested that it may take 6 to 9 months to complete the roll-out. The Associate Medical Director supported this estimate and the Board agreed to this approach.

139/21 Patient story

The Chief Nurse introduced the patient story, which was provided in the form of a video featuring the daughter of one of the foundation trust's patients who had been discharged to a nursing home where she sadly died two days later. The Board heard about the challenges faced by the patient's family whilst in the foundation trust's care; particularly around the response provided to the complaint that had been submitted. The complaint had highlighted deficiencies in communication whilst an in-patient and in relation to the discharge process.

The Chief Nurse acknowledged the challenges described in the patient story and noted that some steps, including the reinstatement of the paused Patient Experience Group, would hopefully go some way to ensuring oversight of such issues in the future. She did, however, note the comments in the video about the need to share and embed learning to prevent reoccurrence.

In response to a question from Mrs Thorpe around how patients are supported to communicate with relatives, the Chief Nurse noted the use of iPads during the pandemic and the intention to reintroduce patient visiting in areas where that is deemed to be clinically appropriate. Mr Haythornthwaite acknowledged this, but also noted that some of the comments in the video suggested that incorrect information had been provided to the family. The Chief Nurse acknowledged this and briefed on the work being undertaken to share the learning on this important topic.

Mrs Lobley commented on a lack of compassion in the story being shared and suggested that the care appeared fragmented. The Chief Nurse noted the need to revisit the matter of communication more generally.

The Board received the report and noted the content.

140/21 Chief Executive's report

The Chief Executive opened by welcoming the Chair on behalf of the Board to his first formal meeting since taking up post. He noted that the traditional period of winter pressure had arrived and had been compounded by pandemic-related challenges. He noted the emphasis being placed on ambulatory care, with the introduction of a Same Day Emergency Care area for medical patients, to complement the surgical area already in place. He reminded the Board that an enhanced respiratory care unit had also been opened on the Royal Albert Edward Infirmary site at the end of September 2021.

The Chief Executive noted the intention to establish the Jean Heyes Reablement Unit on the Leigh Infirmary site, which would provide 24 beds to support patient recovery in an appropriate setting. He also noted the work that the foundation trust is involved in around the 12 to 15 year-old vaccination programme and staff booster vaccinations, recognising the role of the Director of Strategy and Planning in leading this work and thanking all staff for their continued hard work and dedication.

With regard to mandatory vaccinations for health and care staff, the Chief Executive noted that all staff are encouraged to access COVID-19 vaccinations but that a number

of colleagues remain hesitant about doing so. He highlighted the timescales associated with this, and in particular the need for all staff to have received their first dose of the vaccination by early February 2022. He advised that c.250 clinical staff were yet to receive the vaccine and confirmed that focused discussions will be taking place with all affected staff. The Director of Workforce confirmed that the matter is reviewed on a daily basis and that a dedicated team is making contact with all staff who are not yet fully vaccinated and signposting them to the booking service where necessary. Where staff express concerns, relevant support is being provided to seek to allay their concerns.

The Board received the report and noted the content.

141/21 Committee Chairs' reports

Mrs Tumilty provided a verbal summary of the business transacted at the meeting of the Finance and Performance Committee earlier in the week. She noted that the committee had considered the financial plan for the second half of the financial year and approved a number of business cases in relation to projects that will address areas of risk to the organisation. In addition, she noted that the committee had reviewed performance, particularly in relation to elective recovery and emergency and urgent care.

Mrs Thorpe provided an overview of the most recent Quality and Safety Committee held on 10 November 2021. She noted that the committee had received a report on pressure ulcers and confirmed that evidence of improvement had been seen, whilst noting the challenges around data collection and reporting associated with the wider corporate objective on this topic. With regard to improvements around sepsis and mortality, clear progress had been noted by the committee but it had also noted the need to ascertain clear baseline data in order to be able to demonstrate the level of improvement made. Progress with the ward accreditation scheme had also been reviewed, including a good level of assurance of forecast compliance before year-end.

Mr Haythornthwaite advised that the Audit Committee had recently met and had reviewed a number of matters relating to overall governance. He confirmed that there were no matters to escalate to Board and confirmed that the committee had received a helpful update on progress with recommendations arising from previous internal audit reports. The committee had also received confirmation from the new external auditors that the handover from the previous auditors had progressed smoothly.

The Board received the report and noted the content.

142/21 Board assurance framework

The Chair referred directors to the board assurance framework report which had been circulated with the agenda. He highlighted the fact that much of the content had been reviewed by the committees responsible for each dashboard and outlined the link between the board assurance framework and the delivery of the wider, 10-year strategy for the organisation by allowing the Board to monitor progress against the corporate objectives that have been set for the current financial year. He requested, however, that those identified as lead directors for each objective focus on ensuring that the narrative

is regularly refreshed, and in particular that the dates in the 'evidence last seen' column of the report are recent ones.

The Board considered each of the dashboards in detail and a number of comments were provided. With regard to a digital strategy, the Deputy Chief Executive noted that this had been developed and was currently subject to consultation, with the intention of presenting to the Board at its next workshop session for further scrutiny and challenge.

The Director of Strategy and Planning also took the opportunity to provide an update on research activity and the foundation trust's aim to achieve university hospital status. Prof Austin noted the recent publication of new guidelines by the University Hospital Association and suggested the need to consider any new risks for consideration, to which the Director of Corporate Affairs responded that the Medical Director had established a dedicated Programme Board to ensure oversight of this issue.

The Board received the report and noted the content.

143/21 Maternity reports

The Chief Nurse presented a suite of reports relating to maternity, as recommended in the Ockenden review of maternity services. She noted that good levels of compliance continue to be reported within the dashboard and confirmed that no cases had been reported to Healthcare Safety Investigation Branch during the period. The Chief Nurse also drew the Board's particular attention to the requirement to undertake a safety champion's visit, involving the Chief Nurse and the lead Non-Executive Director for maternity services, and confirmed that this would be undertaken during December 2021 or January 2022, with Lady Bradley attending on behalf of the lead Non-Executive Director who is currently unable to participate on medical grounds.

The Chair noted that the report referenced a meeting with the Regional Chief Midwife during the month and the Chief Nurse confirmed that the foundation trust's submission had been accepted. In response to a question from Mrs Lobley around continuity of care, the Chief Nurse noted the national scale of the issue and confirmed that work continues with the teams to address this.

Mrs Thorpe highlighted that the narrative of the report talks about staffing challenges but noted that this does not feature as a specific risk. She queried whether this was because recent recruitment mitigated this, to which the Chief Nurse confirmed that the position had improved somewhat.

The Board received the report and noted the content.

144/21 Safe staffing report

The Chief Nurse presented a report which had been circulated with the agenda to provide assurance around the ongoing monitoring of nurse staffing levels and the triangulation of staffing levels with quality, safety and patient experience across inpatient areas in line with national requirements. She noted the recent investment by

the Board in supernumerary ward leaders and additional international recruitment; both of which will continue to support improvements to the overall position.

Mrs Thorpe commented on the usefulness of triangulating staffing levels and patient harms. She noted the references to international recruitment and queried whether this would assist in areas such as district nursing, to which the Chief Nurse described the intention to provide opportunities for additional support to be provided to district nursing. In response to a question from Mr Haythornthwaite around registered nursing levels and the regulatory view, the Chief Nurse commented on the importance of being able to demonstrate that, holistically, the standard of care provided by the foundation trust is not compromised as a result.

Mrs Tumilty asked how the intended level of international recruitment would affect the ratio of registered-to-unregistered nurses, to which the Chief Nurse replied that this would be an important element of the wider staffing review which would be presented to the Board in due course.

Prof Austin noted that there also seemed to be a national issue not only with the level of midwife retirement but also with qualified midwives leaving within two years of commencing in role. She noted the reference in the report to retirements and queried whether the foundation trust had been similarly impacted by leavers. In response, the Chief Nurse advised that this had not been a significant issue and confirmed that significant work is undertaken around preceptorship and providing support to staff.

The Board received the report and noted the content.

145/21 Wellbeing and people pledges

The Chair opened this item by noting that he had attended a regional meeting in September where the matter of wellbeing and people pledges had been discussed and noted that a recorded presentation had been circulated to directors for review in advance of the meeting. The Director of Workforce noted that the programme had been coordinated by directors of human resources but iterated that it had been developed in partnership with staff side organisations and national subject matter experts. She also highlighted the involvement of colleagues from across the NHS in sharing their stories.

The Director of Workforce noted that the Board was being asked to consider signing up to a number of pledges which had been included within the report, as well as to consider equality, diversity and inclusion in doing so. In particular, she noted that a clear link to a just culture and a civility framework would be of real importance, as well as a need to focus on presenteeism as well as absenteeism.

In response to a question from Mr Haythornthwaite around a system-wide approach, note was made of the fact that the intention is to roll-out the frameworks on a regional basis and the Director of Workforce confirmed that there was a high level of support for this.

The Board **SUPPORTED** the approach and the specific pledges and agreed that these could be signed on its behalf. In response to a question from the Chair around visibility

of the Board in supporting this, the Director of Workforce agreed to work with the communications team outside the meeting; noting that it also fits well with the wider Our Family, Our Future, Our Focus programme.

146/21 Equality, diversity and inclusion strategy

The Director of Workforce presented the draft Equality, Diversity and Inclusion Strategy for approval, noting that it would be subject to graphic design prior to being published. She emphasised the importance of developing annual objectives for all senior leaders around delivery of the strategy, to ensure that it is a key element of the organisation's approach.

In response to a question from Mrs Lobley around support from partners, the Director of Workforce described areas where real and significant collaborative work had been undertaken and some areas where this could be further improved. The Director of Strategy and Planning also described the work that is ongoing across Wigan as an anchor institution and analysis of the elective recovery programme based on a number of different metrics. The Chief Executive also confirmed that there is a real recognition amongst Wigan-based organisations that there is a need to work collaboratively for the good of the population.

Mrs Tumilty highlighted a reference to learning disabilities within the report and suggested that additional focus on this could be developed, and similarly for mental health conditions.

The Chair summarised by noting that the detailed plans would be reviewed by the People Committee and the Quality and Safety Committee as appropriate.

The Board **APPROVED** the Equality, Diversity and Inclusion Strategy as presented.

147/21 Performance report

The Chair opened this item by noting the intention to review how data is presented to the Board, to allow for better analysis of trends.

The Deputy Chief Executive presented the performance element of the scorecard and reminded the Board of the current operational challenges which were affecting all NHS organisations. She noted that the level of COVID-19 in the borough had raised significantly and noted that the foundation trust's operational focus was on safety in the Accident and Emergency department and maintaining the elective recovery programme.

The Deputy Chief Executive confirmed that robust and realistic recovery plans had been developed and that it was currently performing well against these. In particular, she advised that the organisation was on track in relation to its forecast waiting list size and for delivery of 104-week forecast patient numbers; having the lowest such forecast in Greater Manchester. She confirmed that the foundation trust remained on track for its cancer performance forecast and was ahead of plan for reducing the number of 52-week waits on the elective waiting list.

In terms of unscheduled care, the Deputy Chief Executive advised that the foundation trust continued to have the best performing Accident and Emergency department in Greater Manchester, having met the England national average for Accident and Emergency performance in October 2021 and having been ranked 46th out of 110 acute trusts nationally.

Notwithstanding, the Deputy Chief Executive noted the risk that demand for unscheduled care may continue to increase and advised that a borough-wide winter plan had been developed, alongside a wider system winter plan. As part of this, 50 additional beds would be provided through same day and ambulatory care and through the use of the Jean Heyes Reablement Unit on the Leigh Infirmary site.

The Deputy Chief Executive noted that protection of the elective recovery programme had an associated benefit of supporting staff who work in this area, to give them increased confidence that they will be able to continue in their substantive role rather than being redeployed elsewhere in the organisation. Similar staff benefits from the use of alternative pathways and workforce models were also articulated.

The Director of Communications and Stakeholder Engagement briefed the Board on the communications that have been undertaken in support of NHS messaging and to raise awareness of the various teams and departments within the organisation. The importance of internal communications was also noted and confirmation was provided that this remains a real area of focus.

In response to a question from Mrs Lobley around the wider healthcare system, the Deputy Chief Executive noted that ambulance waiting times had been addressed via the Immediate See and Treat model, with the foundation trust continuing to release ambulance crews in a timely manner in the vast majority of cases. She noted the need to develop a Greater Manchester operational escalation framework and to set out organisational parameters of risk, and confirmed that discussions were ongoing in this regard.

The Director of Strategy and Planning briefed the Board on the development of updated scorecards and noted that the current performance report had been developed over a period of time, following engagement with the Board. He noted, however, that it would be beneficial to amend the dashboard to focus on critical success factors to make it more meaningful, and to include more information on benchmarks and trends. Particular emphasis was placed on developing a suite of board-to-ward metrics, to ensure that all levels of the organisation are considering the same issues of importance. The Director of Strategy and Planning confirmed that further work would be undertaken with lead directors and with a particular focus on the automation of data gathering wherever possible. He confirmed that a further update would be brought to the next meeting of the Board for consideration, with an intention to be able to provide real-time data as well as the ability to generate reports. He also noted the importance of fixing data sets for a period of time once agreed, both to allow for the automation to be developed and to ensure that analysis is more meaningful.

The Board received the report and noted the content.

148/21 Consent agenda

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

1. THAT the finance report as at 31 October 2021 be received and noted.

2. THAT the emergency preparedness, resilience and response core standards report be received and noted.

149/21 Date time and venue of the next meeting

The next meeting of the Board of Directors will be held on 2 February 2022 by videoconference.

Action log

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
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NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Board Assurance Framework update
Presented to:	Board of Directors
On:	2 February 2022
Presented by:	Director of Corporate Affairs
Prepared by:	John Harrop, Head of Risk Paul Howard, Director of Corporate Affairs
Contact details:	T: 01942 822027 E: paul.howard@wwl.nhs.uk

Executive summary

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

Link to strategy

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

Risks associated with this report and proposed mitigations

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

Financial implications

There are no financial implications associated with this report.

Legal implications

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

People implications

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

Wider implications

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

Recommendation(s)

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

1. Introduction

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

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

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

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

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

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

2. Strategic Objectives

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

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

3. Risk Rating Matrix

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

RISK RATING MATRIX (CONSEQUENCE x LIKELIHOOD)

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

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

4. Board Assurance Framework Review

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

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

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

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

5.2 An update to the actions planned section has been provided for all risks where the Director of Workforce is the designated Risk Lead.

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

6.1 The current risk score for the following risk has been reduced to the same score as its target risk score:

- Risk 1.1 (3265) Bed Base artificially inflates our SHMI

6.2 The Board are invited to consider accepting and de-escalating this risk from the Board Assurance Framework in February 2022.

7. Review Date

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

8. Recommendations

8.1 The Board of Directors are asked to:

- Review the risks and confirm that they are an accurate representation of the current significant risks to the delivery of the Trust's strategic objectives
- Approve the recommendation to reduce the risk score, tolerate and de-escalate risk 1.1 (3265) from the Board Assurance Framework as of February 2022.

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Board assurance framework

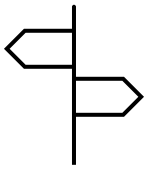
February 2022

The content of this report was last reviewed as follows:

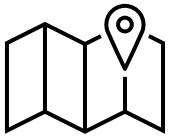
Quality and Safety Committee:	10 Nov 2021
Finance and Performance Committee:	22 Nov 2021
People Committee:	26 Jan 2022
Audit Committee:	16 Nov 2021
Executive Team:	16 Nov 2021

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

How the Board Assurance Framework fits in

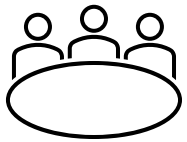


Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how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

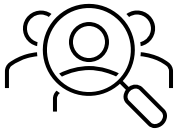


Corporate objectives: Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives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

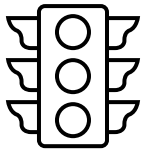
Board Assurance Framework: The board assurance framework provides a mechanism for the Board of Directors to monitor delivery of the agreed objectives by the Executive Team. It sets out the risks to achieving those objectives and provides a clear analysis of progress. It also provides a mechanism for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



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



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



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

Understanding the Board Assurance Framework

RISK RATING MATRIX (CONSEQUENCE x LIKELIHOOD)

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

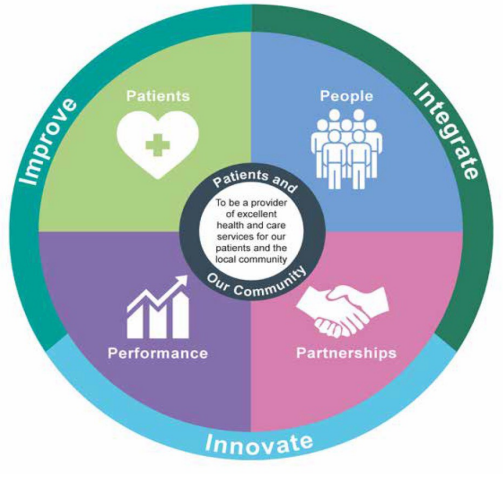
DIRECTOR LEADS

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

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

Our approach at a glance

Our Strategy 2030



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

FY2021/22:
A year of balance

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

Recovering from the impact of COVID-19

- Supporting our workforce
- Recovering the elective care programme

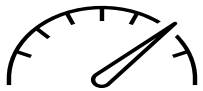
Progressing key elements of the strategy that make us unique

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

Ensuring we have a robust foundation to build on

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

Risk management

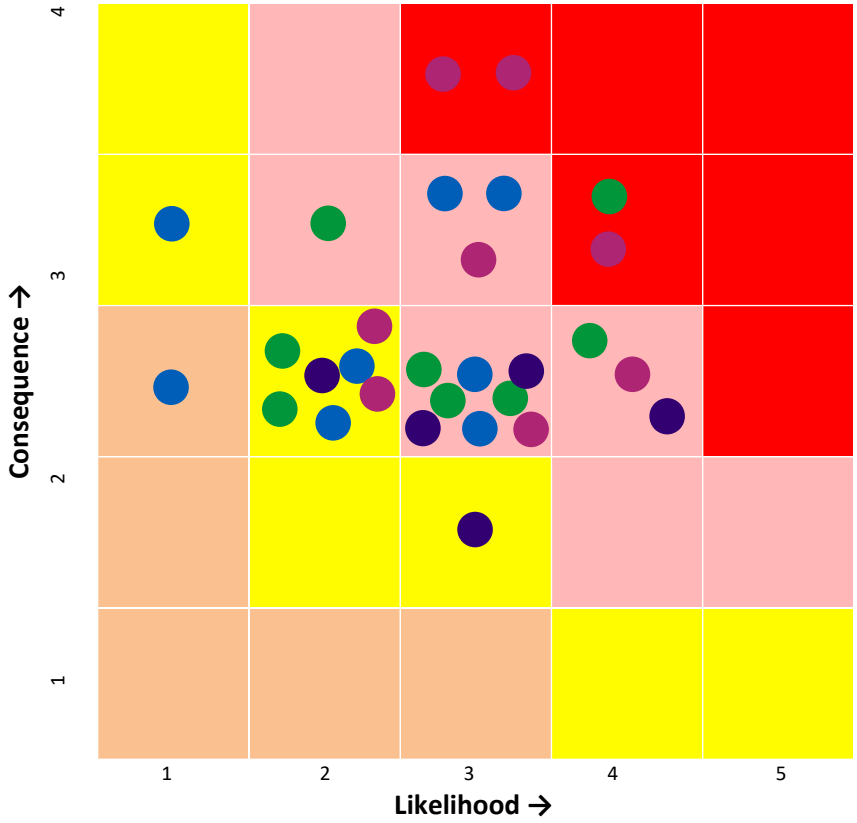


We recognise that it is best practice for organisations to have in place an agreed risk appetite statement to direct and govern decision-making at both Board and operational level. An agreed risk appetite sets the framework for decision-making across the organisation to ensure consistency of decisions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

Our risk appetite statement is as follows:

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

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



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

Patients

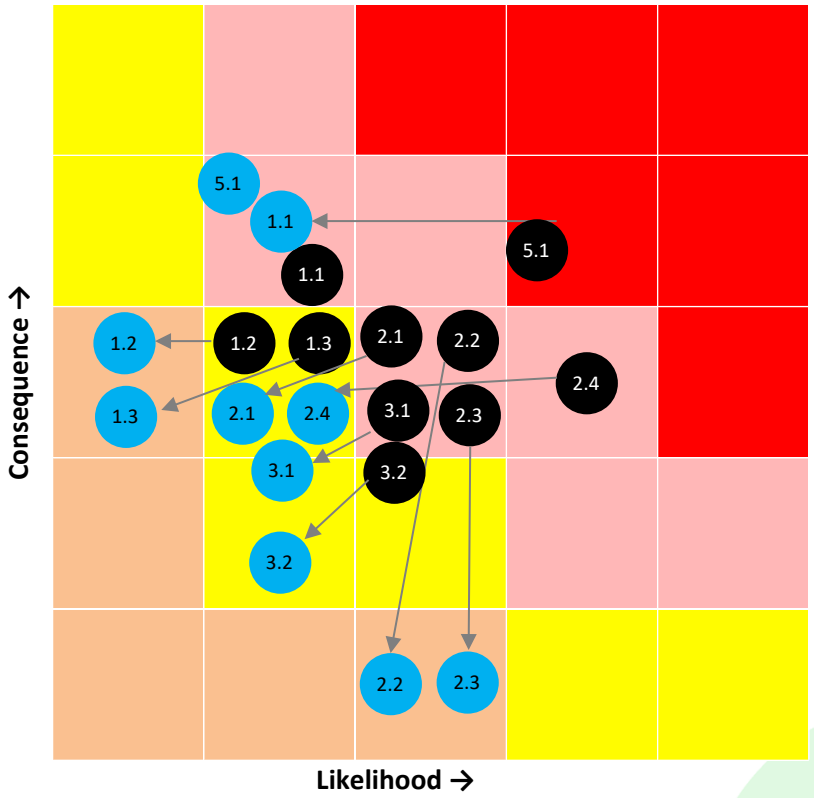
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

Monitoring: Quality and Safety Committee

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

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

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



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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
1.1 (ID 3265) Our bed base is the second lowest in GM and lower than the average general and acute beds per 100,000 population. As SHMI calculations are based on percentages derived from bed figures, there is a risk that this artificially inflates our SHMI.	L4 x C4 16 Significant	L2 x C4 8 High *(Score lowered from L3 x C3 = 9 Nov 2021)*	L2 x C4 8 High	Additional beds are available on Bryn Ward (51 beds) and Jean Heyes Reablement Unit (20 beds). Community Assessment Unit now open which will increase bed capacity (21 beds) for medically optimised patients. Bryn Ward funding approved and staffed Jean Heyes Unit (JHU) now open as escalation ward which will be included within the SHMI calculation	Jun 2021 Jun 2021 Dec 2021	Staffing model for permanent beds on Bryn Ward not funded, therefore the beds cannot be included in our bed base. Retrospective planning permission for Bryn Ward not yet obtained.	A business case to permanently fund the medical and nursing staffing model developed Funding for JHU nursing and medical staffing developed. Funding available till March 22. On-going funding discussions with CCG

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
1.2 (ID 3266) There is a risk that patients will present late or be readmitted following discharge due to the lack of a joined-up pathway between primary and secondary care.	L2 x C3 6 Moderate	L2 x C3 6 Moderate	L1 x C3 3 Low	Dedicated resource now in post to provide a link between primary and secondary care and a joint Mortality Improvement Plan has been developed. Progress is reviewed at Mortality Group. The Trust has moved over from Dr Foster to HED and setup of the system has been completed Mortality Board in place Mortality mandatory agenda item at Divisional Clinical Cabinet	Jun 2021 Jun 2021 Jun 2021 Jun 2021	A pathway for common conditions with high mortality needs to be developed and monitored through the Mortality Board	Community AKI pathway devised; further training requirement identified for community staff before launch. Community AKI pathway now live (16/11/21 Community sepsis pathway currently under development. Meetings commenced to develop audit tools to measure quality priorities and tests of change. LD and Community Paediatrics education planned for February 22.

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
1.3 (ID 3267) There is a risk that patients will return to hospital following a period of admission as a result of being discharged prematurely.	L2 x C3 6 Moderate	L2 x C3 6 Moderate	L1 x C 3 3 Low	Dedicated resource now in post to provide a link between primary and secondary care and working on a joint Mortality Improvement Plan. Monthly meetings with BI/Dr Foster/HED in place to review data Mortality Board in place Mortality mandatory agenda item at Divisional Clinical Cabinet Audit of deaths 30 days post discharge showed 98% patients discharged appropriately	Jun 2021 Jun 2021 Jun 2021 Jun 2021 Sept 21	Review of deaths in community to be undertaken to identify those which have adversely impacted on SHMI.	Audit completed and further workstreams identified to include linking with the discharge letter audit, upskilling in palliative care needs for A&E and education around completion of a comprehensive discharge letter. Further audit completed in September to explore link between length of stay and sepsis - pulling report together Community Division Clinical Director (Dr Malhotra) working on reviewing deaths in community Medical Examiner within the community role out to advert with funding allocated for post

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

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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
2.2 (ID 3269) Limited resources in relation to training and development for staff	L3 x C3 9 High	L3 x C3 9 High	L1 x C3 3 Low	AKI/Sepsis nurse attends all corporate sessions AKI/Sepsis nurse attends clinical audit AKI/Sepsis Bulletins Learning from incidents Monthly AIMS Blood cultures training every 2 weeks via in house trainers who have now undergone train the trainer education programme.	Yes Yes N/A Yes N/A	Workload demands for AKI and sepsis nurses Reduced AIMS faculty members to support the programme Reduced number of blood culture trainers	In addition to monthly AIMS sessions there is a plan in place for AIMS to be added to Clinical induction programmes once training returns to face to face. Two blood culture train the trainer role now in place with a further 2 to undergo this training. First wave of training set to be complete in February 2022 with remaining nurses to have this as part of their return to work schedules
2.3 (ID 3270) No consultant cross-cover from Salford Royal for the AKI service	L3 x C3 9 High	L3 x C3 9 High	L1 x C3 3 Low	Nil	N/A	52 week cover needed as not currently in place and on-call and annual leave by Salford Royal not currently covered.	Clinical lead identified at WWL with an interest in AKI who is able to provide support when required. SLA being drafted between WWL and NCA to provide 52 week cover

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
2.4 (ID 3271) The AKI and sepsis services are currently single nurse led over a 5-day working week.	L4 x C3 12 High	L4 x C3 12 High	L2 x C3 6 Moderate	Separate clinical leads in place Support is provided by the Critical Care Outreach Team Information is cascaded through attendance at corporate and divisional meetings There is a policy and SOP in place	N/A N/A Jun 2021 Jun 2021	No cover is in place during annual leave, Bank Holidays or other absence. There is no contingency plan in place for patient safety nurses.	AKI and sepsis nurse to work collaboratively to provide cross-cover and ensure that work plans are more aligned. Business case for Harm Free Care Services had initial review – further information requested and to be re-presented in Feb 2022. This team will include additional resources to support both Sepsis and AKI

CO3: To improve safety and delivery of harm-free care			
Lead Director: CN	**Risk appetite:** Low (Quality/innovation and outcomes); Moderate (reputation)	**Assurance level:**	
Detailed objective:	We will improve the safety and delivery of Harm Free Care by achieving a 50% reduction in hospital-acquired category 3 and 4 pressure ulcers and a 20% reduction in serious incidents related to deteriorating patients 31 March 2022.		
Rationale for assurance level:	Measures have been put in place at the start of the year and there is no evidence at this stage to suggest they will not be successful.		

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
3.1 (ID 3322) There is a risk that our systems and processes, coupled with challenged staffing, may not facilitate the swift identification of potentially avoidable pressure ulcers resulting in harm to our patients	C 3 x L 4 12 High	C3 x L3 9 High	C3 x L2 6 Moderate	Training package Grade 2/DTI Pressure ulcer Panels in place Grade 3/4/unstageable Pressure ulcer panels in place New pressure ulcer rapid Review template launched for pressure ulcers New Pressure ulcer policy and procedure now approved		Staff being able to be released to undergo training. Package not yet live Junior workforce Investigation of developed ulcers are not investigated to a level to allow for full identification of learning Equipment issues Beds owned by individual Divisions	Pressure ulcer improvement plan updated to include the following: • Training package developed to be uploaded to Training Hub • Harm Free Care Group and Pressure Ulcer Improvement Group to be commenced. • Stop the Pressure Week underway 15th -19th November Datix improvements started to better capture pressure ulcer management.

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

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

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

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

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

People

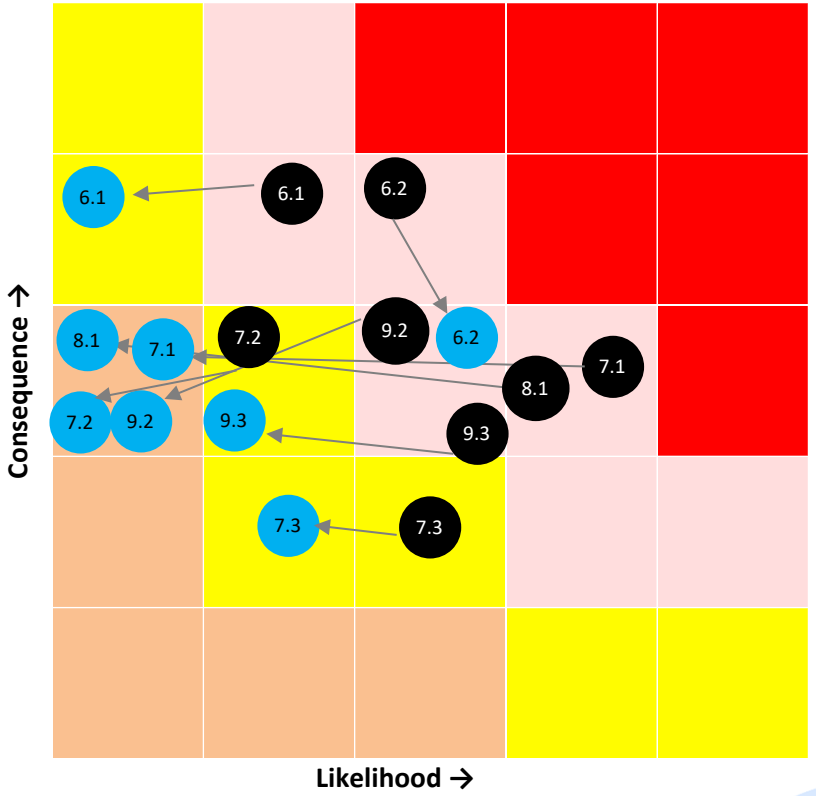
To create an inclusive and people-centred experience at work that enables our WWL family to flourish

Monitoring: People Committee

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

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

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



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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
6.1 (ID 3278) There is a risk that the necessary funding to deliver the stepped care model for physical and mental may not be prioritised, meaning that the service cannot be provided.	L2 x C4 8 High	L2 x C4 8 High	L1 x C4 4 Moderate	Business case drafted and subject to review prior to submission to BCOG Working with GM Resilience Hub where appropriate Transferred OHD MSK and counselling services into Steps 4 Wellness function for better resource efficiency Outline Business Case submitted to BCOG (August 2021) – categorisation awaited Business Case approved at November Trust Board	Apr 2021 August 2021 November 2021	Key roles to provide full stepped care model (included in business case)	Recruitment is ongoing to the positions identified in the business case. Contracts have been made permanent for those involved in the 12-month proof of concept. Expected to have all staff in post by the end of March 2022. In the meantime, reprioritisation has taken place and service offers have been adjusted to maximise impact.

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

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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
7.1 (ID 3281) We do not currently have a robust process which provides a single version of the truth about vacancies, which hinders effective decision making	L5 x C3 15 Significant	L4 x C3 12 High	L1 x C3 3 Low	Currently using finance spreadsheets to understand vacancy position and for reporting purposes (not real time) PID agreed at ETM (shared at People Committee) to implement ESR manager self service and establishment control People committee report – workforce digitisation	Jun 2021 August & September 2021 December 2021	Full establishment control arrangements in ESR Process changes required for recruiting managers as we transition	ESR team recruited – commenced in January 2022. Teams to align with all workforce digital programmes to improve data quality – Empactis, E-roster, establishment control and self-service.

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
7.2 (ID 3282) International recruitment a) National pause of recruitment from India due to Covid travel restrictions Funding risk for any IR requirements in excess of 40 that have been budgeted for in 2021/22	L5 x C3 15 Significant	L2 x C3 6 Moderate	L1 x C3 3 Low *(Score lowered from L2 x C3 = 6 Jan 2022)*	National pause has ended and recruitment pipelines are open again Recruitment & Retention report to People Committee Trust Board approval of escalation areas becoming substantive Approval of international recruitment and supernumerary ward leaders business cases	July 2021 September 2021 November 2021 November 2021 – January 2022		Trajectory to map recruitment and retention trajectory against actual (DCO & DHRD)
7.3 (ID 3283) LNA requirements may not meet the funding criteria set by HEE resulting in gap in funding	L3 x C2 6 Moderate	L3 x C2 6 Moderate	L2 x C2 4 Moderate	Full LNA analysis from Divisions being compiled – to be reviewed against available funding sources and provision methods. Update provided to Education Governance Group LNA reports at Education Governance Committee and People Committee reports	May 2021 September 2021	Ability to roll forward HEE funding allocations (3 year funding, may not be equally distributed over the 3 years)	Full detailed review to be completed (CNO, DCNO, DW and education leads) November 2021 2021/22 HEE allocations have not been able to be used due to staffing and operational pressures restricting the ability to release staff. National staff survey raw data shows personal development as our outlying area – to be added as a 5th theme for priority action under Our family, Our future, Our focus

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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
8.1 (ID 3284) There is a risk that participation in the programmes will not be prioritised as a result of other service pressures.	L2 x C3 6 Moderate	L4 x C3 12 High *(Score increased from L1 x C3 = 3 Jan 2022)*	L1 x C3 3 Low	"Our family – Our future – Our focus" engagement reset programme under DCE leadership Board visibility of programme Launch events for Our FFF and associated programmes of work Prioritisation programme during Omicron Wave - ETM	Jul 2021 September 2021 January 2022	Metrics to be reported via Board	Workforce team There has been good engagement in the pilot teams so far. Escalation has been needed to ensure medical staff are engaged Activities to restart aligned to operational recovery restart

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

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
9.2 (ID 3287) There is a risk that the organisation does not have workforce EDI expertise nor any supporting infrastructure	L3 x C3 9 High	L3 x C3 9 High	L1 x C3 3 Low	Workforce EDI specialist recruited (fixed term contract) EDI strategy update and governance proposal – ETM & People Committee EDI strategy approved	July 2021 August & September 2021 November 2021	No ongoing funding commitment	EDI strategy to be approved at Board November 2021. Staff network remit to be expanded (FAME network) and additional networks launched in January 2022 for disability / long term conditions and LGBTQIA. This was supported at Trust Management Board in November. No substantive EDI workforce resource to support delivery against strategic aims set out in the strategy.

Principal risks	Initial risk score	Current risk score	Target risk score	Key controls and assurance (Ext = external)	Evidence last seen	Gaps in controls/assurance	Actions planned (What? Who? When?)
9.3 (ID 3288) There is a risk that we will not get buy-in or funding for a locality-wide workforce EDI strategy	L3 x C3 9 High	L3 x C3 9 High	L2 x C3 6 Moderate	Proposed EDI governance structures that include links to HWP EDI strategy – Trust Board	September 2021 November 2021	HWP commitment on shared agenda	Discussions around locality-wide approach required at HWP (Chief Executive and Deputy Chief Executive) Engagement is still needed with locality partners through Healthy Wigan Partnership

Performance

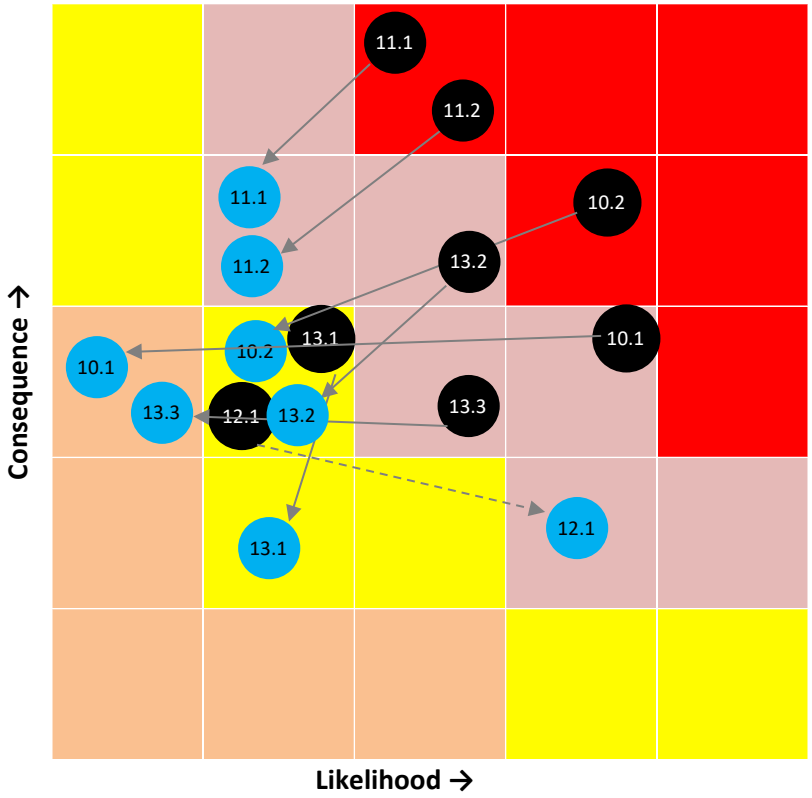
Our ambition is to consistently deliver efficient, effective and equitable patient care

Monitoring: Finance and Performance Committee

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

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

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



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

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

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

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

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

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

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

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

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

Partnerships

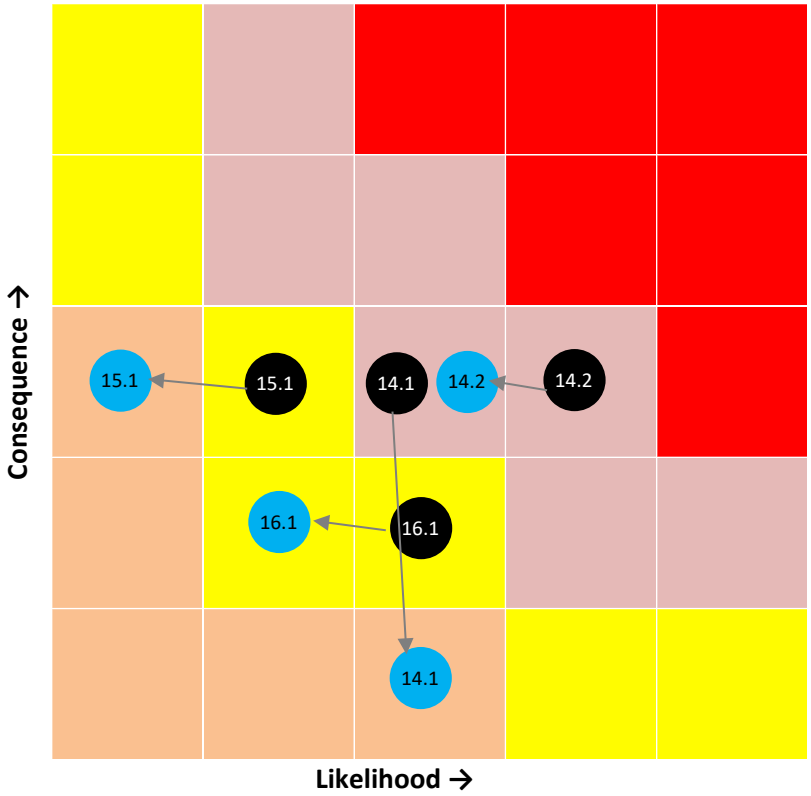
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

Monitoring: Board of Directors

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

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

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



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

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

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

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

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

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

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

Executive summary

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

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

The Board are asked to note

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

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

- There continues to be pressures across the nursing and midwifery workforces associated with vacancies and short notice absence. Of note are ED, Maternity Service, District Nursing, ICU

and Theatres. All vacancies are being appropriately managed within the pertinent services. Within the Division of Surgery, a combined ICU and Theatres recruitment event is being planned in collaboration with HR.

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

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

- In November 7 CDT's were reported. All CDT's have been subject to investigation and Executive Reviews. Increased scrutiny is planned on PPE usage in the forthcoming months as audits have indicated poor compliance in this regard across the Trust.

- In month 3 falls with harm occurred on Swinley, Aspull and the Urgent Treatment Centre (UTC). All falls are being investigated and will be reviewed by the Falls Scrutiny Panel. Following the fall in UTC this incident was escalated to StEIS as the patient sustained a fracture requiring surgical intervention.

- In November there were 2 pressure ulcers reported to StEIS that developed whilst patients were in the care of the community team. These are currently subject to concise investigation and triangulation will be required between caseload and case mix of the teams caring for the patient and the risk stratification approach being taken to ensure patients are reviewed either face-to-face or remotely.

- There were no medicine administration errors that resulted in harm to patients. A review of medication administration incidents has been undertaken by the Medicines Safety Nurse Specialist in partnership by the Deputy Chief Nurse, and an improvement plan developed.

- The percentage of shifts not sent to bank is slowly reducing (36%), however there is insufficient data points currently to indicate that this is a sustained change. The greatest gains could be achieved by improving shifts sent to bank across all theatres within the Trust and within District Nursing Services.

- The Deputy Chief Nurse is currently working in collaboration with HR and Clinical Divisions to determine the IN-recruitment requirements for the forthcoming financial year. This is required to ensure there is a pipeline of registrants entering the country to meet current workforce turnover throughout the course of the year.

- There has been an increase in overall temporary spend in November which triangulates with the increase in vacancies associated with additional funding received, and the escalation of

additional areas of the Trust to support patient safety and flow. Additional spend continues to be incurred to support the unfunded ward and the Pulse Oxcimetry Service.

Link to strategy

Delivery of safe care

Risks associated with this report and proposed mitigations

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

Financial implications

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

Legal implications

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

People implications

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

Wider implications

- Increased scrutiny from Commissioners and Regulators

Recommendation(s)

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

Safe Staffing Report – November 2021.

1.0 INTRODUCTION

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

2.0 SAFER STAFFING EXCEPTION REPORT

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

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

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

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

3.0 CURRENT POSITION – November 2021

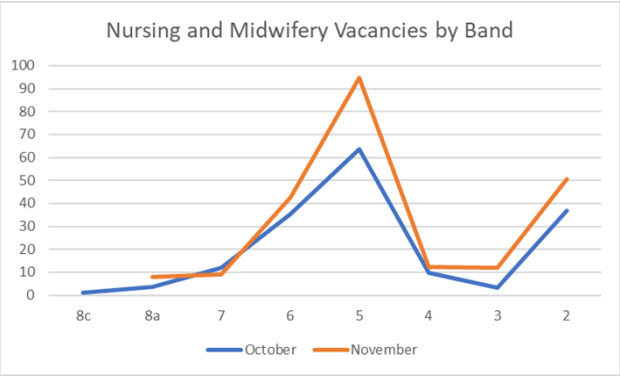
3.1 E-roster staffing levels have been unchanged from the pre-Covid agreed levels.

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

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

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

4 Vacancies



	October	November
8c	1	
8a	3.5	7.8
7	11.9	8.89
6	35.42	42.6
5	63.51	94.73
4	9.82	12.2
3	3.3	11.84
2	37.06	50.47
Total	165.51	228.53

Chart 1

4.1 Divisional data indicates that there were 228.53 WTE nursing and midwifery vacancies in October. The split of the vacancies is demonstrated in Chart 1. As described in the previous months report there are also additional vacancies from the addition of winter pressures monies to support the increased footprint of ED.

4.2 Vacancies have increased at B5, B3 and B2 level in month flowing the approval of business cases to staff Jean Heyes Reablement Unit (JHU) and Bryn Ward.

4.3 Areas of particular concern remain District Nursing Services, ED, Theatres and Maternity Services.

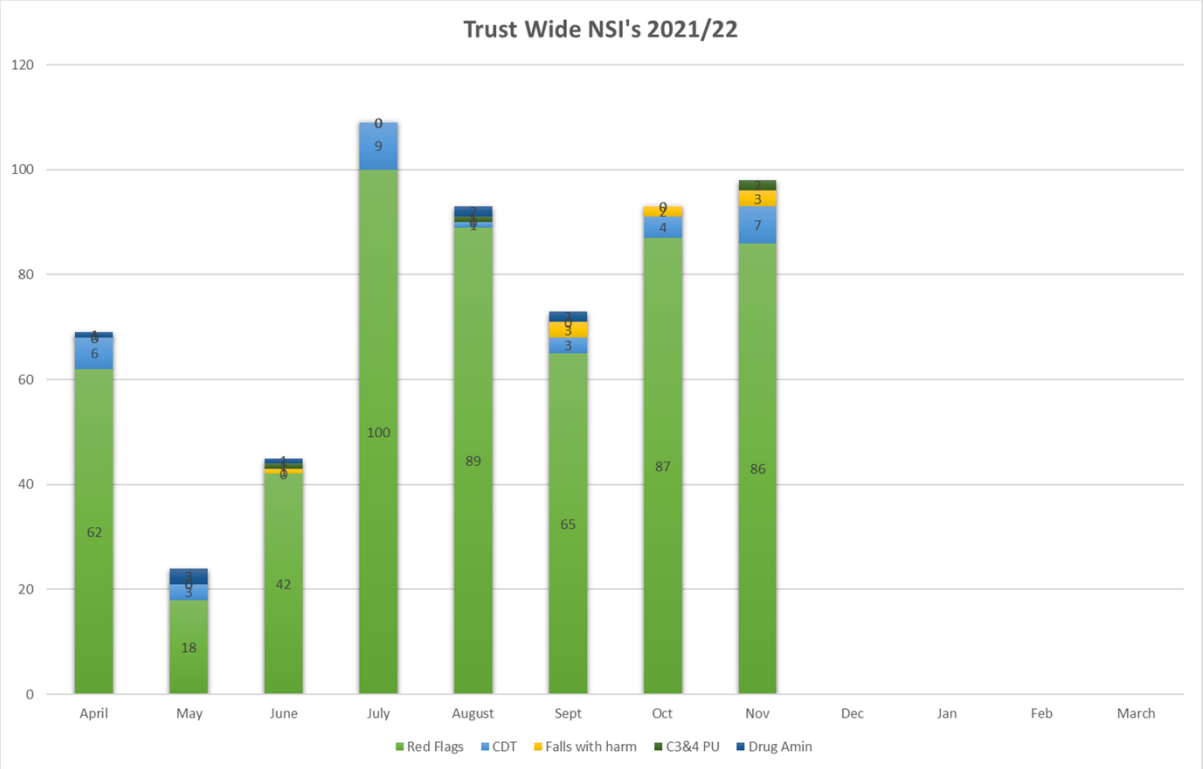
5 Nurse Sensitive Indicators (NSI's)

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

5.2 Chart 2 provides details of the NSI's captured for the purpose of this report.

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

5.4 Within Adult Community Services 148 incidents were reported, none of these resulted in moderate or above harm occurring to the patients. 25 incidents were also reported within Children's Services none of which required escalation due to the level of reported harm.



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

Chart 2

5.4 Within the acute setting 86 Nursing Red Flags were raised in November; this has remained static from the previous months report. 78% of the red flags raised are associated with a reduction of 25% of the registered nurse workforce.

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

5.7 In November 7 CDT's were reported. The CDTs were reported on Ince, Standish, Rainbow, Langtree and Orrell, with an additional 2 CDTs being reported on Winstanley Ward. All CDT's have been subject to investigation and Executive Reviews planned in November to determine lessons learnt.

5.8 In month 3 falls with harm occurred on Swinley, Aspull and within the Urgent Treatment Centre (UTC). The fall on UTC was reported to StEIS as the patient sustained a femoral fracture requiring further surgery. All falls are being investigated and will be reviewed by the Falls Scrutiny Panel.

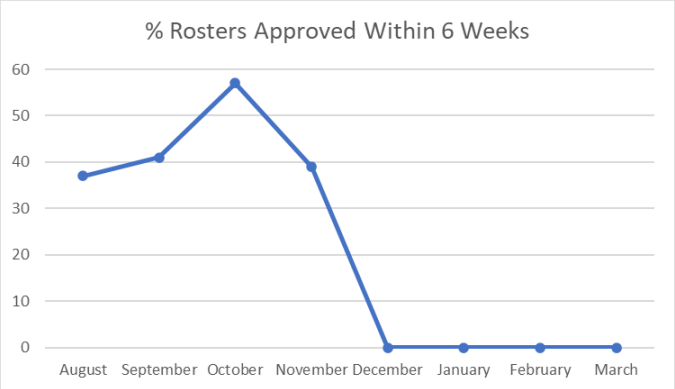
5.9 There were 2 avoidable pressures ulcers escalated to StEIS in November. Both of these were reported to have occurred within the community division. Concise investigations have been requested in accordance with Trust process, however the Board are asked to note the triangulation of the incidents with the increased caseloads of District Nursing Services and the risk stratification

processes being undertaken which may include reduced frequency of face-to-face visits to patients on the caseload.

5.10 There were no medicine administration errors that resulted in harm to patients.

6 Effective Rostering

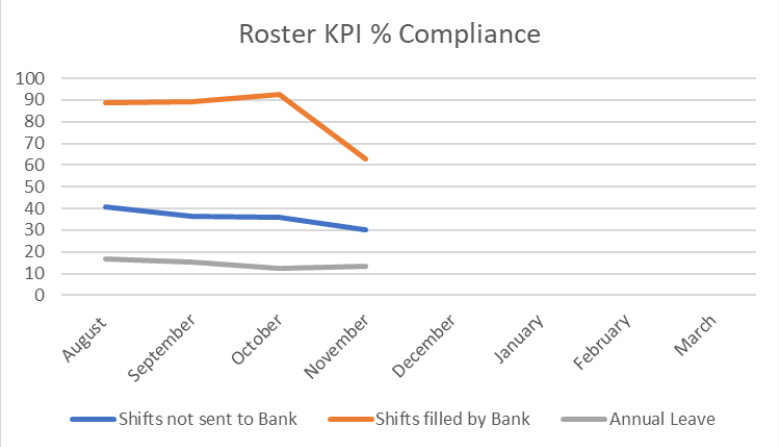
6.1 There has been sustained scrutiny on improvement is roster approval 6 weeks prior to shifts being worked (Chart 3). Compliance with this metric has improved by 20% since monitoring has commenced via this report.



Rosters Approved Within 6 Weeks				
	August	Septembe	October	Novembe
% approved	37	41	57	39

Chart 3

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



	August	Septembe	October	Novembe
Shifts not sent to Banl	40.8	36.5	36	30
Shifts filled by Bank	88.7	89.2	92.6	63
Annual Leave	16.8	15.5	12.6	13.2

Chart 4

6.3 The percentage of shifts not sent to bank continues to show a downward trajectory and has improved by 6% on the previous month's report, however there are insufficient data points currently to indicate that this is a sustained change. The greatest gains could be achieved by improving shifts sent to bank across all theatres within the Trust and within District Nursing Services.

6.4 There was a decrease in performance in roster production times in November however this is not reflected in the number of shifts not sent to NHSP prior to final approval.

7 International Nurse Recruitment (INR)

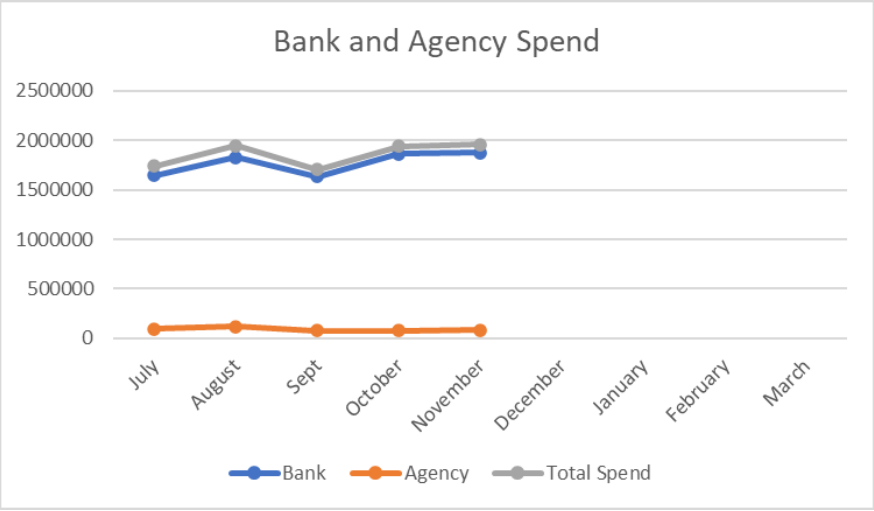
7.1 Nationally there continues to be a shortfall of Registered Nurses, and the impact of the increase in nursing and midwifery training placements has yet to be felt. Work has been completed to identify staffing risks associated with the age profile of registered nurses and midwives and turnover rates and identify emergent and potential staffing and skills shortfalls up to and including financial year 2025/26.

7.2 Recruitment requirements for the next calendar year are currently being determined and are due to be submitted to NHSE/I in December 2021.

7.3 A scoping exercise has been undertaken by the Professional Practice Team (PPT) to identify those staff in years 2 and 3 of the GTEC scheme wish to remain with the trust. This information will be reflected in December's report and will assist in decision making with regards to Visa costs moving forward.

8 Bank and Agency Utilisation

8.1 There has been an increase in overall temporary spend in November, as demonstrated in Chart 5, of £12.5K.

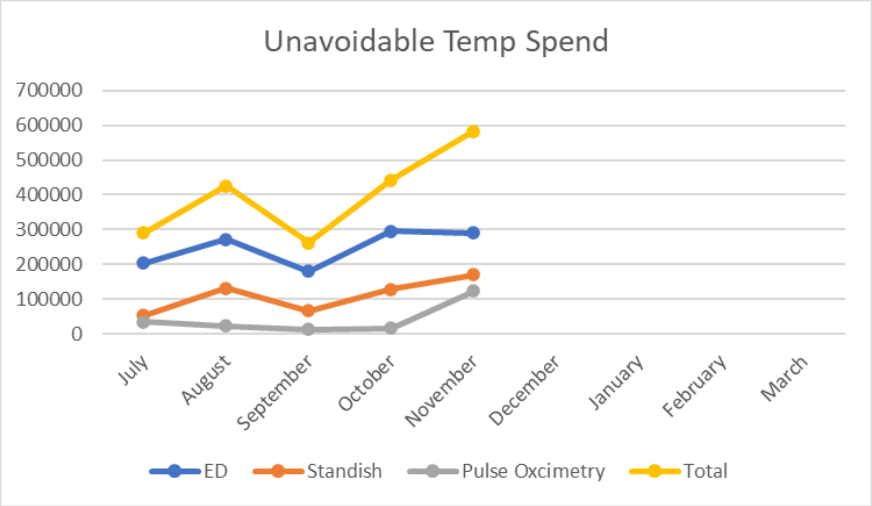


	July	August	Sept	October	November
Bank	1645934	1827818	1632970	1864093	1872876
Agency	93024	120000	74204	78799	82528
Total Spend	1738958	1947947	1707174	1942892	1955404

Chart 5

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

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



	July	August	Septembe	October	Novembe
ED	202804	271954	180848	296183	290413
Standish	53541	130946	66942	128867	169640
Pulse Oxcimetry	34646	23252	13530	16590	122791
Total	290991	426152	261320	441640	582844

Chart 6

8.4 From the information above £582,844 of temporary spend was unavoidable as it was required to maintain IPCC patient flows and the provision of safe patient care. This accounts for approximately 30% of all temporary spend for Nursing and Midwifery Staff.

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

8.6 NHSP have continued the programme of work across all sites to recruit both substantive and multi-post holders to the bank. The success of this campaign has been the collaborative work undertaken between NHSP and the Ward/Departmental Leaders. NHSP are planning to undertake focussed work on the recruitment of Therapy Staff and continue the programme of work to migrate agency staff to bank, assisting in the reduction of cost.

8.7 NHSP are working in collaboration with clinical areas to block book temporary staff where possible in the areas of greatest risk.

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

8.9 NHSP continue to recruit to their services and were successful in adding an additional 95 new starters in November, 41 of which are Bank Only staff, the remaining staff are multi-post holders.

8.10 WWL demand for temporary staffing is significantly higher than other Trusts however fill rates are higher, higher fill rates are largely driven by the higher hourly rate of pay offered to all staff grades.

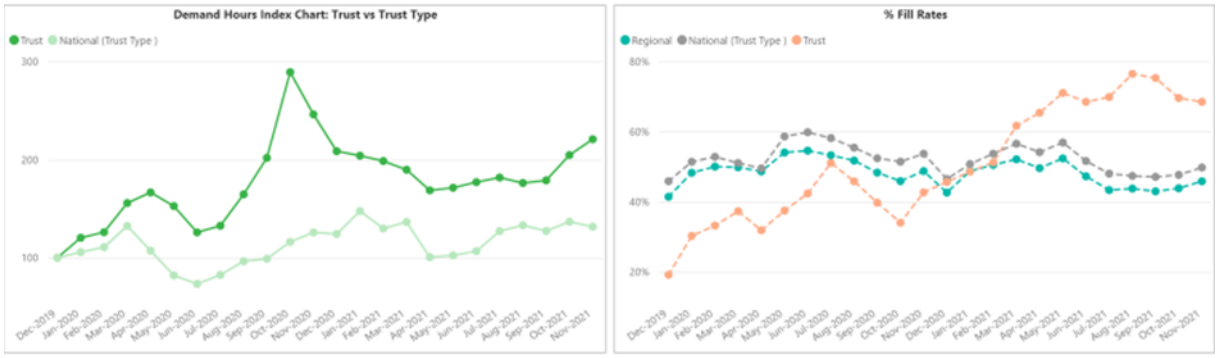


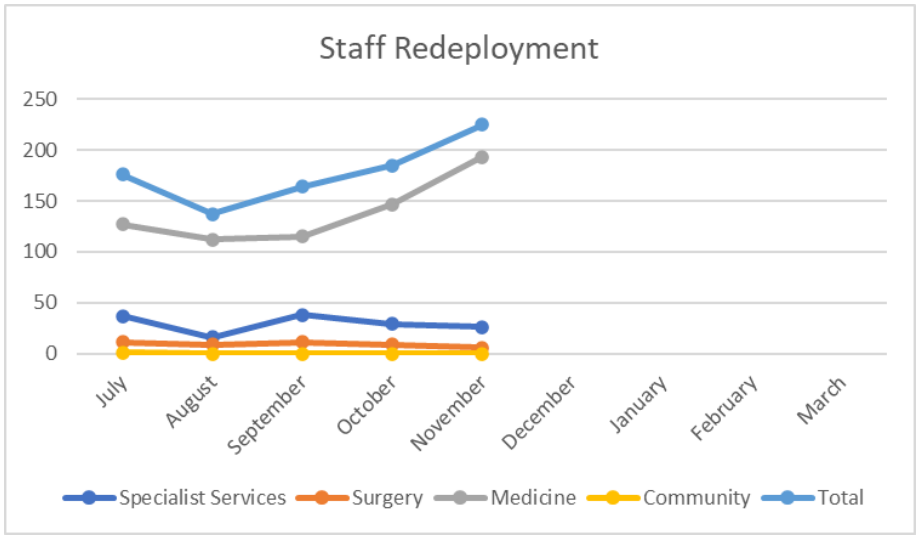
Chart 7

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

9 Staff Redeployment

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

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



	July	August	Septembe	October	Novembe
Specialist Services	37	16	38	29	26
Surgery	11	9	11	9	6
Medicine	127	112	115	147	193
Community	1	0	0	0	0
Total	176	137	164	185	225

Chart 7

9.3 With regards to data on SafeCare there have been 225 staff redeployments to other areas in response to patient acuity, short notice absence and the escalation of additional inpatient areas for overnight stay patients. This is an increase of 40 redeployments from the previous reporting period.

9.4 The Division of Medicine has seen the greatest number of staff redeployments. This can be partly attributed to the Medical Pool established via NHSP for registered and unregistered staff. This group of staff are allocated to work on an area usually prior to arriving for their shift to address workforce shortfalls.

10 Staffing Risks

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

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

10.3 Vacancies within the Maternity service have also impacted on service delivery, resulting in a reduction in the Continuity of Carer (CoC) model of service to support high risk areas.

10.4 Theatre staffing remains a challenge with shortfalls of staff across anaesthetic and recovery services.

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

11 Summary and Next Steps

11.1 There continues to be pressures across the nursing and midwifery workforces associated with vacancies and short notice absence. Of particular note are ED, Maternity Service, District Nursing, ICU and Theatres. All vacancies are being appropriately managed within the pertinent services. Within the Division of Surgery, a combined ICU and Theatres recruitment event is being planned in collaboration with HR.

11.2 Overall vacancies have increased in month following the inclusion of the vacancies associated with Winter Pressures, Elective Recovery Programme, JHU and Bryn. These vacancies are

impacting on the ability of the workforce to respond to workload increases which is negatively impacting on staff wellbeing, patient care and experience, and waiting times.

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

11.3 In November 7 CDT's were reported. The CDT's were reported on Ince, Standish, Rainbow, Langtree and Orrell, with an additional 2 CDTs being reported on Winstanley Ward. All CDT's have been subject to investigation and Executive Reviews planned in November to determine lessons learnt. Increased scrutiny is planned on PPE usage in the forthcoming months as audits have indicated poor compliance in this regard across the Trust.

11.4 In month 3 falls with harm occurred one of which has been StEIS as the patient required surgery to treat the fracture that occurred. All falls are being investigated and will be reviewed by the Falls Scrutiny Panel.

11.5 In November there we 2 pressure ulcers escalated to StEIS both of which occurred within the Community Division.

11.6 There were no medicine administration errors that resulted in harm to patients.

11.7 the Trust continues to proactively pursue international recruitment to fulfil nursing requirements for the forthcoming calendar year to ensure that there is a pipeline of nurses joining the Trust throughout the year.

11.10 There has been an increase in overall temporary spend in November which triangulates with the increase in vacancies associated with additional funding received, and the escalation of additional areas of the Trust to support patient safety and flow. Additional spend continues to be incurred to support the unfunded ward and the Pulse Oximetry Service. Business cases were approved by Board and will fund both the unfunded ward in Medicine and the Jean Heyes Reablement Unit within Community Services.

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

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

Executive summary

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

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

The Board are asked to note

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

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

- There continues to be pressures across the nursing and midwifery workforces associated with vacancies and short notice absence. Of note are ED, Maternity Service, District Nursing, ICU

and Theatres. All vacancies are being appropriately managed within the pertinent services. Within the Division of Surgery, a combined ICU and Theatres recruitment event is being planned in collaboration with HR.

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

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

- In December 5 CDT's were reported. All CDT's have been subject to investigation and Executive Reviews. Increased scrutiny is planned on PPE usage in the forthcoming months as audits have indicated poor compliance in this regard across the Trust.

- In month 2 falls with harm occurred on Shevington Ward and on the Thomas Linacre site. All the falls were reviewed by the Falls Scrutiny Panel. There were no escalations to StEIS but the Health and Safety Team are undertaking some environmental work at Thomas Linacre with regards to the fall on that site.

- Maternity services continue to suspend the Continuity of Carer pathway in order to address staffing gaps in higher risk areas of the service which have arisen through vacancy and short notice absence of staff.

- In December one pressure ulcer was reported to StEIS that developed whilst patients were in the care of the community team. This is currently subject to concise investigation and triangulation will be required between caseload and case mix of the teams caring for the patient and the risk stratification approach to determine whether this was detrimental to the outcome for the patient.

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

- The percentage of shifts not sent to bank increased in month. This is felt to be partly attributable to the lack of ability for the Ward Leaders to be supervisory to practice as a consequence of vacancies, staff absence and the escalation of additional areas.

- The Deputy Chief Nurse has determined that an additional 111 International Nurses will be required over the next calendar year to mitigate staffing risk. Combined with the 69 already funded this will result in the recruitment of 180 International Nurses by the end of 2022.

- Temporary spend has increased by over £500k in month. The expenditure is linked to an increase in the overall vacancies within the Trust, adherence to the Enhanced Observation

Policy, short notice absence and the requirement to back fill posts released to support the Pandemic response plan.

Link to strategy

Delivery of safe care

Risks associated with this report and proposed mitigations

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

Financial implications

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

Legal implications

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

People implications

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

Wider implications

- Increased scrutiny from Commissioners and Regulators

Recommendation(s)

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

Safe Staffing Report – December 2021.

1.0 INTRODUCTION

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

2.0 CURRENT POSITION – December 2021

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

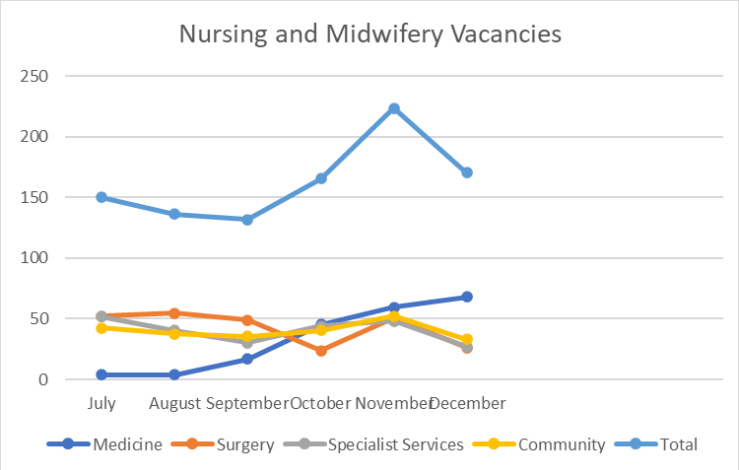
2.2 The ratio of registered nurses to unregistered remains 55:45 as agreed by Trust Board in 2018 with the exception of the assessment areas which are staff at a ratio of 60:40. This ratio remains out with national recommendations of 70:30, with SNCT recommended levels of no less than 65:35 within inpatient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

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

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

3.0 Vacancies

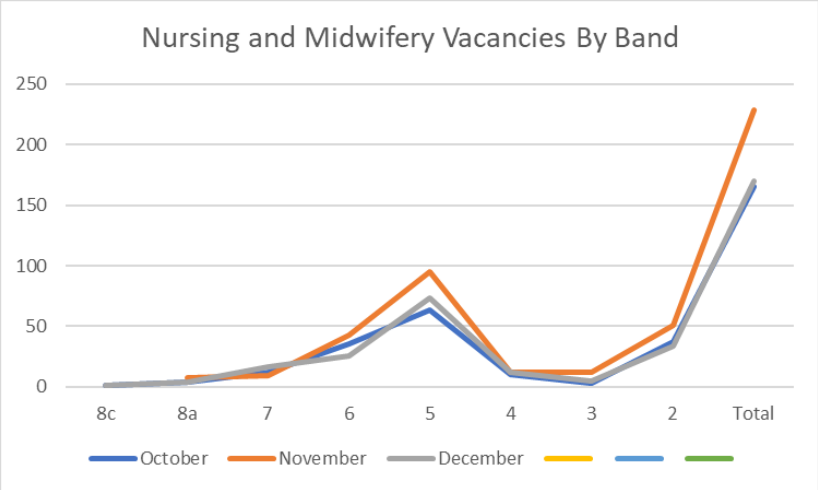
3.1 Divisional data indicates that there were 170.29 WTE nursing and midwifery vacancies in December. The split of the vacancies is demonstrated in Chart 1. As described in the previous months report there are also additional vacancies from the addition of winter pressures monies to support the increased footprint of ED.



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

Chart 1

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



	October	Novembe	December
8c	1		1
8a	3.5	7.8	3.67
7	11.9	8.89	16.4
6	35.42	42.6	25.18
5	63.51	94.73	73.65
4	9.82	12.2	12.09
3	3.3	11.84	4.79
2	37.06	50.47	33.51
Total	165.51	228.53	170.29

Chart 2

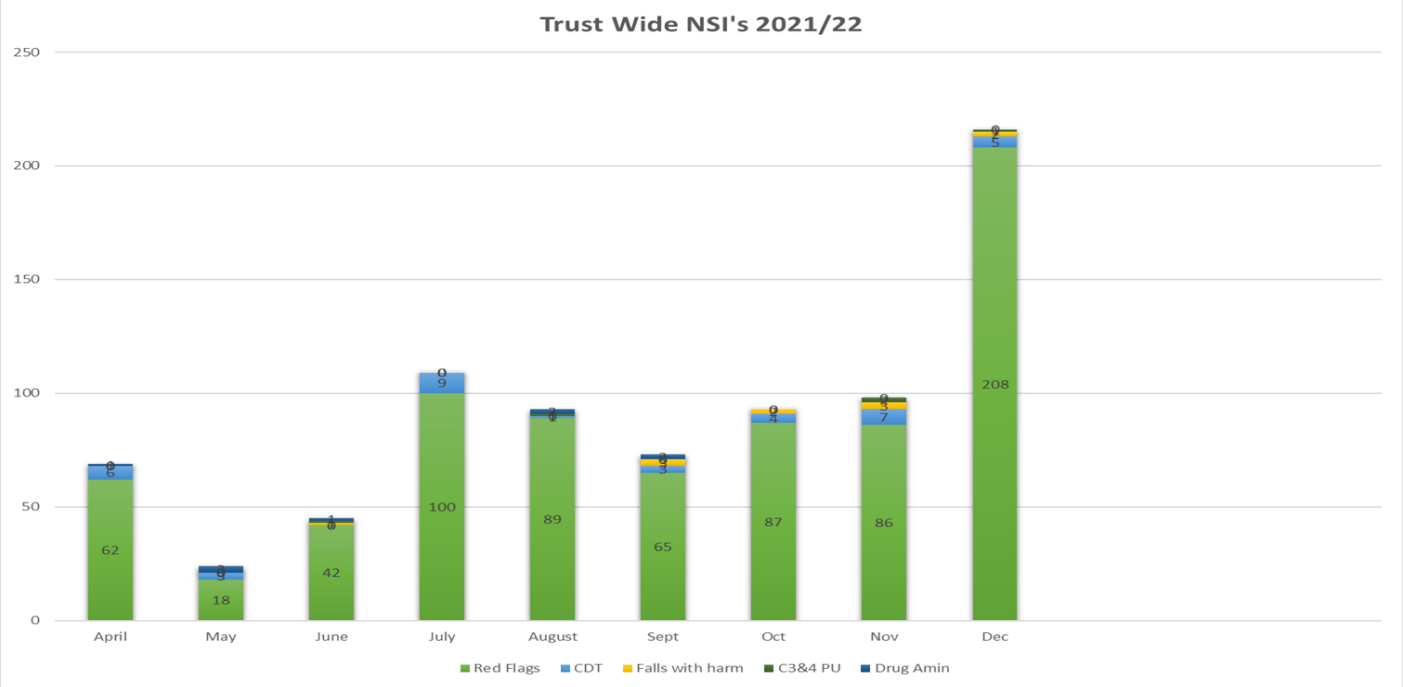
3.3 Areas of particular concern remain District Nursing Services, ED, Theatres and Maternity Services.

4 Nurse Sensitive Indicators (NSI's)

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

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

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



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

Chart 3

4.4 Within the acute setting 207 Nursing Red Flags and 1 Midwifery Red Flag were raised in December, an overall increase of 117% from the November report. 89% of the red flags raised are associated with a reduction of 25% of the registered nurse workforce and are reflective of the vacancy position, short notice sickness, escalation of clinical areas, and staff absence related to the Omicron Covid-19 variant.

4.5 The Midwifery Flag raised related to a delay in care for a woman requiring sutures following the birth of her baby. No harm occurred because of this incident, however there were shortfalls in staffing on the day of the incident.

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

4.7 In December 5 CDT's were reported. The CDTs were attributed to on Astley, Swinley, Aspull and Ward B. A further CDT was also reported on Winstanley Ward; 2 CDTs were reported in this area in November's report. All CDT's have been subject to investigation and Executive Reviews scheduled or undertaken to determine lessons learnt.

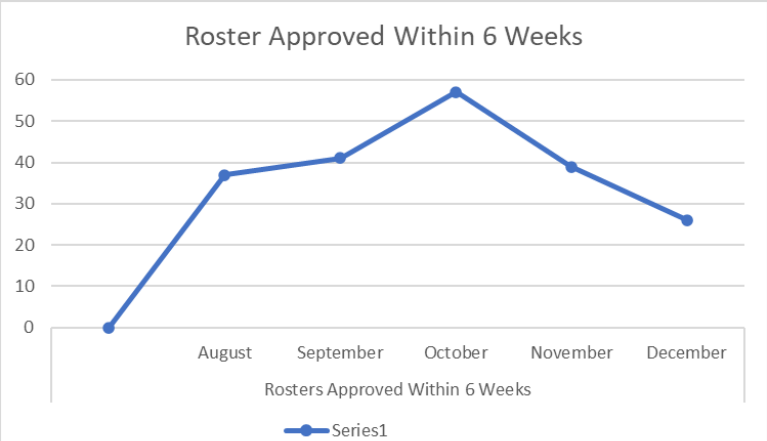
4.8 In month 2 falls with harm occurred on Shevington Ward and on the Thomas Linacre site. Review of the falls indicated that neither met the requirement for escalation to StEIS due to the severity of the harm that occurred and neither fall met the criteria for RIDDOR reporting. The Health and Safety Team are undertaking some environmental work on the Thomas Linacre site in relation to the fall that occurred within this area.

4.9 All pressures ulcers reported across the Trust are reviewed by a scrutiny panel to determine whether all appropriate actions to mitigate the risk of skin damage have been undertaken and to assist in determining whether a patient has come to avoidable harm whilst in our care. In December 7 pressure ulcers were reviewed by the Moderate Harm Panel however lapses in care were identified in one of the cases within the community Division and this was appropriately escalated to StEIS for concise investigation. The Board should note that throughout December there were considerable pressures on the District Nursing (DN) workforce associated with short notice absence, including loss of B6 and B7 staff, and there are high numbers of newly qualified staff within the service who are still requiring support to achieve their competencies. DN ratios were between 1:19 and 1:25 throughout the month. Pressures on staffing were mitigated by further risk stratification, reduction of face-to-face visits to telephone consultation, and with the wrap around of staff from other services to relieve pressures. The impact on staffing and this harm occurring will be further explored in the concise investigation commissioned by the Trust.

4.10 There were no medicine administration errors that resulted in harm to patients reported for the second consecutive month.

5 Effective Rostering

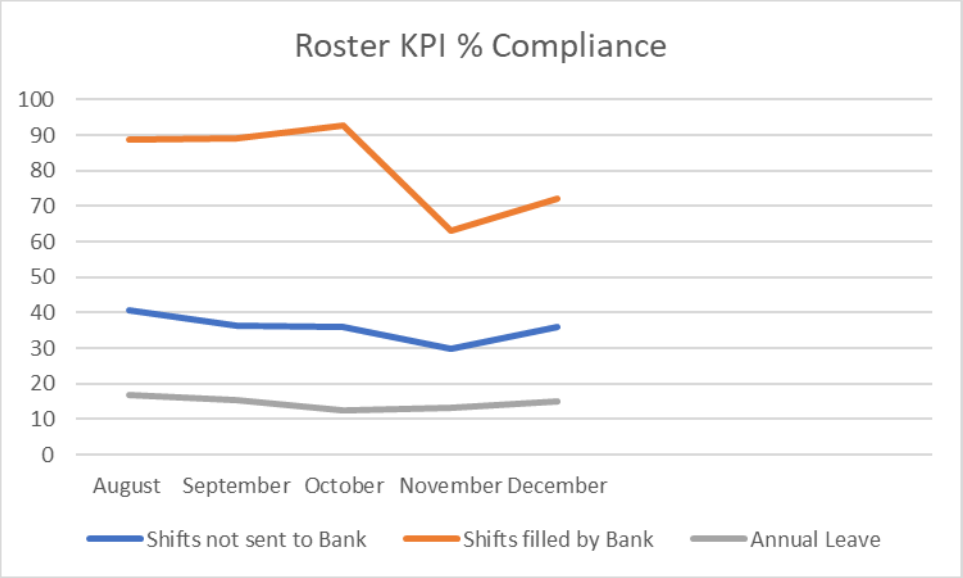
5.1 There has been sustained scrutiny on improvement is roster approval 6 weeks prior to shifts being worked (Chart 3). Compliance with roster approval significantly deteriorated from the previous months reported and local intelligence suggests this is related to the increased frequency of ward leaders working clinically and short notice absence associated with COVID.



	August	Septembe	October	Novembe	December
% approved	37	41	57	39	26

Chart 4

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



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

Chart 5

5.3 The percentage of shifts not sent to bank increased by 6 % in month (Chart 5) and is linked to the issues raised in 5.1. The greatest gains could be achieved by improving shifts sent to bank across all theatres within the Trust and within District Nursing Services.

5.4 Despite the deterioration of roster completion times and shifts sent to bank, bank fill rate increased to 72%.

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

6 International Nurse Recruitment (INR)

6.1 International Nurses Recruitment figures for the forthcoming financial year have been scoped by the Deputy Chief Nurse and Divisional Directors of Nursing. In order to address current workforce pressures and forecast turnover rates funding for an additional 111 nurses is to be requested. As NHSE/I funding for recruitment runs from January to December this will result in 180 additional international nurses joining the Trust before the end of December 2022 and should significantly contribute to the overall resilience of the nursing workforce.

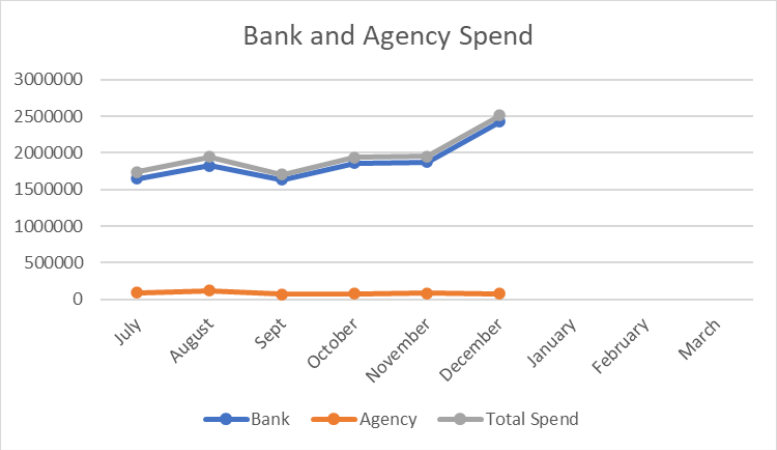
6.2 The clinical divisions are continuing to work in partnership with GTEC and have identified staff to assist in the recruitment process. This initiative will ensure front line staff are engaged with our International Nurses and increase the interview capacity for WWL within the GTEC team.

6.3 GTEC continue to work collaboratively to support recruitment to priority areas and have successfully recruited 6 Theatre nurses who should all be in post in the Trust by the end of February, a further 2 respiratory nurses are due to commence with the trust in January 2021.

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

7 Bank and Agency Utilisation

7.1 There has been an increase in overall temporary spend in December, as demonstrated in Chart 6, of £554.7k.



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Bank	1645934	1827818	1632970	1864093	1872876	2430015
Agency	93024	120000	74204	78799	82528	80133
Total Spend	1738958	1947947	1707174	1942892	1955404	2510148

Chart 6

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

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

7.6 NHSP have continued the programme of work across all sites to recruit both substantive and multi-post holders to the bank. The success of this campaign has been the collaborative work undertaken between NHSP and the Ward/Departmental Leaders. NHSP are planning to undertake focussed work on the recruitment of Therapy Staff and continue the programme of work to migrate agency staff to bank, assisting in the reduction of cost.

7.7 NHSP are working in collaboration with clinical areas to block book temporary staff where possible in the areas of greatest risk.

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

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

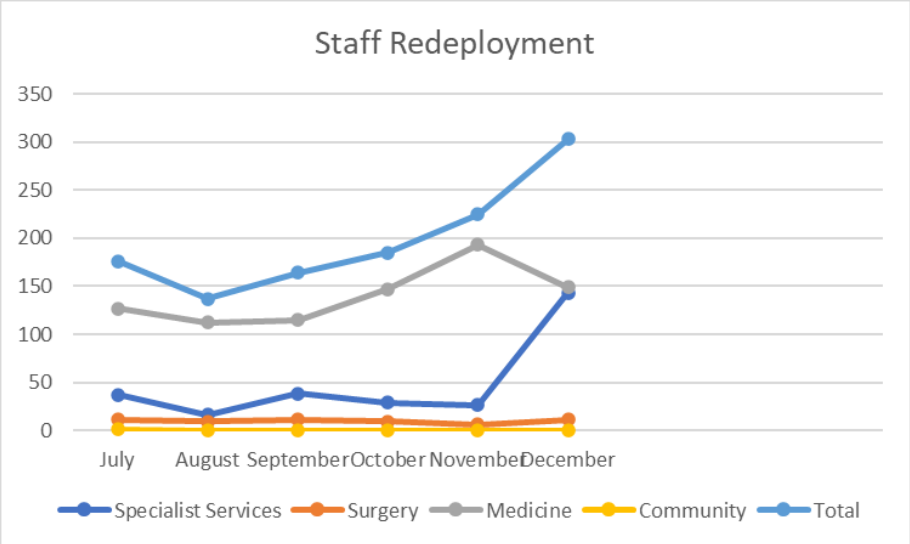
7.10 Focussed work has been undertaken with agencies to source staffing to support high risk areas associated with emergency care and admission avoidance. 6 WTE agency staff have been provided with 3-month contracts for block bookings in ED and on SDEC to support flow.

8 Staff Redeployment

8.1 In December the Trust recommenced short term redeployment of staff to support the current surge in the COVID-19 pandemic initially within Critical Care and to support additional pressures within the Emergency Department (ED). This deployment was undertaken based on skills and staff volunteering to assist the pressures being experienced by staff.

8.2 Discussions also took place with staff to permanently move them to Same Day Emergency Care (SDEC) to facilitate extension of the opening times and support admission avoidance.

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



	July	August	Septembe	October	Novembe	December
Specialist Services	37	16	38	29	26	143
Surgery	11	9	11	9	6	11
Medicine	127	112	115	147	193	149
Community	1	0	0	0	0	0
Total	176	137	164	185	225	303

Chart 7

8.2 With regards to data on SafeCare there have been 225 staff temporary redeployments to other areas in response to patient acuity, short notice absence and the escalation of additional inpatient areas for overnight stay patients. This is an increase of 78 redeployments from the previous reporting period.

8.3 The Division of Medicine has seen the greatest number of staff redeployments. This can be partly attributed to the Medical Pool established via NHSP for registered and unregistered staff. This group of staff are allocated to work on an area usually prior to arriving for their shift to address workforce shortfalls.

8.4 The greatest increase in staff redeployment to assist with short term absence was seen within Specialist Services. Redeployment from this area peaked over the last 2 weeks of the month where staff were sent to assist with additional areas of escalation within ED and the opening of additional

inpatient areas. Staff were able to be released due to reduced elective activity on the Wrightington site and their assistance was greatly received.

9 Staffing Risks

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

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

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

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

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

10 Summary and Next Steps

10.1 There continues to be pressures across the nursing and midwifery workforces associated with vacancies and short notice absence. Of particular note are ED, Maternity Service, District Nursing, ICU and Theatres. All vacancies are being appropriately managed within the pertinent services. Within the Division of Surgery, a combined ICU and Theatres recruitment event is being planned in collaboration with HR.

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

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

10.4 In December 5 CDT's were reported. The CDTs were attributed to on Astley, Swinley, Aspull and Ward B. A further CDT was also reported on Winstanley Ward; 2 CDT's were reported in this area in November's report. All CDT's have been subject to investigation and Executive Reviews scheduled or undertaken to determine lessons learnt. Increased scrutiny is planned on PPE usage in the forthcoming months as audits have indicated poor compliance in this regard across the Trust.

10.5 In month 2 falls with harm occurred on Shevington Ward and on the Thomas Linacre site. Review of the falls indicated that neither met the requirement for escalation to StEIS due to the severity of the harm that occurred and neither fall met the criteria for RIDDOR reporting. The Health and Safety Team are undertaking some environmental work on the Thomas Linacre site in relation to the fall that occurred within this area.

10.6 In December there was 1 pressure ulcers escalated to StEIS which occurred within the Community Division. It should be noted that at the time the harm occurred the District Nursing Teams were operating with increased caseload numbers requiring teams to risk stratify patients and review remotely. It is not yet clear whether this was a contributory factor in the harm occurring.

10.7There were no medicine administration errors that resulted in harm to patients.

10.8 The Trust has established that a further 111 International Nurses are required to support and sustain safe staffing levels within the Trust

10.9 There has been an increase in overall temporary spend in December which triangulates with the increase in vacancies associated with additional funding received, and the escalation of additional areas of the Trust to support patient safety and flow. This has further been exacerbated by an increase in short notice absence associated with Covid-19 isolations and infections within the workforce.

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

10.11 Deployment of staff commenced in month in response to the surge in the Omicron variant particularly to Critical Care and ED.

10.12 GTEC have recruited 6 Theatre nurses who should all be in post in the Trust by the end of February, a further 2 respiratory nurses are due to commence with the Trust in January 2021.

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

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	A&E Safe Staffing
Presented to:	Board of Directors
On:	2 February 2022
Presented by:	Sanjay Arya
Prepared by:	Sue Davies, Medical eRostering Project Manager Saleem Naseer, A&E CD and Consultant
Contact details:	sue.davies@wwl.nhs.uk

Executive summary

The footprint of A&E has changed significantly from previously covering 4 areas to now covering 8 areas with the additional rise of A&E attendees increasing to 300+ per day. A&E has been working hard to cover all these additional areas without any review/increase of the staffing with the help of internal and external locums. Locums are getting extremely difficult to acquire because of the national shortage and better options/rates available in other trusts.

- The A&E footprint has increased by 50% covering 8 areas in comparison to the 4 areas A&E was covering with the same staff.
- Attendances has increased from 230/250 to almost 300+ per day.
- There is currently 1 WTE Consultant and 1.5WTE speciality Doctor vacancies, interviews are planned early February.
- Established there are 175 funded shifts for FY1, FY2 -ST2, Clinical Fellow and SAS Dr's based in the current rota templates.
- Established the number of unfunded Locum requirements needed each week for the additional areas and extra cover total is 62 shifts FY2, ST3+ and SAS graded Locums
- The calculations highlights that there is an additional 26% increase of shifts required to staff all the areas within A&E safely, which totals to an additional 13.26WTE to be recruited.
- Evidence that there is a consistent 30% locum requirement over a 3-month period which consistently covers the 26% additional unfunded requirements.

The WWL Way

Link to strategy

Patient safety

Risks associated with this report and proposed mitigations

Risks

- Patient safety
- Patient flow
- Patient and staff experience
- NWAS hand over times
- Reputational harm

Mitigations

- Reduce A&E areas (once Covid pandemic is over)
- Recruit to vacant posts
- Establish funded posts against Locum posts
- Work with primary care to reduce A&E attendances

Financial implications

Recruitment of addition medical workforce to meet the increasing demand

Legal implications

[XXX]

People implications

Improve staff experience and well-being

Wider implications

[XXX]

Recommendation(s)

This is the first time a paper on Safe Medical staffing has been presented. The committee is advised to take a note of the paper. Further work on the above risks and mitigations is on-going within the division of medicine.

Report

A&E Safe Staffing

- **Escalated Areas**

The footprint of A&E has changed significantly from previously covering 4 areas to now covering 8 areas (See below) with the additional rise of A&E attendees increasing to 300+ per day. A&E has been working hard to cover all these additional areas without any review/increase of the staffing with the help of internal and external locums. Locums are getting extremely difficult to acquire because of the national shortage and better options/rates available in other trusts.

Previously	Current
Majors 1&2	Majors 1&2
Paediatrics	Paediatrics 1
Resus	Paediatrics 2
	Resus 1
	Resus 2
	Urgent Treatment Centre (UTC)
	ISAT (Initial Senior Assessment and Triage)

- **Existing Staff and Current Vacancies**

The information below has been extracted from ESR and displays the current funded WTE and the vacancies.

Description	Funded WTE	Current Vacancies
Consultant	12.00 WTE	1.0 WTE
Staff/Associate Specialist & Specialty Doctors	2.0 WTE	0
Specialty Doctors	16 WTE	1.50 WTE
Clinical Fellow	3.0 WTE	0
Trust FY2	1.0 WTE	0
International Training Fellow (FY2 - ST2)	2.0 WTE	0

- **Funded & Additional Unfunded shifts totals per week**

Funded	Mon	Tue	Wed	Thurs	Fri	Sat	Sun	Total
Total Shifts	30	30	28	29	28	15	15	175
Unfunded	**Mon**	**Tue**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**	**Total**
Total Shifts	7	7	8	8	8	12	12	62
Total	**Mon**	**Tue**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**	**Total**
Total Shifts	37	37	36	37	36	27	27	237

The figures above are the totals of funded and the additional unfunded requirements each week, these figures illustrates that there is a requirement of an increase of 26% of additional unfunded shifts.

- **Additional Unfunded WTE Required Each Week by Grade**

Grade	Hours per Week	WTE Per Week	+ 20% Headroom
ST3+ UTC	165	4.25	5.1
FY2 -ST2	146	3.65	4.38
SAS	126	3.15	3.78
Total	437 hrs	11.05 WTE	13.26 WTE

The above illustrates the total of the additional unfunded shifts required each week by grade this has been calculated to display in hours and WTE per grade. * Calculation is based on 40hrs per week

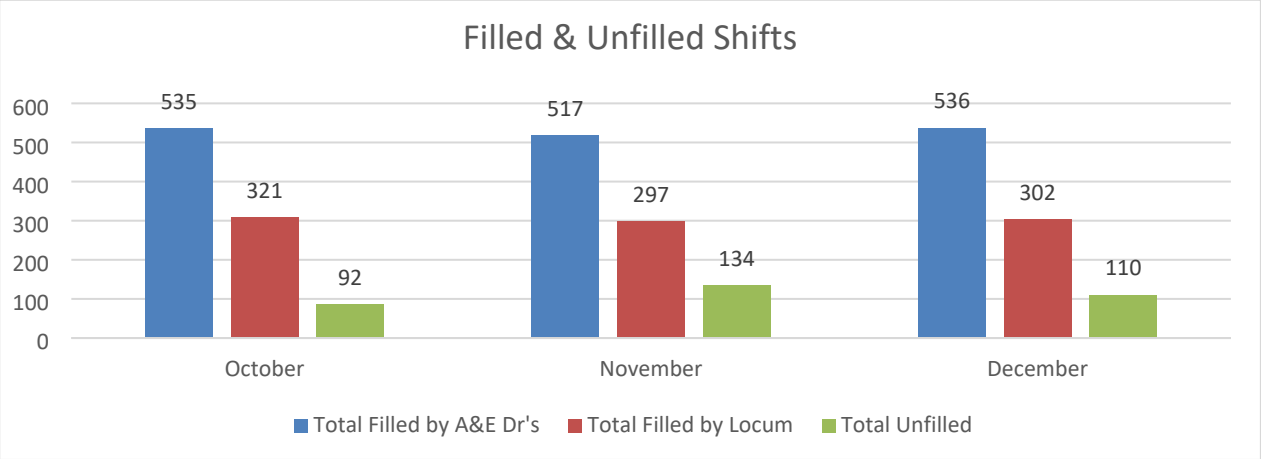
- **Fill Rates**

The figures below are based on 237 required shifts per week multiplied by 4 weeks (1 month) stating a total of 928 shifts required each month

Month	No Filled by A&E Dr's	%	No Filled by Locum	%	No of Unfilled	%
October	535	~58%	321	~34%	72	~8%
November	517	~55%	297	~32%	114	~13%
December	536	~58%	302	~32%	90	~10%

The information above illustrates the total number of shifts and percentages filled and unfilled per month for the periods October, November to December 2021. These data and figures have been extracted from Allocate Healthroster (reports available if required)

The chart below provides a visual comparison and summary of the filled and unfilled shifts for the months of October, November, and December 2021



- **Summary**

- The A&E footprint has increased by 50% covering 8 areas in comparison to the 4 areas A&E was covering with the same staff.
- Attendances has increased from 230/250 to almost 300+ per day.
- There is currently 1 WTE Consultant and 1.5WTE speciality Doctor vacancies, interviews are planned early February.

- Established there are 175 funded shifts for FY1, FY2 -ST2, Clinical Fellow and SAS Dr's based in the current rota templates.
- Established the number of unfunded Locum requirements needed each week for the additional areas and extra cover total is 62 shifts FY2, ST3+ and SAS graded Locums
- The calculations highlights that there is an additional 26% increase of shifts required to staff all the areas within A&E safely, which totals to an additional 13.26WTE to be recruited.
- Evidence that there is a consistent 30% locum requirement over a 3-month period which consistently covers the 26% additional unfunded requirements.

Title of report:	Bi-annual Staffing Review
Presented to:	Trust Board
On:	2 February 2022
Presented by:	Rabina Tindale, Chief Nurse
Prepared by:	Deputy Chief Nurse and Divisional Directors of Nursing and Allied Health Professionals
Contact details:	T: 01942 82 2176 E: allison.luxon@wwl.nhs.uk

Executive summary

The purpose of this report is to provide the Board with the mandated requirement from NHS England in providing assurance of ongoing monitoring and review of adult inpatient staffing establishments and to advise the Board of any recommended changes to these establishments.

This report is produced in addition to the monthly assurance reports.

There is coloration with areas of diluted skill mix and the number of harms captured by Nurse Sensitive Indicators (NSI's) particularly Hospital Acquired Pressure Ulcers and falls.

The acuity and dependency of patients continues to increase in line with the previous report, this is most notable for levels 1b and 2.

SNCT data suggests that there is a shortfall of nursing time as outlined within the recommendations of this report.

It is recommended that:

- The skill mix for core wards is reset to 65:35.
- Assessment areas skill mix is adjusted to 70:30.
- There is an uplift in staffing to address workforce pressures within the Community Division.
- There is an uplift in staffing to address workforce pressures within the Emergency Department
- The funded uplift in staffing is increased from 20% to 23%.
- There is an increase in the establishment of B6's within inpatient areas to ensure senior leadership presence 24/7.
- Supernumerary status is afforded to identified B7 Team leaders within departments/services as detailed within the report

- There is uplift and adjustments to establishments in accordance with SNCT and professional judgement as detailed within the report
- A pool of 40 WTE B2 care staff is funded to support delivery of enhanced observations in a more planned manner to improve patient safety and reduce reliance on temporary staffing.

. **Link to strategy**

Delivery of safe care

Risks associated with this report and proposed mitigations

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

Financial implications

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

Legal implications

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

People implications

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

Wider implications

- Increased scrutiny from Commissioners and Regulators

Recommendation(s)

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

Bi Annual Nurse Staffing Review

1 Introduction

1.1 The purpose of this paper is to provide Trust Board with an assessment of the funded nurse staffing levels for inpatient areas within WWL, and to advise the Board of any recommended changes to these establishments to ensure safe care.

1.2 This report will include reference to current funded establishments, national guidance, acuity and dependency measures and incidents of harm which have been triangulated to formulate the recommendations within this report.

2 Background

2.1 Throughout 2012 and 2013[1][2][3][4][5] a series of reports were published describing the critical role of nurse staffing in the delivery of high-quality care and excellent outcomes for patients.

2.2 In 2013 it was nationally mandated that all NHS Organisations review staffing levels at least twice/year and for the findings of the review to be shared with the Trust Board and that decisions made following receipt of the report to Board be documented to provide assurance of Board level accountability and responsibility for staffing levels.

2.3 In November 2014 NHS England published 'Safer Staffing: A Guide to Care Contact Time[6]. This report outlines further requirements to provide assurance of staffing levels and the importance of the provision of nurse-to-patient direct care time.

2.4 Developing Workforce Safeguards 2018 states each Trust must demonstrate compliance with National Quality Board guidelines with respect to workforce, and for a declaration of safety in this regard to be made within the Trust Annual Governance Statement. This should be jointly signed by the Chief Nurse and the Medical Director.

2.5 The last thorough Bi-annual Staffing Review was undertaken in September 2019 and presented to Board in January 2020. A Biannual Staffing Review was undertaken in 2021, however this review did not meet all the national recommendations and, due to the Pandemic, provided assurance of safe staffing against revised workforce metrics. As a consequence there was no request to review or amend staffing establishments at this time.

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[1] NHS England (2012): *Compassion in Practice*

[2] The Mid-Staffordshire NHS Foundation Trust Public Inquiry (2013): *Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry.*

[3] Prof. Sir Bruce Keogh, NHS England (2013): *Review into the quality of care provided by 14 hospital trusts in England: overview report.*

[4] Don Berwick. Department of Health (2013): *A promise to learn, a commitment to act: improving the safety of patients in England.*

[5] Cavendish, C., Department of Health (2013): *The Cavendish Review: an independent review into healthcare assistants and support workers.*

[6] NHS England (2014): *Safer Staffing: A Guide to Care Contact Time.*

3 Methodology

3.1 Since 2011 WWL has undertaken adult nursing establishment review on a quarterly basis; March, June, September and December utilising the Safer Nursing Care Tool™ (SNCT). This tool was developed in collaboration with the Association of United Kingdom Hospitals (AUKUH) utilising the research evidence undertaken by Keith Hurst[7]. The tool is recognised by the Quality Management Board (QMB)[8]. SNCT utilises methodology to determine the staffing required to delivery care to patients within a given area dependent on actual individual patient levels of acuity and dependency. The tool also takes into consideration patient flow and nurse sensitive indicators (NSI's) in determining the appropriate level of care. Professional judgement is required to determine the skill mix of the staff employed within each area, and to assess the variability of staffing requirements which may be affected by changes in acuity and dependency levels of patients.

3.2 In January 2019 the Trust invested in SafeCare, a system that allows the measurement of the acuity and dependency needs of patients within inpatient areas to determine the hours of care required by the patient occupying the beds. This was rolled out in Q4 of 2018/19, and data from this system was used to provide the staffing recommendations within this report alongside professional judgement. Patient requirements on escalation areas, with the exception of CCU and safer placement beds, was not captured during this period of time and therefore, this report will apply professional judgement to advise on staffing required to enable the Trust to be responsive to patient need.

4 Safer Nursing Care Tool (SNCT)

4.1 As previously described the Trust utilises SNCT to determine the acuity and dependency of patients within our hospital. The tool incorporates agreed multipliers for adult and paediatric inpatient and assessment areas. Descriptions of the multipliers can be found at Table 1. Staff undertake assessment of the acuity and dependency needs of patients 3 times during the course of their shift and this information, aligned with actual staffing levels on the wards, provides an indication of whether there is surplus or insufficient nursing time available to deliver care to the patients in each clinical area.

4.2 Professional judgement can be applied to this depending on the ward configuration, e.g. patient need may indicate that there are surplus hours, however the ward area may have a high configuration of single rooms resulting in reduced patient visibility which warrants the additional nursing hours. Data from this census has been utilised within the report to inform staffing recommendations alongside professional judgement.

4.3 The Trust renewed the licences to utilise the SNCT tool and acquired a licence for the newly published ED staffing toolkit in October 2021.

5 Quality Indicators

[7] Hurst, K (2012): *Safer Nursing Care Tool Staffing Multipliers (2012) – Method and Results*

[8] Quality Management Board (2013): *How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing, midwifery and care staffing capacity and capability.*

5.1 Data with respect to hours of time required based on acuity and dependency cannot be viewed in isolation to determine staffing levels, this must be viewed alongside quality metrics, which provide an indication of outcomes and avoidable harms that occur within our clinical areas. These are reported monthly to the Trust Board within the performance report and also within the safe staffing report. These metrics are CDT rates, number of falls, number of pressure ulcers, number of medicine administration errors and number of red flags reported and are usually referred to as Nurse Sensitive Indicators (NSI's).

6 Professional Judgement

6.1 Allied to the use of SNCT is the use of Professional Judgement to confirm appropriate staffing levels. This is a bottom-up approach to the determination of staffing levels based on the judgement of experienced nurses to agree and determine the number and grade of staff required to provide care on a specific ward. This is agreed with Divisional Directors for Nursing and includes the agreed allowance for the uplift of staff.

7.Skill Mix

7.1 The RCN[9] recommends a ratio of 65:35 registered nurses/unregistered staff in inpatient areas and 70/30 for assessment areas. Following nursing establishment review in 2017 the Trust Board agreed the minimum ratio for registered/unregistered staff was to be set at 55:45; this was revised following the Bi-annual staffing review in February 2020 to 60:40 in inpatient areas and 65:35 within assessment areas. It is recommended that the Board agrees to amend the skill mix to reflect the RCN recommended ratios of registered to unregistered staff and bring the Trust in line with other organisations across Greater Manchester.

8 Uplift

8.1 The RCN recommend that nursing establishments are uplifted by 23% to support study leave, annual, and sickness/absence; NHSI recommend that the uplift in staffing is 22-25%. Trust Board agreed previously that the uplift would be set at 20% and this has remained unchanged. Across Greater Manchester the average uplift is 23% and it is recommended that the Board uplifts staffing establishment to this level to create parity across Greater Manchester and increase the ability of the Trust to flex to the peaks and troughs in activity that will provide further assurance with regards to safe staffing.

9 Supervisory Ward Managers

9.1 National guidance suggests that all Ward Leaders should be supervisory to practice. In July 2021 the Trust agreed to follow this guidance within inpatient areas, however Ward/Departmental Leaders out with this cohort remain clinical for 50% of their time. It is recommended that consideration of extending the supernumerary status of B7 leaders to key areas is considered, within the areas detailed in section 16 of the report, to fully undertake their leadership, management and quality improvement roles.

10 Current Position, SNCT and Professional Judgement

[9] RCN (2010): *Guidance on safe nurse staffing levels in the UK*

10.1 When funded establishments and SNCT data is compared it is evident that there has been an increase in acuity and dependency of patients and their care requirements highlight a need to increase funded nursing hours. SNCT does not always capture the requirements re national guidance, and this is where professional judgment needs to be applied. The difference between WTE funded establishment, SNCT WTE recommendations and professional judgement is provided in Table 1 below. Included within the table is the adjusted skill mix following the application of professional judgement and movement towards the recommended skill mix.

10.2 The Trust utilises a bottom-up approach to the application of professional judgement which aids in finalising and agreeing staffing requirement with the composition of a roster template to ensure there are sufficient staff to meet ward requirements within the recommended establishment. On occasion this approach can result in marginal differences in skill mix in order to ensure the roster template is correct and there is a consistent approach to staffing throughout the 24-hour 7-day continuum.

10.3 The Trust obtained a licence for the ED Safer Nursing Staffing Tool in October 2021. Launch dates for the tool are being scheduled in February 2022 and it is intended to incorporate this information into future staffing reports.

10.4

Division	Ward	Nos of Beds	Sept 21 WTE	September SNCT	Professional Judgement	Revised Skill Mix
Specialist Services	Aspull	28	48.16	53.18	55.37	63:27
	JCW	16	25.29	32.77	25.29	73:27
	Ward A	28	38.53	42.25	44.3	63:37
	Ward B	24	35.2	38.84	44.3	63:37
Surgery	Langtree	28	32.26	40.81	44.3	63:37
	Orrell	17	24.19	28.23	27.69	60:40
	Swinley	26	32.26	32.8	33.22	67:33
	Swinley clinic		3.68	N/A	6.56	
Scheduled Care	Astley	27	43.49	46.3	44.3	63:37
	Standish	28	48.38	48.38	44.3	63:37
	ASU	22	39.9	39.9	41.53	47:53
	CCU	11	32.69	28.7	32.69	73:27
	Ince	28	49.48	41.1	44.3	63.37
	Winstanley	27	44.84	67.2	63.78	65:35

Division	Ward	Nos of Beds	Sept 21 WTE	September SNCT	Professional Judgement	Revised Skill Mix
	Pemberton	12	23.8	23.8	27.69	60:40
	Shevington	28	44.26	44.26	44.3	63:37
Unscheduled Care (Assessment Areas)	*CDW	10	22.84	25.53	22.15	63:37
	MAU	25	44.77	48.13	49.85	67:33
	Lowton	28	43.99	49.1	49.85	67:33
	Bryn*	26	41.9	46.4	49.85	67:33
	Total	**490**	**719.91**	**777.61**	**795.62**	

Table 1

11 Application of Professional Judgment (*Bryn Ward is a new clinical area opened in 2020 and therefore is not reflected in previous reports received by the Board)

11.1 SNCT does not always capture the requirements re national guidance, and this is where professional judgment needs to be applied.

- *National recommendations stipulate that CCU should have a staffing ration of 1 RN per 2 Patients this is reflected in the recommendations which is reflected within the current staffing model.*
- *CDW the model of care has changed to part bedded part ambulatory this has resulted greater level of activity which in turn impacts of nursing hours required this is reflected within the recommendations.*
- *Winstanley Ward: The clinical area has been reconfigured since the last report and provides an increased dependency unit for the provision of NIV. The British Thoracic Society Guidance for the care of patients receiving Non-Invasive Ventilation (NIV) which specifies that patients receiving acute NIV should be cared for ration of 1 RN per 2 Patients this is reflected in the recommendations. Currently 9 NIV beds are provided within the ward bed complement. The remaining staffing requirements are to provide care to the rest of the respiratory ward.*
- *JCW on the Wrightington site has a higher skill mix of registered to unregistered staff. This skill mix reflects the lay out of the unit.*
- *Pemberton ward skill mix is below the recommended 65:35 ratio. This reflects the layout of the unit and the requirement for additional cleaning within the clinical area to safely manage inpatient care.*
- *Orrell Ward has been reconfigured since the last Bi-annual review and comprises an assessment area and inpatient beds. This is not accurately reflected in the SNCT data and the staffing model has been developed in accordance to patient need.*
- *ASU skill mix is reduced from the 65:35 recommended by AUKUH. The skill mix reflects the balance between acute and ongoing care of patient who have experienced a stroke and therefore is a blended acute and rehabilitation staffing model.*

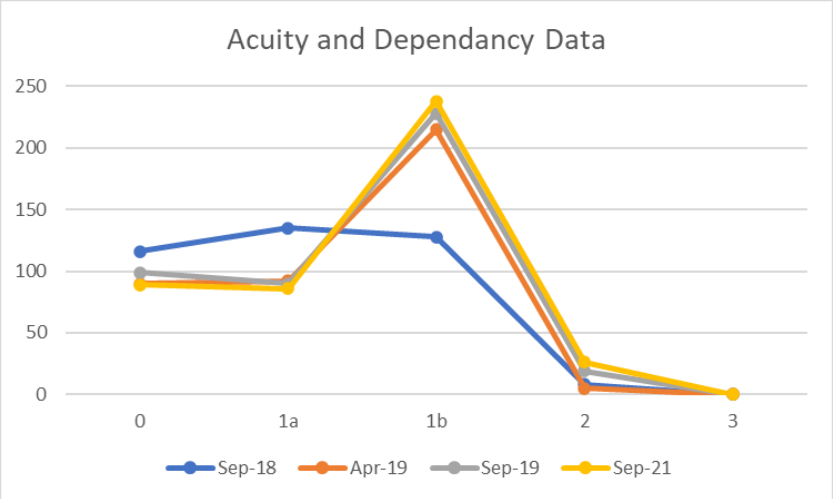
- *Since the commencement of the Pandemic ED has been operating across a wider footprint in order to reduce the transmission of nosocomial infections in accordance with National Guidance. Approval was given to the clinical area to over-recruit by 10% to B5 positions to assist with staffing and winter pressures monies were provided in 2021 to support a temporary increase in staffing within the department. Due to the ongoing requirement to segregate patient flow over a wider footprint it is recommended that the winter pressures staffing levels are maintained.*

11.2 This information has been reviewed by the Divisional Directors for Nursing and in line with professional judgement considering skill mix, consideration of nursing sensitive quality indicators and patient experience, the professional recommendation is that overall staffing establishment needs to revert back to the previously agreed skill mix as a minimum as outlined within the recommendations within this report.

12 Position regarding acuity

12.1 Comparison of acuity and dependency data has identified a continuing shift in the care requirements of the patients (Chart 1). Level 1b patients remain the highest category of patients occupying inpatient beds across the Trust. These patients generally require all nursing care and in addition often have complex health and social care needs requiring oversight and scrutiny by registered staff. The data also demonstrates an ongoing increase in the number of SNCT Level 2 patients occupying beds on core ward. This is reflective of the increased provision of NIV on Ince and Winstanley and the increasing number of patients requiring escalation to higher levels of care from core wards. This is reflective of the age group of those admitted, post pandemic surge requirements, and the complexity of managing their multiple co-morbidities, and the increasing number of patients who are ill but do not meet the criteria for admission to HDU/ICU.

12.2 Registered staff are essential in the planning, co-ordination, supervision and delivery of care, and the reduced performance in the quality metrics detailed within the report indicate that the care being provided is being compromised as a result of this dilution.



8/18

	Sep-18	Apr-19	Sep-19	Sep-21
0	116	90	99	89
1a	135	92	90	86
1b	128	215	228	238
2	8	5	19	26
3	0	0	0	0

Chart 1

12.3 SNCT data provides evidence that there are insufficient care hours to meet the needs of our patients, therefore conversion of unregistered posts to registered posts will not address the issue of dilution, and this is will also negatively impact on nurse sensitive indicators.

12.4 Community Services transferred to WWL from Bridgewater in April 2019 and there has been no formal staffing review undertaken across these services since the transfer occurred. At the time of the transfer, concerns were being raised to the previous provider with regards to caseload numbers as they were significantly above the benchmark position of 12 patients per nurse. It was recognised at the time of the transfer that significant transformation within community services.

12.5 Since the transfer of these services there has been no further investment by commissioning or WWL. This is reflected in the ongoing increased caseload numbers which have not been resolved despite recruitment to vacancies, and further reflected in high staff absences, and increased turnover in the service. Staff within the Division are also verbalising that they feel their services are being overlooked from an investment perspective.

12.6 The Acuity within community services is currently monitored via the OPEL status of the service. It should be noted that District Nursing Services (DNS) have consistently remained on OPEL level 3 throughout the course of 2020 and 2021 and caseloads have continued to increase. The average caseload of a District Nurse is 12 patients; the range within WWL has been between 15 and 28 patients (Mean 21.5 patients per registered nurses).

12.7 The division has taken a risk stratification approach to case load management, wrapping additional services around to support where appropriate, reducing the number of face-to-face visits and increasing the number of telephone contacts with patients/families. Although there has been no reported increase in avoidable harm there has been an increase in the number of complaints received within the division and professional concerns raised with regards to the inability to appropriately monitor patients in accordance with an agreed plan.

12.8 A community acuity and dependency tool is currently being developed and trailed by the National Staffing Team.

12.9 Emergency Department (ED) staffing has not been formally reviewed since 2011 and the current establishment levels reflect those set at this time. There is investment in workforce to support winter planning on a temporary basis to support anticipated increases in attendances within the department.

12.9 As stated within 10.3 a Safe Staffing Tool has been developed for ED, however this has yet to be launched and therefore when considering staffing requirements, the environment, attendances and demands on resuscitation areas needs to factor into the modelling to support safely staffing the area.

12.10 The Minor Injuries Unit opened in 2015. In 2019 this evolved into an Urgent Treatment Centre (UTC). There was no additional funding to support the nursing hours required or reflect the opening time requirements. The future model is to run 24 hour/7 days which will not be achieved without

recurrent funding; winter pressures money is currently supporting this service up to 0100hrs. The recommendation is that UTC is staff to support provision of a 24/7 service and the investment in the ED streamers within this service will support flipping of the streaming model.

12.11 In accordance with Royal College of Emergency Medicine Guidelines, staff to patient ratios within resuscitation areas should be either 1:1 or 1:2 depending on the acuity of the patients. 7 beds are currently being provided. The current staffing model only supports a 1:3 ratio and therefore there is a patient safety risk. The recommendation is that this area is staffed to the current capacity required.

12.12 The Shelford Safer Nursing Care Model for ED supports the role of the B7 supernumerary Nurse-in Charge role within the department. It is the recommendation that investment in position is considered as an essential requirement to support ED flow and promote patient safety.

12.13 The recommendations to support staffing within ED assumes the unit operates without the requirement to segregate patients as is current practice due to COVID measures.

13 Nurse Sensitive Indicators (NSI's)

13.1 NSI's are measures and indicators reflecting the structure, process and outcomes of nursing care. These measures help to reflect the impact of care that nurses working in inpatient services provide. In addition, they assist in determining the link between the care provided and funded staffing establishment within the ward. NSI data is reported monthly to Board within the Safe Staffing Report.

13.2 Strong visible leadership is key to the maintenance of high standards, avoidance of harms and continuous quality improvement. It is therefore recommended that the number of budgeted Band 6 staff within inpatient areas is standardised to ensure senior leadership presence throughout the 7-day, 24-hour continuum. This will also offer greater opportunity for staff progression and assist in recruitment and retention of staff.

13.2 Chart 2 shows the increased prevalence of CDT within the Trust from Q1 2019 to Q2 2021. Where lapses in care have been identified this has been linked to poor compliance with Personal Protective Equipment (PPE), cleanliness standards within inpatient areas, and a lack of side room capacity to facilitate the isolation of patients.

13.3 The increase in CDT is not an isolated issue within WWL, the increasing prevalence of CDT is apparent across the majority of hospital Trusts and is partly associated with the increasing complexity and vulnerability of patients being admitted into hospital.

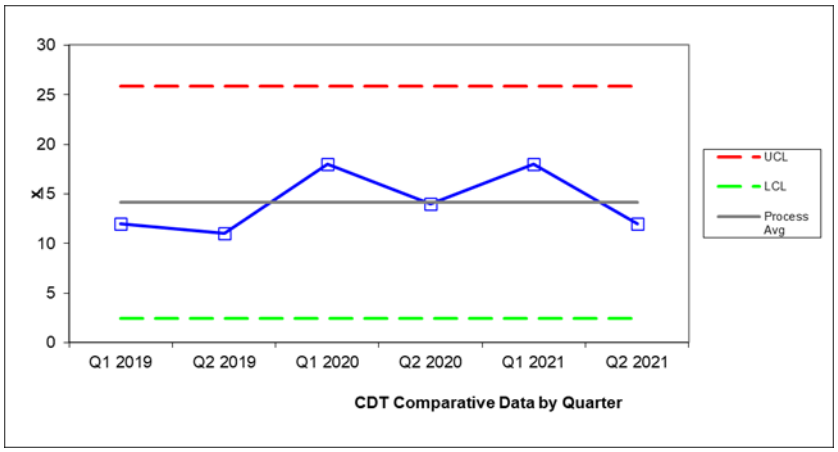


Chart 2.

13.4 Following investment in staffing in April 2020 the Trust saw a reduction in overall fall numbers as demonstrated in Chart 3.

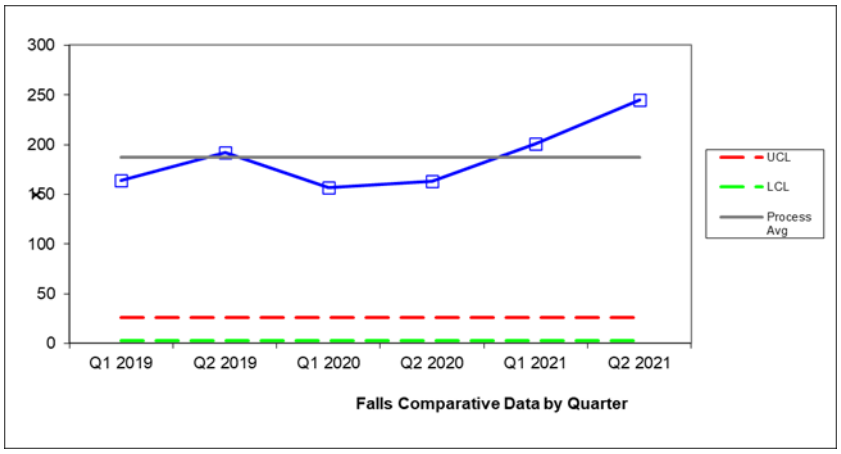


Chart 3

13.5 The reduction in falls is partly attributable to increased and appropriate utilisation of the Enhanced Observation Policy and focused work on keeping patients active to prevent deconditioning. It is recommended that the Trust invests in a pool of 40 WTE unregistered staff to assist in the provision of enhances observations. This resource can be deployed to support areas in response to patient need and will reduce reliance on temporary staffing.

13.6 The requirements of patients admitted in 2020 because of the COVID-19 pandemic increased both the acuity and dependency of patients admitted to our care, and the length of stay. The complexity of their needs resulted in an increase in multi-professional input into active and recovery care to ensure that patients were holistically fit for discharge.

13.7 By April 2020 the Trust also had zero Band 2 vacancies which greatly assisted in observations across inpatient areas.

13.8 The Community Assessment Unit opened in 2021; the intention of this area was to see, assess and discharge elderly patients or, where this was not possible, to provide a short inpatient stay within the unit to optimise and discharge back into the community with a package of care. The staffing model for the unit was lean, and the geography of the unit negatively impacted on the ability of staff to view all patients resulting in several falls occurring before the staffing was increased to assist in the mitigation of risk.

13.9 Chart 4 details medication administration incidents reported across the Trust involving nurses or midwives. The chart details an increasing trend of incidents since Q2 2019; however it should be noted that the Trust actively encourages the reporting of incident to provide the opportunity for analysis and learning. 96% of incidents reported resulted in no harm to patients.

13.10 A focused piece of work has been undertaken by the Medicines Safety Nurse Specialist and the Deputy Chief Nurse to determine the reasons for the increase in reported incidents, and a programme of work has been developed to address some of the cultural and practice issues identified as a consequence of the review.

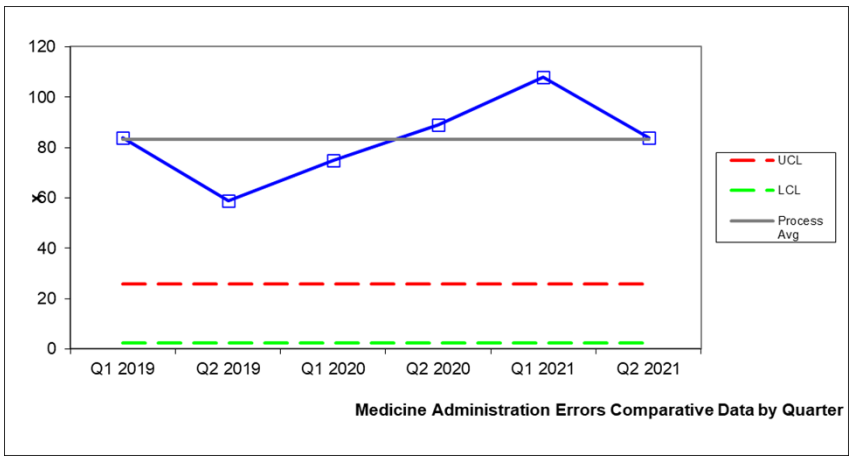


Chart 4

13.11 Chart 5 details verified pressure ulcers of all categories reported in the data capture period.

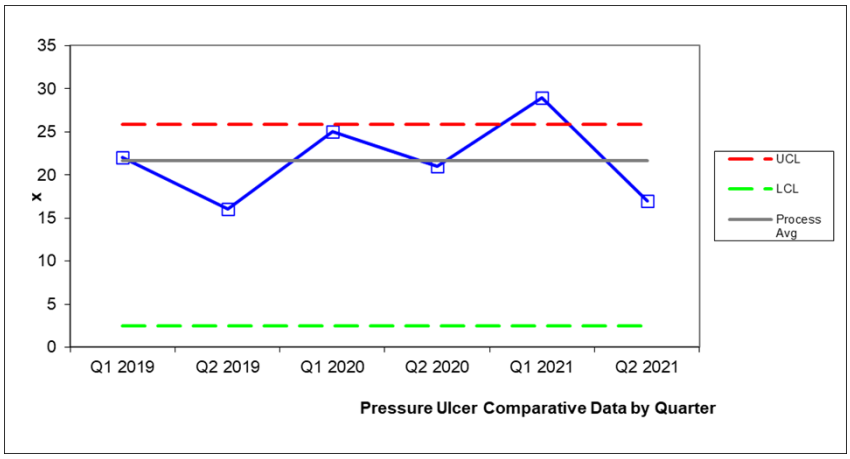


Chart 5

13.12 In Q2 2019 the pressure ulcer review panels were reinstated by the Deputy Chief Nurse in response to the increasing number of pressure ulcers being reported. These review meetings had been stood down during the first wave of the COVID-19 pandemic and it was felt that the lack of oversight on the incidents had contributed to the increase in harms reported, coupled with redeployment of staff into areas that were not familiar to them.

13.13 Despite initial improvement the situation deteriorated again in subsequent waves of the pandemic.

13.14 A common finding of the reviews was the lack of registered nurse oversight of the management and delivery of direct patient care. This is partly attributable to vacancies and partly to the reduced skill mix off staff which results in most of the direct patient care being delegated to unregistered staff.

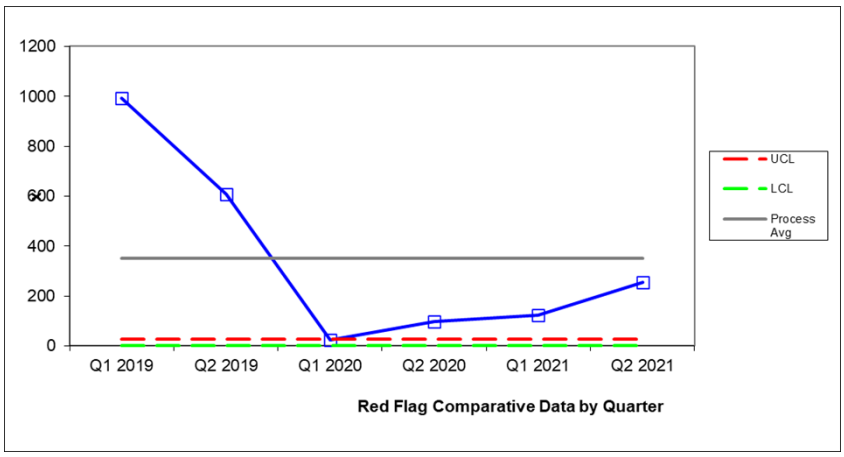


Chart 6

13.15 The data provided in Chart 6 demonstrates the number of red flags reported by staff.

13.16 Nursing Red Flags were launched in 2014 by the National Institute for Clinical Excellence (NICE). The Red Flag events are warnings that identify when there are insufficient registered nurses to meet the needs of the patients on any ward. Red Flag events are currently captured on SafeCare and are reported monthly in the Safe Staffing Report.

13.17 Overall there has been a decrease in the number of Red Flags reported within the timescales above. This reflects the investment in staffing in April 2019, and the redeployment of staff and the agreed reduction in staffing ratio's particularly in the first 2 waves of the Covid-19 pandemic which impacted directly on the reporting triggers.

13.18 The greatest number of Red Flags reported relate to a reduction in the number of registered nurses available to work versus planned levels agreed. These account for approximately 79% of all red flags raised.

14 Mortality

14.1 Evidence suggests that there are higher levels of mortality and poor patient outcomes and experience when registered nurse staffing levels are reduced. The Board should note the potential for this risk and consider nurse staffing and skill mix as part of the mortality reviews within specialty services. Evidence suggests that there are higher levels of mortality and poor patient outcomes and experience when registered nurse staffing levels are reduced[10]

15 Compliance with the Developing Workforce Safeguards, Nursing and Midwifery

15.1 The Workforce safeguards published by NHSI in October 2018 are used to assess Trusts compliance with the Triangulated approach to staff planning in accordance with the National Quality Board Guidance. This combines evidence-based tools with professional judgement and outcomes to ensure the right staff, with the right skills are in the right place at the right time.

15.2 Although the guidance applies to all staff, this paper will outline Nursing current compliance with the 14 safeguards recommendations and identify any areas of improvement.

15.3 Compliance with the Safeguards can be found in Appendix A.

[10] P Griffiths (2019): *Registered nurse and HCA staffing levels: the effects on mortality.* Nursing Times; January 2019/Vol 115 Issue 1

16 Recommendations

16.1 It is evident from the information provided within the report that the Trust does not meet the minimum requirements for the skill mix, uplift to funded establishments and compliance with the supervisory Ward/Departmental Leaders. The lack of appropriate skill mix is impacting on patient care as there are insufficient registered nurses to oversee and evaluate the impact of care delivered and is reflected in avoidable harms, most notably pressure ulcers and falls. This further triangulates with incidents reported to StEIS where there have been delays in the escalation of the deteriorating patient.

16.2 It is therefore recommended that the Board agree with the below actions being taken. To aid decision making this have been divided into "strongly recommend" and "consider" categories as detailed below.

Strongly Recommend:

1. The skill mix for core wards is reset to 65:35 and the skill mix for assessment areas is uplifted to 70:30 to reflect the high turnover of patients and the increasing demands and acuity on these areas. Amendments to skill mix also incorporate the increased of the B6 inpatient establishment number incorporated into ward establishments to ensure a B6 nurse is on duty 24/7 to improve visibility.
   To address the skill mix and SNCT requirements the establishment would increase by 63 WTE at an investment of £3.1m.

2. To adequately staff ED based on increased attendances, staffing requirements in resuscitation, and the extension of hours within UTC, and ensure the provision of a B7 co-ordinator.
   This would require an increase in establishment of 57 WTE and require investment of £2.6m.

3. To increase the relief percentage to 23.6% based on the national recommendation of 23.0% plus 0.6% for birthday leave.
   This would be an increase in establishment of 28 WTE at an investment of £1.2m.

4. To uplift 319 WTE from band 2 to band 3 following settlement of the collective grievance. The establishment change is based on the required number of posts at this grade per ward.
   This is an investment of £0.7m.

5. In response to the increasing caseloads within Community Services it is recommended that there is an uplift in staffing of 18 WTE.
   This represents an establishment increase of 18 WTE and the investment required is £0.8m.

6. Agree to support the development of an internal pool of 40 WTE B2 staff to support enhanced observations and reduce the reliance on temporary staffing.
   The cost of this is £1.1m which can be funded from the fall sitters' budgets within the divisions.

All must do actions will result in an increase in staff of 206 WTE with a total cost of £8.4 m
There is existing budget of £1.8m which could be diverted to reduce the investment required to £6.6 m.

Consider:

7. Agree to make the following B7 leaders of departments supervisory to practice and backfill with B5 staff.
   Medicine

   - Cardiac Catheter Laboratory
   - Endoscopy Leigh and WTN
   - COPD
   - VTE
   - Planned Investigation Unit (PIU)
   - Same Day Emergency Care

   Specialist Services

   - Theatres Wrightington
   - Cancer Care

   Community Division

   - District Nursing

   Surgery

   - Theatres RAEI and Leigh
   - Antenatal Clinic
   - Ward 3 Leigh
   - Surgical Assessment Lounge
   - Women's Unit

   The cost of this investment is £0.4m (11 WTE).

16.3 If all recommendations are accepted this would result in an increase in staff of 217 WTE at total cost of £ 7m.

Appendix A:

Compliance with the Developing Workforce Safeguards, Nursing and Midwifery

Recommendation	Compliance
Recommendation 1: Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.	**Fully Compliant Evidence.** SNCT is used across all adult and paediatric inpatient areas.
Recommendation 2: Trust must ensure the three components are used in their safe staffing process.	**Fully Compliant Evidence**: SNCT in use at Trust to evidence based our establishments.
Recommendation 3 & 4: Assessment will be based on review of the annual governance statement in which Trusts will be required to confirm their staffing governance processes are safe and sustainable.	**Fully Compliant Evidence:** Confirmation included in annual governance statement that our staffing governance processes are safe and sustainable.
Recommendation 5: As part of the yearly assessment assurance will be sought through the Single Oversight Framework (SOF) in which performance is monitored against five themes.	**Fully Compliant Evidence**: We collate and review data every month for a range of workforce metrics, quality and outcomes indicators and productivity measures – as a whole and not in isolation from each other. We also demonstrate evidence of continuous improvements
Recommendation 6: As part of the safe staffing review the Chief Nurse and Medical Director must confirm in a statement to their Board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.	**Fully Compliant Evidence;** Recorded within the Trust Board Minutes
Recommendation 7: Trusts must have an effective workforce plan that is updated annually and signed off by the Chief Executive and Executive Leaders. The Board should discuss the workforce plan in a public meeting	**Fully Compliant Evidence:** Annual submission to NHSI
Recommendation 8: They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their Board monthly.	**Fully Compliant Evidence:** Monthly Safe Staffing paper triangulates this information.
Recommendation 9: An assessment or resetting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the Board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.	**Fully Compliant Evidence:** Bi-annual review is completed across all inpatient services

Recommendation	Compliance
Recommendation 10: There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool	Fully Compliant Evidence: SNCT ready for use with no manipulation
Recommendation 11 & 12: As stated in CQC's Fully Compliant Evidence: Completed Nursing, Midwifery and Allied Health Professional Bi-annual staffing Report. October 2020. V1.1 24 well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes and new roles, must have a full quality impact assessment (QIA) review.	Fully Compliant Evidence QIA's undertaken as described.
Recommendation 13 & 14: Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments. Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the Board to maintain safety and care quality.	Fully Compliant Evidence: TDS staffing meetings. Staffing also discussed at the flow and capacity meetings throughout the day. Safe Staffing escalation process. Safe Staffing SOP. Redeployment Triggers agreed.

Summary of nurse establishment review costing

Proposal	Increase / (Decrease in WTE)						Cost of Proposal at Midpoint £'000						Existing Budget £'000	Additional Budget Required £'000	Finance Comments
	Medicine	Surgery	Specialist	Community	Other	Total	Medicine	Surgery	Specialist	Community	Other	Total			
Ward staffing review	10.21	23.46	29.34			**63.01**	913	958	1,276			**3,147**		3,147	Based on the recommended staffing levels and skill mix
Emergency department recurrent investment	68.52					**68.52**	2,877					**2,877**		2,877	Based on recurrent investment in the expanded capacity currently funded non-recurrently via Winter and Covid.
Increase relief from 20% to 23%	12.43	5.68	5.58			**23.69**	486	232	214			**932**		932	May offset bank and agency expenditure to cover existing backfill for staff absence. This has only been applied to the specific wards identified in the review.
Increase relief to 23% to 23.6% for birthday leave	2.49	1.14	1.12			**4.74**	97	46	43			**187**	187	0	Birthday leave backfill equates to an additional 0.6% relief. Could be funded from the cost pressures budget given to divisions.
HCA band 2 to band 3 uplift:															The HCA costing is based on the uplift of 319 WTE band 2 to band 3 based on information provided by the professional practice team about the required band 3 establishment in each area. The number in scope is 367 WTE and therefore higher by 48 WTE which could create a budget pressure.
Wards	0.00	0.00	0.00			**0.00**	281	73	109			**463**		463	
Other areas	0.00	0.00	0.00			**0.00**	46	70	96			**212**		212	
Create 40 WTE band 2 fall sitters pool					40.00	**40.00**					1,125	**1,125**	1,218	(93)	This could be funded from the fall sitters budget within the divisions (generally funding bank expenditure at present).
Community additional staffing				18.48		**18.48**				838		**838**		838	
Supernumerary additional band 7 posts	8.41	5.75	5.75	4.50		**24.41**	293	198	199	157		**847**		847	Based on backfill at band 5 to release band 7 leaders to be supernumerary.
Fast track band 5 to band 6 funding						**0.00**						**0**	390	(390)	The staffing review increases the number of band 6 posts within the establishment so could be offset against the reserve for fast tracks. The programme could still be offered with the expectation that staff then slot into a band 6 vacancy.
TOTAL	**102.06**	**36.03**	**41.79**	**22.98**	**40.00**	**242.85**	**4,994**	**1,577**	**1,937**	**994**	**1,125**	**10,627**	**1,795**	**8,832**	

Heather Shelton
Complied by the DFM for each division
25/01/2021

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Maternity Dashboard Report
Presented to:	Trust Board
On:	2 February 2022
Presented by:	Rabina Tindale
Prepared by:	Gemma Weinberg for Cathy Stanford
Contact details:	gemma.weinberg@wwl.nhs.uk

Executive summary

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

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

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

• Green – Performance within an expected range.

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

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

Recommendation(s)

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

Maternity Dashboard December 2021

Introduction

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

The maternity dashboard is reviewed at Directorate, Divisional and Corporate Clinical Governance Meetings.
The metrics are measured using a RAG system.
• **Green** – Performance within an expected range
• **Amber** – Performing just below expected range, requiring close monitoring if continues for 3 consecutive months
• **Red** – Performing below target, requiring monitoring and actions to address.

December 2021 Exception report

Summary

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

- There have been no cases reported to the Healthcare Safety Investigation Branch (HSIB) or babies diagnosed with HIE 2 or 3.
- There were no midwifery red flags reported due to the shift coordinator being unable to remain supernumerary in December and 1-2-1 care in labour has been maintained at 100%, a noted improvement on previous months.
- 2 Maternity complaints were received in December however the service continues to receive positive feedback letters and messages from Women regarding the excellent care they have received. Of these complaints one was from over 12 months ago.

Steis reportable Incidents

There were 2 stillbirths, but the overall stillbirth rate remains low to date. There was one maternity divert that occurred which was due to covid related absence within the theatre team.

Green

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

Women booked by 12+6 weeks has seen a big improvement from November's figures and has returned to normal levels, it now stands at 92%.

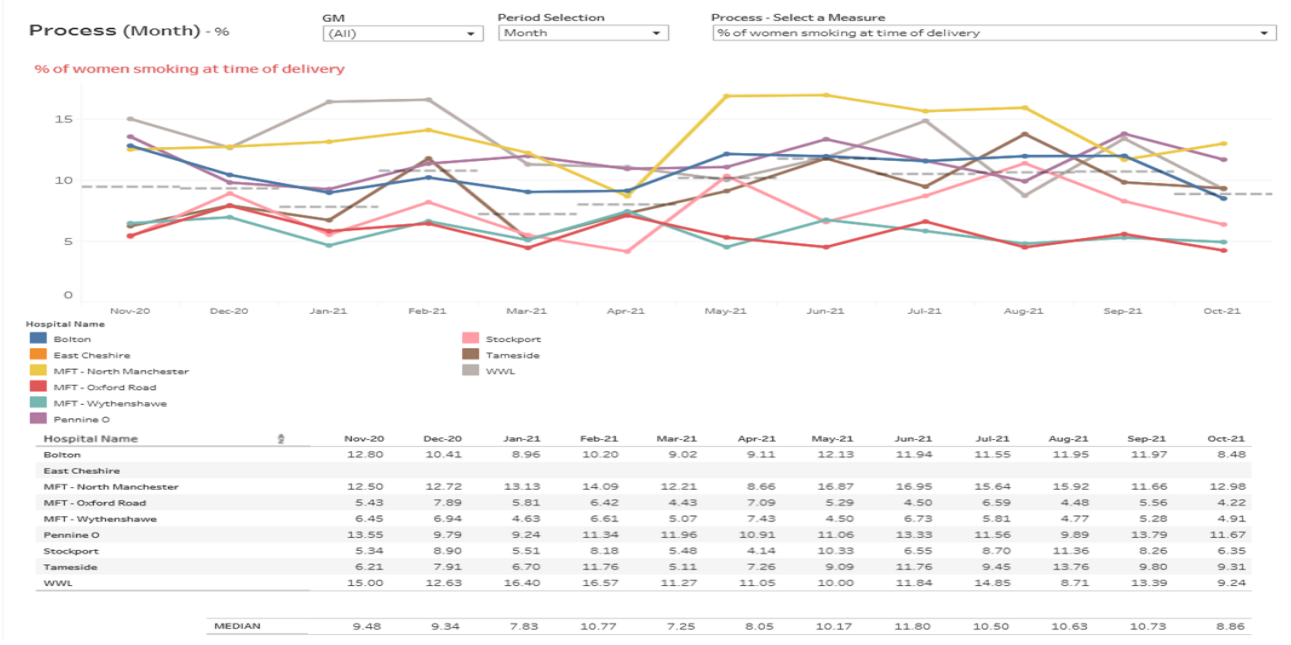
Skin -Skin. The percentage of babies receiving skin to skin within 1 hour of birth had fallen for 2 consecutive months but is back to 79% and well within target limits again.

Term admissions to NNU. After a spike in numbers in September and October these have returned to usual levels in December.

Supernumerary Shift coordinator despite ongoing staffing issues and increased activity and acuity we are at 100% compliance for December. The service strives to maintain safe staffing

levels, and any shortfalls are covered by NHSP whenever possible. Recruitment to vacancies remains an ongoing priority

Smoking at the time of Delivery (SATOD)
There has been a slight uptick of women smoking at delivery, but the figures are showing a generally downward trend since a year ago

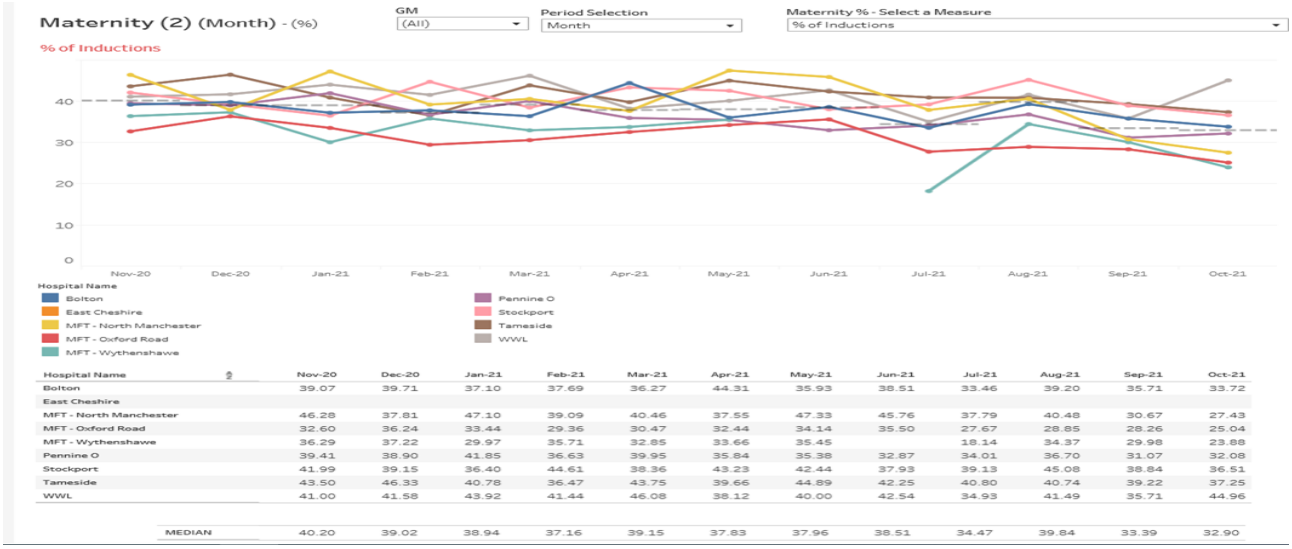


Hospital Name	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Bolton	12.80	10.41	8.96	10.20	9.02	9.11	12.13	11.94	11.55	11.95	11.97	8.48
East Cheshire												
MFT - North Manchester	12.50	12.72	13.13	14.09	12.21	8.66	16.87	16.95	15.64	15.92	11.66	12.98
MFT - Oxford Road	5.43	7.89	5.81	6.42	4.43	7.09	5.29	4.50	6.59	4.48	5.56	4.22
MFT - Wythenshawe	6.45	6.94	4.63	6.61	5.07	7.43	4.50	6.73	5.81	4.77	5.28	4.91
Pennine O	13.55	9.79	9.24	11.34	11.96	10.91	11.06	13.33	11.56	9.89	13.79	11.67
Stockport	5.34	8.90	5.51	8.18	5.48	4.14	10.33	6.55	8.70	11.36	8.26	6.35
Tameside	6.21	7.91	6.70	11.76	5.11	7.26	9.09	11.76	9.45	13.76	9.80	9.31
WWL	15.00	12.63	16.40	16.57	11.27	11.05	10.00	11.84	14.85	8.71	13.39	9.24
MEDIAN	9.48	9.34	7.83	10.77	7.25	8.05	10.17	11.80	10.50	10.63	10.73	8.86

Amber

Re-admissions of babies within 30 days has remained at normal levels with increased Jaundice levels being the main reason for readmission. All cases were managed appropriately.

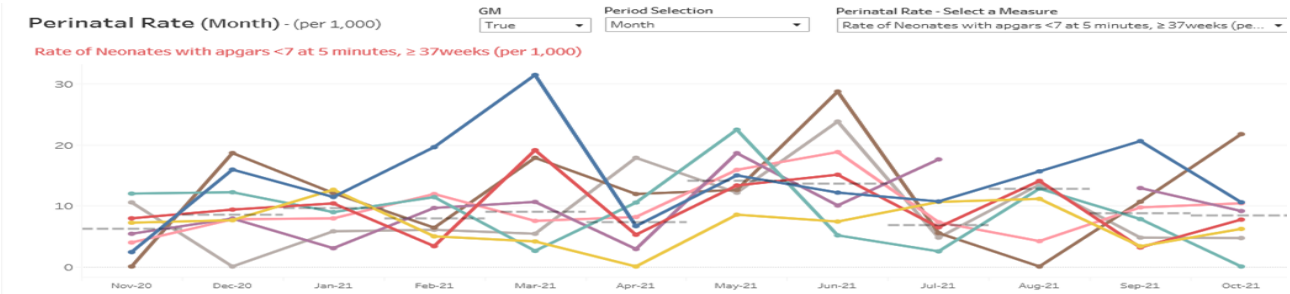
Induction of Labour (IOL) - has seen a slight increase this month but we are not an outlier within GM. All cases are reviewed for appropriate medical reasons, gestations, and outcomes.



Hospital Name	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Bolton	39.07	39.71	37.10	37.69	36.27	44.31	35.93	38.51	33.46	39.20	35.71	33.72
East Cheshire												
MFT - North Manchester	46.28	37.81	47.10	39.09	40.46	37.55	47.33	45.76	37.79	40.48	30.67	27.43
MFT - Oxford Road	32.60	36.24	33.44	29.36	30.47	32.44	34.14	35.50	27.67	28.85	28.26	25.04
MFT - Wythenshawe	36.29	37.22	29.97	35.71	32.85	33.66	35.45		18.14	34.37	29.98	23.88
Pennine O	39.41	38.90	41.85	36.63	39.95	35.84	35.38	32.87	34.01	36.70	31.07	32.08
Stockport	41.99	39.15	36.40	44.61	38.36	43.23	42.44	37.93	39.13	45.08	38.84	36.51
Tameside	43.50	46.33	40.78	36.47	43.75	39.66	44.89	42.25	40.80	40.74	39.22	37.25
WWL	41.00	41.58	43.92	41.44	46.08	38.12	40.00	42.54	34.93	41.49	35.71	44.96
MEDIAN	40.20	39.02	38.94	37.16	39.15	37.83	37.96	38.51	34.47	39.84	33.39	32.90

Red

All infants with Apgar's less than 7. This has shown a further spike in numbers. All cases were managed appropriately. We are not an outlier within GM. We will continue to monitor this safety indicator.



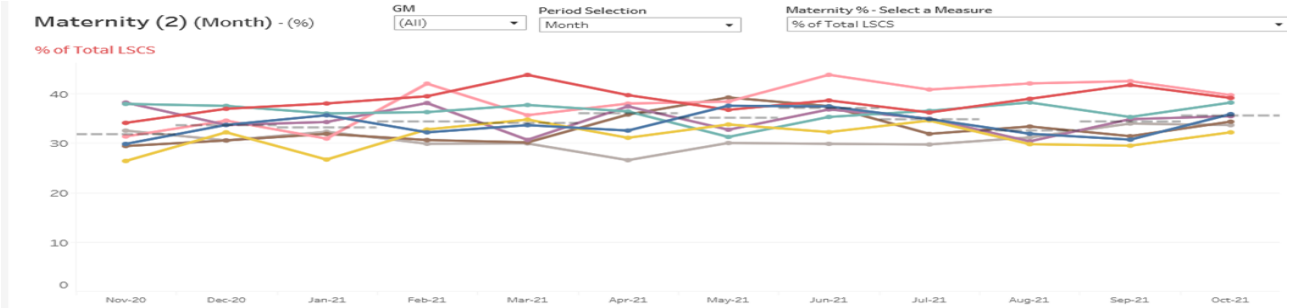
Hospital Name	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Bolton	2.37	15.92	11.42	19.61	31.46	6.64	14.96	12.14	10.68	15.63	20.59	10.55
East Cheshire												
MFT - North Manchester	7.19	7.60	12.61	4.95	4.12	0.00	8.51	7.38	10.60	11.11	3.32	6.17
MFT - Oxford Road	7.91	9.35	10.36	3.34	19.11	5.22	13.31	15.08	6.44	14.06	3.13	7.70
MFT - Wythenshawe	11.98	12.20	8.93	11.40	2.56	10.50	22.47	5.12	2.49	12.79	7.79	0.00
Pennine O	5.38	7.87	3.00	9.62	10.61	2.87	18.62	10.03	17.59		12.89	9.11
Stockport	3.94	7.75	7.91	11.90	7.49	8.13	15.87	18.80	7.27	4.17	9.71	10.38
Tameside	0.00	18.63	12.05	6.37	17.86	11.90	12.58	28.74	5.49	0.00	10.64	21.74
WWL	10.53	0.00	5.78	6.02	5.38	17.86	12.12	23.81	4.74	13.45	4.74	4.67
MEDIAN	6.29	8.61	9.65	7.99	9.05	7.38	14.14	13.61	6.86	12.79	8.75	8.41

Women readmitted within 28 days of Delivery. This has increased from the lower numbers seen previously. However only one of these readmissions was related to delivery. The other two were medical / surgical issues. There were no concerns identified and no omissions in care.

The number of mothers who have opted to breastfeed – There was a significant improvement in October with an increase of nearly 8%. This has decreased again in December, but the yearly average remains within target levels and work continues to encourage breastfeeding.

Maternal steroids - are given to mature the fetal lungs when premature labour is suspected, or early delivery is required. There were three eligible mothers who had four babies born in December (2 singletons and one set of twins). One Mother had a complete course prior to delivery. One had an incomplete course due to delivery needing to be expedited. The twins needed immediate delivery due to an obstetric emergency so steroids could not be administered.

The overall Caesarean section rate has remained amber for the last 6 months however there is now a slight upward trend and, as a direct consequence, the normal birth rate has fallen just below the red flag figure of 55%. We currently have 2 rooms to be refurbished as low risk birth rooms and work to promote normality and optimise birth outcomes continues across the maternity service. Instrumental deliveries have decreased this month and have gone from amber to green.



Hospital Name	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Bolton	29.80	33.66	35.61	32.15	33.61	32.51	37.53	37.39	34.83	31.87	30.67	35.84
East Cheshire												
MFT - North Manchester	26.35	32.16	26.64	32.73	34.73	31.05	33.74	32.20	34.53	29.76	29.45	32.15
MFT - Oxford Road	34.07	36.91	37.99	39.45	43.78	39.69	36.71	38.60	36.16	38.94	41.73	39.10
MFT - Wythenshawe	37.90	37.50	35.97	36.24	37.68	36.39	31.22	35.27	36.51	38.19	35.25	38.17
Pennine O	38.18	33.65	34.24	38.08	30.62	37.40	32.68	36.78	34.92	30.33	34.81	35.42
Stockport	31.32	34.52	30.88	42.01	35.62	37.97	38.38	43.79	40.80	42.05	42.51	39.68
Tameside	29.38	30.51	31.84	30.59	30.11	35.75	39.20	37.43	31.84	33.33	31.37	34.31
WWL	32.50	30.53	32.28	29.83	29.90	26.52	30.00	29.82	29.69	31.12	33.93	33.61
MEDIAN	31.91	33.65	33.26	34.49	34.17	36.07	35.23	37.08	34.88	32.60	34.37	35.63

Conclusion

Normal variation and fluctuations are noted with the figures this month and many positive factors have been sustained. No issues are raised with care given or in the management of cases. Despite some months showing red safety indicators, the annual rates are shown to be green and amber. The maternity dashboard continues to be reviewed quarterly by GM and the Maternity Dashboard steering group.

	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of Women Delivered	166	216	238	200	190	189	181	204	181	180	228	229	241	224	238	205	212
Number of Registerable Births	167	220	241	202	193	192	182	208	181	182	232	229	241	229	242	205	213
Number of Bookings(retrospective 1 month)	216	247	233	226	246	238	252	285	231	214	222	205	222	242	227	244	233
Normal Births as % of births	104	120	130	135	120	101	105	125	106	112	132	131	137	127	143	112	116
% of Successful Planned Home Births	2	2	2	4	4	5	7	4	4	5	0	4	2	2	1	1	4
Instrumental Deliveries as % of births	16	22	43	20	15	30	23	22	27	16	32	30	29	26	19	27	23
Total Caesarean Sections as % of births	46	78	68	65	58	61	54	61	48	54	68	68	75	76	80	61	73
% Emergency Caesaean Sections	29	51	35	37	34	40	34	37	26	28	44	32	36	36	57	38	41
% Elective Caesarean Sections	18	27	33	28	24	21	20	24	22	26	24	36	39	40	23	23	32
Number of successful VBAC deliveries	2	3	2	7	3	8	6	3	5	8	9	7	6	7	5	4	4
%of Caesarean Sections at Full Dilatation	7	7	1	5	6	6	4	1	4	4	5	1	2	4.00	7	7	3
Induction of Labour as % of women delivered	74	77	92	80	79	82	75	94	69	72	97	80	100	80	107	78	86
% of women induced when RFM is the only indication <39 weeks	2	3	2	4	0	2	3	3	2	2	1	1	4	3	0	0	0
% of women induced for Suspected SGA	13	15	15	13	14	13	22	25	14	20	14	26	16	28	27	23	15
Average Postnatal Length of Stay	1.6	1.5	1.7	1.6	1.5	1.4	1.6	1.6	1.5	1.6	1.3	1.5	1.2	1.3	1.4	1.6	1.6
Number of In-utero transfers in from other units	2	1	0	1	1	1	0	0	0	0	0	3	1	3	1	0	0
Number of In-utero transfers out to other units	1	1	6	0	0	0	4	1	0	5	0	0	0	0	2	0	0
%of Women Smoking at Booking	14%	16%	18%	15%	10%	15%	10.71%	8.42%	11.69%	7.94%	13.51%	13.10%	11.20%	13.83%	13.02%	13.93%	12.90%
% of Women Smoking at Delivery	16%	19%	15%	15%	12%	15%	16.57%	10.10%	15.10%	10%	11.84%	14.85%	8.6%	12.50%	9.24%	10.73%	12.26%
Babies in Skin-to-Skin within 1 hour of birth	144	176	195	169	160	156	146	171	146	145	174	184	192	170	183	148	166
Percentage of Women Initiating Breastfeeding	85	101	121	112	100	109	104	108	93	93	125	117	114	110	134	103	104
Percentage of Women booked by 12+6 weeks	190	218	212	210	232	219	223	263	210	193	202	200	198	228	206	215	215
Prospective Consultant hours on Delivery Suite	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60
Midwife: Birth Ratio	23	22	23	25	25	25	24	25	24	25	25	26	28	28	28	28	28
1:1 Care in Labour	139	172	196	167	156	156	153	172	151	145	192	200	200	184	215	182	100%
Percentage of shifts where shift Co-ordinator able to remain supernumerary	100%	100%	100%	100%	100%	100%	100%	100%	100%	95.20%	100%	98.45%	95.16%	93.33%	95.16%	100.00%	100.00%
Diverts: Number of occasions unit unable to accept admissions	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	1
Diverts: Number of women during period affected by unit closure	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
Number of Midwives in Post	138	140	140	133	134	134	134	137	137	137	144	144	144	145		130	128
Attendance at Skills Drills/Mandatory Training	16	14	13	14	16	18	14	23	16	10	9	9	12	12	12	0	15
3rd/4th Degree Tear as % of births	2	3	8	6	3	6	6	6	7	5	8	9	3	4	5	8	7
with unassisted births (normal)	2	1	4	4	3	5	3	3	2	4	5	3	2	1	3	7	5
with assisted births (Instrumental)	0	2	4	2	0	1	3	3	5	1	3	6	1	3	2	1	2
Episiotomies in Normal Birth	11	12	11	6	9	8	5	11	8	9	9	4	10	5	10	6	3
PPH >2.5L as % of births	1	0	3	1	2	1	0	1	0	1	0	0	0	0	0	1	0
Number of Blood Transfusions > 4 Units	1	0	1	1	1	1	0	1	0	4	0	0	0	0	1	1	0
Number of Women Requiring Level 2 Critical Care	4	4	0	2	2	2	3	1	1	0	1	1	4	0	1	1	2
Number of Women Requiring Level 3 Critical Care	1	0	0	0	0	0	0	1	0	0	1	0	1	0	0	0	0
Maternal Deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of women re-admitted within 28 days of delivery	1	2	2	0	1	2	2	1	1	3	5	1	1	3	1	2	3
Stillbirths **	1	1	0	1	0	1	1	0	0	0	1	0	1	0	0	1	2
Early Neonatal Deaths (before 7 days)	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0
Number of Neonates with Apgars <7 at 5 minutes (>37 weeks gestation)	1	2	4	2	0	1	1	1	3	2	5	1	3	1	1	1	4
HIE 2 &3 > 37 weeks (reported retrospectively)	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Shoulder Dystocia	2	6	2	1	0	0	4	2	4	3	4	2	1	4	1	2	0
Singleton Babies born <30 weeks gestation	3	1	0	1	1	0	2	1	0	0	1	2	1	0	0	2	0
% whose mother received magnesium sulphate	3	1	0	1	1	0	2	1	0	0	1	2	1	0	0	2	0
Singleton Babies born <34 weeks gestation	8	3	7	2	2	4	4	3	3	4	4	5	5	3	6	3	4
% whose mother received full course steriods (1 week prior to delivery)	6	1	5	0	1	3	3	1	3	2	4	3	3	2	4	1	1
Births >37 weeks gestation	149	204	225	190	171	173	166	186	168	165	210	211	223	211	214	179	190
Unexpected Term Admissions to NNU as % of births > 37 weeks gestation.	5	5	4	5	5	8	2	8	8	3	9	5	10	10	12	1	6
Number of babies re-admitted with 28 days of birth	12	15	18	14	12	21	9	14	17	14	18	15	28	18	12	15	19
Number of indicents reported	53	57	91	42	53	67	58	51	61	70	86	60	65	46	74	57	51
Number of Concise Investigations	0	0	0	0	0	0	1	2	0	0	0	0	0	1	1	0	0
Number of StEIS Reported Incidents	0	0	0	0	0	1	0	1	0	0	0	0	0	2	0	0	0
Number of Midwifery Red Flags Reported	0	0	0	0	0	0	0	0	0	4	0	2	3	4	3	3	0
Number of Complaints	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	2
Number of Letters of Claim Received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
REGIONAL METRICS																	
Number of Live Births born ≥16 weeks to <24 weeks	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Number of Live Births born ≥24 weeks to <37 weeks	17	15	16	11	22	18	14	23	13	17	21	17	16	18	27	21	22
Number of Live Births born ≥24 weeks to <34 weeks	9	3	7	4	4	6	6	3	3	6	6	5	5	3	6	3	4
Number of Live Births ≥38 weeks	132	175	198	177	149	159	149	167	152	147	182	191	203	180	194	165	169
Number of Live Births ≥39 weeks	115	146	170	144	112	134	129	133	120	113	130	150	163	147	164	131	136
Number of Episiotomies performed	27	26	47	21	21	36	25	27	29	25	34	27	37	30	27	30	19
Number of babies born <3rd centile									9	9	14	9	9	8	8	6	11
Number of Major Haemorrhages ≥ 2500mls	1	0	3	1	2	1	0	1	0	1	0	0	0	0	0	1	0
Intrapartum Stillbirths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of Early Neonatal Deaths 20+0 to 23+6 weeks	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Number of Early Neonatal Deaths > 24 weeks	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received magnesium sulphate	5	1	2	4	2	6	6	2	2	3	4	4	4	3	4	3	2
Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received steroids	6	1	3	4	3	5	6	2	3	4	4	5	5	2	6	3	2
Number of babies less than 3rd centile delivered >38 weeks	2	9	4	3	7	0	4	5	3	4	8	4	5	1	1	1	3
Number of women smoking at the time of booking	30	40	43	33	25	36	28	24	27	17	30	30	27	31	31	34	30
Number of women smoking at delivery	26	41	37	30	24	31	30	23	20	18	27	34	21	28	22	22	26
Friends & Family Test:Q2 Birth:Percentage returned complete																	
Friends & Family Test:Q2 Birth:Percentage of completed surveys returned as recommended																	
Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were symptomatic		0	1	3	0	2	0	0	0	0	2	4	2	2	2	2	22
Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were asymptomatic		1	12	4	4	1	3	3	1	1	0	3	5	2	1	2	2
Number of babies born at Home Midwife NOT present		2	1	1	1	2	1	0	4	0	1	1	1	1	0	0	4
Number of babies born in Other location Midwife NOT present		1	0	0	0	1	0	0	0	1	1	1	1	1	0	1	1
Episiotomies with Episcissors	25	22	40	18	19	27	21	21	22	22	29	19	32	26	21	28	14

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Maternity Dashboard 2021

					2020 Data					2021 Data																
		Goal	Red Flag	Measure	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	YTD	Trend
Activity	Number of Registerable Births	>200	<180	2020 Births	167	220	241	202	193	192	182	208	181	182	232	229	241	229	242	205	213	582	595	699	660	2536	
	Number of Bookings(retrospective 1 month)	≥240	≤200	2020 Bookings	216	247	233	226	246	238	252	285	231	214	222	205	222	242	227	244	233	775	667	669	704	2815	
	Normal Births as % of births	>=60%	<55%	Nat Standard	62.3%	54.5%	53.9%	66.8%	62.2%	52.6%	57.7%	60.1%	58.6%	61.5%	56.9%	57.2%	56.8%	55.5%	59.1%	54.6%	54.5%	56.9%	58.8%	56.5%	56.2%	57.1%	
	% of Successful Planned Home Births			Births/month	1.2%	0.9%	0.8%	2.0%	2.1%	2.6%	3.8%	1.9%	2.2%	2.7%	0.0%	1.7%	0.8%	0.9%	0.4%	0.5%	1.9%	2.7%	1.5%	1.1%	0.9%	1.5%	
	Instrumental Deliveries as % of births	<12%	>15%	Nat Average	9.6%	10.0%	17.8%	9.9%	7.8%	15.6%	12.6%	10.6%	14.9%	8.8%	13.8%	13.1%	12.0%	11.4%	7.9%	13.2%	10.8%	12.9%	12.6%	12.2%	10.5%	12.0%	
	Total Caesarean Sections as % of births	<29%	≥34%	GM Average	27.5%	35.5%	28.2%	32.2%	30.1%	31.8%	29.7%	29.3%	26.5%	29.7%	29.3%	29.7%	31.1%	33.2%	33.1%	29.8%	34.3%	30.2%	28.6%	31.3%	32.4%	30.7%	
	% Emergency Caesaean Sections				17.4%	23.2%	14.5%	18.3%	17.6%	20.8%	18.7%	17.8%	14.4%	15.4%	19.0%	14.0%	14.9%	15.7%	23.6%	18.5%	19.2%	19.1%	16.5%	14.9%	20.6%	17.7%	
	% Elective Caesarean Sections				10.8%	12.3%	13.7%	13.9%	12.4%	10.9%	11.0%	11.5%	12.2%	14.3%	10.3%	15.7%	16.2%	17.5%	9.5%	11.2%	15.0%	11.2%	12.1%	16.5%	11.8%	13.0%	
	Number of successful VBAC deliveries			Births/month	2	3	2	7	3	8	6	3	5	8	9	7	6	7	5	4	4	17	22	20	13	72	
	%of Caesarean Sections at Full Dilatation			Births/month	15.2%	9.0%	1.5%	7.7%	10.3%	9.8%	7.4%	1.6%	8.3%	7.4%	7.4%	1.5%	2.7%	5.3%	8.8%	11.5%	4%	6.3%	7.6%	3.2%	7.9%	6.2%	
	Induction of Labour as % of women delivered	<38%	>=42%	Births/month	44.3%	35.0%	38.2%	39.6%	40.9%	42.7%	41.2%	45.2%	38.1%	39.6%	41.8%	34.9%	41.5%	34.9%	44.2%	38.0%	40%	43.1%	40.0%	37.2%	41.1%	40.2%	
	% of women induced when RFM is the only indication <39 weeks				1.2%	1.4%	0.8%	2.0%	0.0%	1.0%	1.6%	1.4%	1.1%	1.1%	0.4%	0.4%	1.7%	1.3%	0.0%	0.0%	0%	1.4%	0.8%	1.1%	0.0%	0.8%	
	% of women induced for Suspected SGA				7.8%	6.8%	6.2%	6.4%	7.3%	6.8%	12.1%	12.0%	7.7%	11.0%	6.0%	11.4%	6.6%	12.2%	11.2%	11.2%	7%	10.3%	8.1%	10.0%	9.8%	9.6%	
	Average Postnatal Length of Stay	≤1.5	≥1.8	Births/month	1.6	1.5	1.7	1.6	1.5	1.4	1.6	1.6	1.5	1.6	1.3	1.5	1.2	1.3	1.4	1.6	1.6	1.5	1.5	1.3	1.5	1.5	
	Number of In-utero transfers in from other units				2	1	0	1	1	1	0	0	0	0	0	3	1	3	1	0	0	1	0	7	1	9	
	Number of In-utero transfers out to other units				1	1	6	0	0	0	4	1	0	5	0	0	0	0	2	0	0	5	5		2	12	
	%of Women Smoking at Booking			2020 Bookings = 17%	14.0%	16.2%	18.5%	14.6%	10.2%	15.1%	10.7%	8.4%	11.7%	7.9%	13.5%	13.1%	11.2%	13.8%	13.0%	13.9%	13%	11.4%	11.0%	12.7%	13.3%	12.1%	
	% of Women Smoking at Delivery	14%	17%	2020 Births	15.7%	19.0%	15.1%	14.5%	12.1%	15.3%	16.6%	10.1%	15.1%	10.0%	11.8%	14.9%	8.6%	12.5%	9.2%	10.7%	12%	14.0%	12.3%	12.0%	10.7%	12.3%	
	Percentage of Babies in Skin-to-Skin within 1 hour of birth	≥80%	≤70%	Regional average	86.7%	80.4%	80.9%	84.1%	82.9%	81.7%	80.7%	82.2%	80.7%	79.7%	75.3%	80.3%	80.0%	74.2%	75.6%	72.5%	79%	81.6%	78.3%	78.2%	75.6%	78.3%	
	Percentage of Women Initiating Breastfeeding	≥55%	≤50%	2020 Births	51.2%	46.1%	50.2%	55.7%	51.8%	57.1%	57.5%	51.9%	51.4%	51.1%	54.1%	51.1%	47.5%	48.0%	55.4%	50.5%	49%	55.3%	52.4%	48.9%	51.9%	52.0%	
	Percentage of Women booked by 12+6 weeks	≥90%	≤80%	Nat Standard	88.0%	88.3%	91.0%	92.9%	94.3%	92.0%	88.5%	92.3%	90.9%	90.2%	91.0%	97.6%	89.2%	94.2%	90.7%	88.1%	92%	91.0%	90.7%	93.6%	90.3%	91.4%	
Workforce	Prospective Consultant hours on Delivery Suite	60 hours	< 60 hours	Nat Standard	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	180	180	180	180	720	
	Midwife: Birth Ratio	≤1:28	≥1:24	WTE/Births	1.23	1.22	1.23	1.25	1.25	1.25	1.24	1.25	1.24	1.25	1.25	1.26	1.28	1.28	01:28	1.28	1.28	1.74	1.74	1.82	1.84	4.14	
	1:1 Care in Labour	100%	<100%	Nat Standard	98.59%	99.42%	98.99%	98.80%	100%	99.40%	100%	99.42%	99.38%	99.32%	99.48%	99.44%	99.44%	99.44%	99.44%	99.44%	100	99.6%	99.4%	99.4%	3399.6%	924.5%	
	Percentage of shifts where shift Co-ordinator able to remain supernumerary	100%	<100%	Nat Standard	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.2%	100.0%	98.5%	95.2%	93.3%	95.2%	100.0%	100%	100.0%	98.4%	95.6%	98.4%	98.1%	
	Diverts: Number of occasions unit unable to accept admissions				0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	1	0	0	2	1	3	
	Diverts: Number of women during period affected by unit closure				0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	1	1	2	
	Attendance at Skills Drills/Mandatory Training	≥8%	<8%	Training Database	11.6%	10.0%	9.3%	10.5%	11.9%	13.4%	10.4%	16.8%	11.7%	7.3%	6.3%	6.3%	8.3%	8.3%		0.0%	12%	13.6%	8.4%	7.6%	10.5%	9.9%	
Maternal Morbidity	3rd/4th Degree Tear as % of births	<3%	≥4%	2020 Births	1.2%	1.4%	3.4%	3.0%	1.6%	3.2%	3.3%	2.9%	3.9%	2.8%	3.5%	3.9%	1.2%	1.8%	2.1%	3.9%	3%	3.1%	3.4%	2.3%	3.1%	2.9%	
	with unassisted births (normal)			2020 Births	1.2%	0.5%	1.7%	2.0%	1.6%	2.6%	1.7%	1.5%	1.1%	2.2%	2.2%	1.3%	0.8%	0.4%	1.3%	3.4%	2%	1.9%	1.9%	0.9%	2.3%	1.7%	
	with assisted births (Instrumental)			2020 Births	0.0%	0.9%	1.7%	1.0%	0.0%	0.5%	1.7%	1.5%	2.8%	0.6%	1.3%	2.6%	0.4%	1.3%	0.8%	0.5%	1%	1.2%	1.5%	1.4%	0.8%	1.2%	
	% of Episiotomies in Normal Birth			Births/month	10.6%	10.0%	8.5%	4.4%	7.5%	7.9%	4.8%	8.8%	7.5%	8.0%	6.8%	3.1%	7.3%	3.9%	7.0%	5.4%	3%	7.3%	7.4%	4.8%	5.1%	6.1%	
	Episiotomies with Episcissors				92.6%	84.6%	85.1%	85.7%	90.5%	75.0%	84.0%	77.8%	75.9%	88.0%	85.3%	70.4%	86.5%	86.7%	77.8%	93.3%	74%	78.9%	83.1%	81.2%	81.6%	81.2%	
	PPH >2.5L as % of births			Births/month	0.6%	0.0%	1.2%	0.5%	1.0%	0.5%	0.0%	0.5%	0.0%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	0.3%	0.2%	0.0%	0.2%	10.3%	
	Number of Blood Transfusions ≥ 4 Units			Births/month	1	0	1	1	1	1	0	1	0	4	0	0	0	0	1	1	0	2	4		2	8	
	Number of Women Requiring Level 2 Critical Care			Births/month	4	4	0	2	2	2	3	1	1	0	1	1	4	0	1	1	2	6	2	5	4	17	
	Number of Women Requiring Level 3 Critical Care			Births/month	1	0	0	0	0	0	0	1	0	0	1	0	1	0	0	0	0	1	1	1		3	
	Maternal Deaths			Nat rate per 1000	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0	

	Number of women re-admitted within 28 days of delivery	≤1	>2	16 in 2020	1	2	2	0	1	2	2	1	1	3	5	1	1	3	1	2	3	5	9	5	6	25	
Neonatal Morbidity & Mortality	Stillbirths **			Nat rate 3.5 per 1000 births	1	1	0	1	0	1	1	0	0	0	1	0	1	0	0	1	2	2	1	1	3	7	
	Early Neonatal Deaths (before 7 days)			Nat rate per 1000 births	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	1	0			1	
	Number of Neonates with Apgars <7 at 5 minutes (≥37 weeks gestation)	≤1	>2	GM av 10 per 1000	1	2	4	2	0	1	1	1	3	2	5	1	3	1	1	1	4	3	10	5	6	24	
	HIE 2 &3 > 37 weeks (reported retrospectively)			GM av 1.95 per 1000	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0			1	
	Shoulder Dystocia as % of births			Births/month	1.2%	2.7%	0.8%	0.5%	0.0%	0.0%	2.2%	1.0%	2.2%	1.6%	1.7%	0.9%	0.4%	1.7%	0.4%	1.0%	0.0%	1.0%	1.8%	1.0%	0.5%	1.1%	
	Singleton Babies born <30 weeks gestation			Births/month	3	1	0	1	1	0	2	1	0	0	1	2	1	0	0	2	0	3	1	3	2	9	
	% whose mother received magnesium sulphate	100%	90%	Rolling% of eligible babies	100.0%	100.0%	0	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	0.0%	100.0%	100.0%	100.0%	n/a	n/a	100.0%	n/a	66.7%	33.3%	100.0%	100.0%	66.7%	
	Singleton Babies born <34 weeks gestation			Births/month	8	3	7	2	2	4	4	3	3	4	1	2	5	3	6	2	0	3	1	3	2	9	
	% whose mother received full course of steriods (1 week prior to delivery)	100%	90%	Rolling% of eligible babies	75.0%	33.3%	71.4%	0.0%	50.0%	75.0%	75.0%	33.3%	100.0%	50.0%	100.0%	60.0%	60.0%	66.7%	66.7%	33.3%	25.0%	63.6%	81.8%	61.5%	46.2%	62.5%	
	Unexpected Term Admissions to NNU as % of births > 37 weeks gestation.	3.50%	>4.5%	Births> 37 weeks /month	3.4%	2.5%	1.8%	2.6%	2.9%	4.6%	1.2%	4.3%	4.8%	1.8%	4.3%	2.4%	4.5%	4.7%	5.6%	0.6%	3.2%	3.4%	3.7%	3.9%	3.3%	3.6%	
	Number of babies re-admitted with 28 days of birth	<16	>20	194 in 2020	12	15	18	14	12	21	9	14	17	14	18	15	28	18	12	15	19	44	49	61	46	200	
Risk Management	Number of indicents reported				53	57	91	42	53	67	58	51	61	70	86	60	65	46	74	57	51	176	217	171	182	746	
	Number of Concise Investigations				0	0	0	0	0	0	1	2	0	0	0	0	0	1	1	0	0	3	0	1	1	5	
	Number of StEIS Reported Incidents				0	0	0	0	0	1	0	1	0	0	0	0	0	2	0	0	0	2	0	2	0	4	
	Number of Midwifery Red Flags Reported				0	0	0	0	0	0	0	0	0	4	0	2	3	4	3	3	0	0	4	9	6	19	
	Number of Complaints				0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	2	1	0	0	3	4	
	Number of Letters of Claim Received				0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

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

			2020 Data					2021 Data												
		Indicator	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
DENOMINATOR Metrics	1	Number of Bookers	216	247	233	226	246	238	252	285	231	214	222	205	222	242	227	244	233	2815
	2	Number of Registrable Births	167	220	241	202	193	192	182	208	181	182	232	229	241	229	242	205	213	2536
	3	Number of Women Delivered	166	216	238	200	190	189	181	204	181	180	228	229	241	224	238	205	212	2512
	4	Number of Successful Planned Home Births	2	2	2	4	4	5	7	4	4	5	0	4	2	2	1	1	4	39
	5	Number of Midwifery Led Unit births	166	216	238	200	190	189	181	204	181	180	228	229	241	224	238	205	212	2512
	6	Number of Live Births at any gestation	167	220	241	202	193	192	182	208	181	182	232	229	241	229	242	205	213	2536
	7	Number of Live Births born ≥16 weeks to <24 weeks	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
	8	Number of Live Births born ≥24 weeks to <37 weeks	17	15	16	11	22	18	14	23	13	17	21	17	16	18	27	21	22	227
	9	Number of Live Births born ≥24 weeks to <34 weeks	9	3	7	4	4	6	6	3	3	6	6	5	5	3	6	3	4	56
	10	Number of Live Births ≥37 weeks	149	204	225	190	171	173	166	186	168	165	210	211	223	211	214	179	190	2296
	11	Number of Live Births ≥38 weeks	132	175	198	177	149	159	149	167	152	147	182	191	203	180	194	165	169	2058
	12	Number of Live Births ≥39 weeks	115	146	170	144	112	134	129	133	120	113	130	150	163	147	164	131	136	1650
	13	Number of Episiotomies performed	27	26	47	21	21	36	25	27	29	25	34	27	37	30	27	30	19	346
	14	Episiotomies with Episcissors	25	22	40	18	19	27	21	21	22	22	29	19	32	26	21	28	14	282
	15	Number of babies born <3rd centile									9	9	14	9	9	8	8	6	11	83
MATERNAL Morbidity and Mortality Metrics	16	Number of Maternal Deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	17	Number of Blood Transfusions ≥ 4 Units	1	0	1	1	1	1	0	1	0	4	0	0	0	0	1	1	0	8
	18	Number of Women Requiring Level 2 Critical Care	4	4	0	2	2	2	3	1	1	0	1	1	4	0	1	1	2	17
	19	Number of Women Requiring Level 3 Critical Care	1	0	0	0	0	0	0	1	0	0	1	0	1	0	0	0	0	3
	20	Number of Major Haemorrhages ≥ 2500mls	1	0	3	1	2	1	0	1	0	1	0	0	0	0	0	1	0	4
	21	Number of Women readmitted to same Obstetric unit within 30 days of delivery	1	2	2	0	1	2	2	1	1	3	5	1	1	3	1	2	3	25
	22	Number of 3rd and 4th degree tears	2	3	8	6	3	6	6	6	7	5	8	9	3	4	5	8	7	74
	23	Number of Episiotomies in normal birth	11	12	11	6	9	8	5	11	8	9	9	4	10	5	10	6	3	88
	24	Number of Emergency LSCS	29	51	35	37	34	40	34	37	26	28	44	32	36	36	57	38	41	449
	25	Number of Elective LSCS	18	27	33	28	24	21	20	24	22	26	24	36	39	40	23	23	32	330
	26	Number of LSCS at Full Dilatation	7	7	1	5	6	6	4	1	4	4	5	1	2	4	7	7	3	48
	27	Number of Operative Vaginal Deliveries	16	22	43	20	15	30	23	22	27	16	32	30	29	26	19	27	23	304
	28	Number of Normal Vaginal Deliveries	104	120	130	135	120	101	105	125	106	112	132	131	137	127	143	112	116	1447
	29	Number of Inductions (excluding augmentations)	74	77	92	80	79	82	75	94	69	72	97	80	100	80	107	78	86	1020
	30	Number of women induced only when RFM is the only indication < 39 weeks	2	3	2	4	0	2	3	3	2	2	1	1	4	3	0	0	0	21
PERINATAL Morbidity and Mortality Metrics	31	Number of Stillbirths	1	1	0	1	0	1	1	0	0	0	1	0	1	0	0	1	2	7
	32	Number of Intrapartum Stillbirths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	33	Number of Early Neonatal Deaths 20+0 to 23+6 weeks	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
	34	Number of Early Neonatal Deaths > 24 weeks	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
	35	Number of Neonates with suspected HIE Grade 2 and 3, ≥ 37 Weeks	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
	36	Number of Neonates with Apgars <7 at 5 Minutes, ≥ 37 Weeks	1	2	4	2	0	1	1	1	3	2	5	1	3	1	1	1	4	24
	37	Number of admissions to Neonatal Unit ≥ 37 Weeks	5	5	4	5	5	8	2	8	8	3	9	5	10	10	12	1	6	82
	38	Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received magnesium sulphate	5	1	2	4	2	6	6	2	2	3	4	4	4	3	4	3	2	43
	39	Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received steroids	6	1	3	4	3	5	6	2	3	4	4	5	5	2	6	3	2	47
	40	Number of babies less than 3rd centile delivered >38 weeks	2	9	4	3	7	0	4	5	3	4	8	4	5	1	1	1	3	39
PROCESS	41	Average Postnatal Length of Stay for Women	1.6	1.5	1.7	1.6	1.5	1.4	1.6	1.6	1.5	1.6	1.3	1.5	1.2	1.3	1.4	1.6	1.6	17.6
	42	Number of In-utero Transfers In	2	1	0	1	1	1	0	0	0	0	0	3	1	3	1	0	0	9
	43	Number of In-utero Transfers Out	1	1	6	0	0	0	4	1	0	5	0	0	0	0	2	0	0	12
	44	Diverts: Number of occasions the unit has been unable to accept admissions	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	1	3
	45	Diverts: Number of women during the period affected by the units closures	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	2
	46	Number of women booked by 12 + 6 weeks	190	218	212	210	232	219	223	263	210	193	202	200	198	228	206	215	215	2572
	47	Number of women smoking at the time of booking	30	40	43	33	25	36	28	24	27	17	30	30	27	31	31	34	30	345

	48	Number of women smoking at delivery	26	41	37	30	24	31	30	23	20	18	27	34	21	28	22	22	26	302
	49	Number of women initiating breast feeding including attempted and expressed	85	101	121	112	100	109	104	108	93	93	125	117	114	110	134	103	104	1314
	50	Number of babies that received Skin to Skin contact within 1 hour of birth	144	176	195	169	160	156	146	171	146	145	174	184	192	170	183	148	166	1981
	51	Number of successful VBAC deliveries	2	3	2	7	3	8	6	3	5	8	9	7	6	7	5	4	4	72
Patient Experience	52	Friends & Family Test:Q2 Birth:Percentage returned complete																		0
	53	Friends & Family Test:Q2 Birth:Percentage of completed surveys returned as recommended																		0
Workforce	54	Number of women receiving 1:1 midwifery in labour	139	172	196	167	156	156	153	172	151	145	192	200	200	184	215	182	1	1951
	55	Midwife to Birth Ratio	23	22	23	25	25	25	24	25	24	25	25	26	28	28	28	28	28	314
COVID -19	56	Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were symptomatic		0	1	3	0	2	0	0	0	0	2	4	2	2	2	2	22	38
	57	Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were asymptomatic		1	12	4	4	1	3	3	1	1	0	3	5	2	1	2	2	24
Safety	58	Number of babies born at Home Midwife NOT present		2	1	1	1	2	1	0	4	0	1	1	1	1	0	0	4	15
	59	Number of babies born in Other location Midwife NOT present		1	0	0	0	1	0	0	0	1	1	1	1	1	0	1	1	8

Wrightington, Wigan And Leigh NHS Foundation Trust

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

	2021											
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Findings of review of all perinatal deaths using the real time data monitoring tool (quarterly reports)		See attached Appendix 1 in Board Report			Q1 report to be presented at June Meeting		Presented in CNST complaince report		See narrative in Exception report			2 Stillbirths in December, will be included in the quarterly report when all clinical investigations completed. Report due 31/01/2022
Findings of review all cases eligible for referral to HSIB.		Summary of cases to be provided for April Board Report	To be submitted with April Board papers	To be submitted with April Board papers	Draft report recieved from HSIB will be presented once finalised.	Finalised report received. No concerns or recommendations highlighted.	No cases for HSIB	No cases for HSIB	No cases for HSIB	No cases for HSIB	No cases for HSIB	No cases for HSIB
The number of incidents logged graded as moderate or above	7	6	5	6	6	7	9	2	4	2	3	1
Training compliance for all staff groups in maternity as per CNST requirments (need 90% compliance rate for all staff groups by July 2021) Attendance = Midwives = 10-15 per month Consultant = 1 per month Registrars = 2 per month To maintain % over 95%												
Cardiotocograph (CTG) training and competency assessment	Midwives 82% Consultant 72% Registrars 75%		Midwives 92.8% Consultant 100% Registrars 90.4%	Midwives 98% Consultant 100% Registrars 90.4%	Midwives 98% Consultant 92% Registrars 100%	**New Training Year(June - May) commenced.** *Rolling% Midwives 7 * 95% Consultant 0 *92 % Registrars 1 *100%	Midwives 9 *96.7% Consultant 0 * 92% Registrars 1 *100%	No Training In August	*Rolling% Midwives 11 * 97% Consultant 0 *100 % **Registrars 1 *67%**	*Rolling% Midwives 13 * 95% Consultant 0 *100 % **Registrars 4 *89%**	Training Suspended due to Covid Isolations	Training Suspended due to Covid Isolations
Practical Obstetric Multi-Professional Training (PROMPT) (emergency Skills Drills Training)	Midwives 42% HCA's 21% Consultant 18% Registrars 24% Anaesthetists 18% Anaesthetic Staff 0%	Midwives 62% HCA's 42% Consultant 81% Registrars 90% Anaesthetists 81% Anaesthetic Staff 0%	Midwives 78% HCA's 53% Consultant 90% Registrars 100% Anaesthetists 81% Anaesthetic Staff 0%	Midwives 88% HCA's 67% Consultant 90% Registrars 100% Anaesthetists 88% Anaesthetic Staff 3	Midwives 98% HCA's 81% Consultant 99% Registrars 100% Anaesthetists 93% Anaesthetic Staff 3	Midwives 4.82% *96% HCA's 0% *90% **Consultant 0% *83%** Registrars 9% *100% Anaesthetists 0% *93%	Midwives 6.2% *95% HCA's 6 % *90% **Consultant 0% *83%** Registrars 9% *100% Anaesthetists 7% *93%	No Training In August	Midwives 6.8% *97% HCA's 10 % *94% **Consultant 0% *83%** **Registrars 12% *47%** Anaesthetists 7% *100%	Midwives 8.6 % *90% HCA's 0% *75% **Consultant 8.3% *83%** **Registrars 12% *47%** Anaesthetists 7% *100%	Training Suspended due to Covid Isolations	Midwives 9% *81% HCA's 6% *68% **Consultant 0% *66.7%** **Registrars 17%*66.7%** Anaesthetists 0% *80%
Prospective Consultant Delivery Suite Cover (60 as standard for WWL)	60	60	60	60	60	60	60	60	60	60	60	60
1:1 care in labour	99.40%	100%	99.42%	99.38%	99.32%	99.48%	99.44%	100%	100%	100%	99%	100%
Supernumeray Shift Co-ordinator	100%	100%	100%	100%	95.20%	100%	98.50%	95.20%	93.30%	95.20%	100.00%	100.00%
Number of Datix submitted when shift co-ordinator not supernumerary	0	0	0	0	3	0	4	5	6	5	0	0
Service User Voice feedback		Bi-monthly meetings in place. No services users currently sitting on the committee. Actively recruiting women.	The Maternity section of the Trust website is to be re-vamped with input from staff and members of the MVP. There will also be collaboration with MVP for review of Patient Leaflets. There will also be a further 15 Steps Walkabout.	Meetings have taken place with regards to revamping the maternity pages of the trust website. Ongoing recruitment by MVP chair continues	Meetings with Comms Team and MVP chair have taken place and plan agreed on way forward.	Work ongoing with Comms Team with a view to initial go-live in August 2021	Work ongoing with Comms Team with a view to initial go-live in August 2021	New web pages are almost complete and currently being tested.	**Feedback** Very helpful supportive staff . Excelent support provided in community settings . Some issues with Breasfeeding support. Buzzers not always answered in a timely manner. Pain relief delayed . Communication issues . feeling lonely and isolated as staff too busy.	**Maternity Voice Partnership Feedback** **H**elpful supportive staff but some issues identified with pain relief and buzzers not being answered in a timely manner. Still some issues reported with breastfeeding support however initiation of BF has increased in October.	**Maternity Voice Partnership Feedback** . Antenatal care was friendly and welcoming any questions were answered. Admission with premature labour not communicated to diabetes team, when she was transferred to a tertiary unit and delivered there. Following repatriation noted that the outreach manager was supportive as	**Maternity Voice Partnership Feedback** . Thank you Thursdays are regularly received via the MVP and consistently provide positive feedback for the Maternity Service.

Staff feedback from frontline champions and walk-abouts	N/A	N/A	Information regarding CoC to be cascaded to staff... webinar has been facilitated with staff and National CoC leads as requested and agreed. Additional staff training for BCG vaccinations ahs been requested New equipment requests (Biliblankets, light boxes) has be forwarded to Matron to explore funding. More user-friendly pool to be explored by management team. Access to NIPE system for locum paediatric staff to be explored.	Safety Walkabout to take place on 21 May 2021	Safety Walkabout took place where staff mainly raised concerns regarding Continuity of Carer. Webinars continue for staff.	Safety Walkabout will take place on 12 August 2021		Staff reported frustrations with the printers continually going offline and this causing delays in discharges and patient flow across the maternity floor as discharge paper work could not be generated. Staffing shortages across the service due to staff isolations having an increased impact , causing low morale as continually working without breaks and shorfalls in numbers, during an especially busy period.	Next Scheduled Safety Walkabout October 21	Unable to shedule walkabout due to staffing issues. , planned for November	Walkabout took place on 30/11/21. Staff raised that were staffing shortages across the service still; rest breaks being missed. Not always being able to provide one to one care or work supernumerary (Co-ordinators and staff new to areas). Accessibility to and availability of equipment. Issues with the process of payments for shifts worked through NHSP.	Next Scheduled Safety Walkabout January 22
Healthcare Safety Investigation Branch (HSIB)/NHS Resolution (NHSR)/CQC or other organisation with a concern or request for action made directly with Trust	1 from CQC re Maternity Emergnecy Theatre	0	0	0	0	0	0	0	0	0	0	0
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0	0	0	0	0	0
Progress in achievement of CNST 10		To be presented at March Board Meeting.	8 Safety Actions compliant. On track to achive remaining 2 by July 15 deadline . See Board Report	8 Safety Actions compliant. On track to achive remaining 2 by July 15 deadline . See Board Report	9 Safety Actions compliant. On track to achive remaining 1 by July 15 deadline . See Board Report	10 Safety Actions compliant. Board Assurance report presented to board for sign off	Awaiting outcome of submission	Awaiting outcome of submission. Year 4 standards published.	Awaiting outcome of submission. Year 4 standards published.	Outcome of Year 3 submission expcted in Dec, work ongoing with year 4		
Number of StEIS Reportable Incidents/HSIB case	1	0	1	0	0	0	0	0	2	0	0	0
Number of Stillbirths	1	1	0	0	0	1	0	1	0	0	0	2
Number of Neonatal Deaths	0	1	0	0	0	0	0	0	0	0	0	0
Number of Maternal Deaths	0	0	0	0	0	0	0	0	0	0	0	0

Agenda item: [26]

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Maternity Board Provider Report
Presented to:	Trust Board
On:	02.02.2022
Presented by:	Rabina Tindale
Prepared by:	Cathy Stanford Acting Divisional Director of Midwifery and Neonates
Contact details:	Cathy.stanford@wwl.nhs.uk 01942 773107

Executive summary

Safety action 9: of the CNST Maternity Safety Actions requires that Maternity Services submit a declaration that the Board Level Safety Champions have reviewed The Maternity Continuity of Carer (MCoC) action plan in the light of Covid-19. With the revised action plan describing how Maternity services will work towards MCoC being the default model of care offered to all women by March 2023, prioritising those most likely to experience poor outcomes.
This action plan was ready to be Submitted in January, however letters received from NHSE/I regarding CNST and the Long-Term plan review, and notification from the national team have advised that the timeframes for reporting have been paused with a further review in 3 months' time.

Recommendation(s)

Due to the scheduling of the Board meetings and the likelihood that reporting will be reinstated the Board are asked to discuss and agree the action plan submitted outlining the plans to implement Maternity Continuity of Carer (MCoC) as a default model of care to all eligible women, in readiness for submission the Local Maternity system (LMS) and onwards to the National team.

Incident exception reporting for December 2021

At this time no babies diagnosed with HIE 2 or 3,
1 Steis reportable incident occurred in December for a Maternity Divert due to reduced staffing levels for 8 hours within theatres which had implications to safely provide adequate cover across the Trust if 2 emergencies occurred at the same time .

There were 2 Stillbirths in December both of which are under review utilising the Multi-disciplinary Perinatal Mortality Review Tool (PMRT)
No Neonatal or Maternal Deaths occurred in December

Report

Midwifery Continuity of Carer (MCoC) and Staffing.

Midwifery Continuity of Carer (MCoC) has been proven to deliver safer and more personalised maternity care. Building on the recommendations of Better Births and the commitments of the NHS Long Term Plan, the ambition for the NHS in England is for MCoC to be the default model of care for maternity services, and available to all pregnant women in England – with rollout prioritised to those most likely to experience poorer outcomes. Where safe staffing allows and building blocks are in place, this should be achieved by March 2023.(NHSE&I Oct 2021).

The staffing paper submitted in December 2021 indicated how MCoC can be introduced at a pace to ensure staffing levels are safe and at the correct establishment before rolling out of additional teams.

At present there are two established MCoC teams but due to staffing pressures the intra-partum element of care has been paused and will be delivered by core delivery suite midwives until the staffing establishment required can be recruited to.
Maternity services are undergoing a national staffing crisis, and this is also a problem here at Wrightington Wigan and Leigh Maternity services. We currently have 13.8 wte vacancies we are unable to recruit to, due to the low numbers of staff available within the system. Within recent months we have been greatly affected by staff sickness due to covid isolations and viral infections. The service has been out to recruitment continually since we received funding from the Ockenden Bid to increase our establishment due to the shortfall we had in staffing at the time the bid was submitted.
We were unable to fully recruit to all the vacancies at that time and have since accrued several more. We continue to actively recruit to address the ongoing attrition of the aging workforce and the reduced number of Student midwives that will qualify in 2022 which will add additional pressure within the system.

Please see additional Board Report : Maternity Continuity of Carer Building Blocks Plan

CS Jan 2022

CNST

NHS Resolution and the Collaborative Advisory Group (CAG) have continued to monitor Trusts position in relation to Covid-19, staffing and acuity and the challenges faced by Trusts in achieving the Scheme's safety actions.

In recognition of the current pressures on Maternity Services and the NHS as a whole most of the reporting requirements relating to the maternity incentive scheme 10 safety actions have been paused for a minimum of 3 months, commencing in December 2021.

Trusts are asked to continue to apply the principles of the 10 safety actions in order to continue to deliver safe maternity care, especially in relation to workforce and oversight provided by the Board level maternity and neonatal safety champions.

Every effort will be made to continue where possible with all the recommendations and to continue to apply this principle. Planned reporting periods will now be subject to change and may potentially be extended further, confirmation of this will be received in due course.

Digital Transformation

As with other areas of the Trust maternity have been successful in receiving funds from the Digital Maternity Fund which will be used to purchase end user devices (laptops/ desktops etc), the remainder of the funds will enable upgrades to the maternity work flows and system integrations and improved reporting and dashboard developments, which will accelerate the modernisation projects previously identified within the service both on the acute site and the community setting.

Ockenden Next steps update

All provider level reports have been sent back to Trusts identifying any gaps that remain. For WWL the key areas that still require further assurance are:

- External reviewer for all PMRT cases
- Evidence of Non-Executive Director (NED) Oversight of Maternity services and NED walkabouts
- Evidence that Maternity funding allocated for training is ring fenced

- Demonstration of maternity leadership requirements that meets the recommendations of the Royal College of Midwives strengthening midwifery leadership manifesto

All Heads and Directors of Midwifery have been informed by the Regional Chief Midwife that the next step in the process will be assurance visits. These will be on site and multi-disciplinary inclusive of the Maternity Voices Partnership (MVP) with representation from the Local Maternity System (LMS) and peers in the first instance. They will then be superseded in the long term by assurance reporting from the LMS when they become part of the Integrated Care System (ICS). There is currently an assurance template and Key lines of Enquiry being drafted that will be utilised to assess compliance in addition to face-to-face appreciative enquiry .

Professor Jackie Dunkley Bent National Chief Midwife will be visiting all Trust Boards in the coming months to discuss what Boards should be assuring themselves of in relation to safety within Maternity Services.

Ockenden 2 report is due to be published by the end of March 2022 followed by the East Kent report, which are both expected to have additional recommendations for all providers.

Work remains ongoing to embed the recommendations from the 7 Immediate and Essential Actions (IEA's)

Maternity Risks

There are no maternity risks scoring 15 or above.

The highest scoring maternity risks are:

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

There is a centralised CTG monitoring system to provide additional surveillance of all CTG traces within the delivery rooms, allowing a helicopter view and timely intervention if required.

All mitigations are in place however training compliance for all staff groups has slightly fallen in recent months due to cancellation of training due to shortfalls in staffing across the service. Plans are in place to get this back above the 90% compliance rate

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

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

CS Jan 2022

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

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

Conclusion

A robust training programme remains in place to meet the requirements of CNST and Saving Babies Lives recommendations with monthly review in progress and actions taken where recommendations are not being met. Plans have been made to address the shortfalls in compliance due to increased staff sickness, online training packages are available and have been confirmed by NHSLA as suitable to use where face to face teaching cannot take place and these will be utilised if necessary as a backup.

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

Staffing levels remain a challenge. However, covid related sickness appears to be decreasing across the service.

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

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Maternity Continuity of Carer Building Blocks Plan
Presented to:	Trust Board
On:	02 February 2022
Presented by:	Rabina Tindale
Prepared by:	Cathy Stanford Interim Divisional Director of Midwifery and Neonates
Contact details:	T: 01942 773107 E: cathy.stanford@wwl.nhs.uk

Executive summary

Midwifery Continuity of Carer has been proven to deliver safer and more personalised maternity care. Building on the recommendations of Better Births and the commitments of the NHS Long Term Plan, the ambition for the NHS in England is for Continuity of Carer to be the default model of care for maternity services, and available to all pregnant women in England. Where safe staffing allows, and the building blocks are in place this should be achieved by March 2023 – with rollout prioritised to those most likely to experience poorer outcomes first.

In line with *Better Births* and the *NHS Long Term Plan*, all women should be offered the opportunity to receive the benefits of Continuity of Carer across antenatal, intrapartum, and postnatal care. However, not all women will be able to receive continuity of carer, through choosing to receive some of their care at another maternity service. In a small number of cases, women will be offered a transfer of care to a specialist service for maternal / fetal medicine reasons.
Maternity services and Local Maternity Systems (LMS's) are asked to prepare a plan to reach a position where midwifery Continuity of Carer is the default position model of care available to all women.

Providing Continuity of Carer by default therefore means:

1. Offering all women Midwifery Continuity of Carer as early as possible antenatally; and
2. Putting in place clinical capacity to provide Continuity of Carer to all those receiving antenatal, intrapartum and postnatal care at the provider.

As a first step, LMS's agree a local plan that includes putting in place the 'building blocks' for sustainable models of Continuity of Carer by March 2022; so that Continuity of Carer is the default model of care offered to all women. This plan will include:

- The **number of women** that can be expected to receive continuity of carer, when offered as the default model of care
- **When** this will be achieved, with a redeployment plan into MCoC teams to meet this level of provision, that is phased alongside the fulfilment of safe staffing levels
- **How** continuity of carer teams are established in compliance with national principles and standards, to ensure high levels of relational continuity

MCoC teams will be prioritised for roll out in the highest areas of Black, Asian and Mixed ethnicity populations and the postcodes of the lowest deciles. This ensures that we target women who are most likely to experience adverse outcomes first.

- How **rollout will be prioritised** to those most likely to experience poor outcomes, including the development of enhanced models of continuity of carer
- **How care will be monitored locally**, and providers ensure accurate and complete reporting on provision of continuity of carer using the Maternity Services Data Set

The planning guidance sets out that building blocks need to be in place prior to and during rollout of MCoC. They are set out as a readiness to implement and sustain MCoC assessment framework. This provides an opportunity to RAG rate all the building blocks that need to be in place to achieve and monitor sustained transformation. These building blocks are the key elements in the plan to roll out MCoC from the current position to default MCoC for most women.

This paper outlines:

- Background
- Current position including
    - Activity
    - Imports and exports
    - Current staffing
- Staffing deployment plan with time scales and recruitment plan ensuring building blocks are in place
- Framework of activities that will ensure readiness to implement and sustain MCoC
- Time frame and monitoring process.

Link to strategy
This report links to the National Maternity Transformation Plan

Risks associated with this report and proposed mitigations
Failure to meet National recommendations may result in regulator scrutiny

Financial implications
There are no financial implications associated with this report

Legal implications
There are no legal implications arising from this report.

People implications
MCoC will affect current and future workforce planning

Wider implications
Non-compliance may result in women choosing not to Birth at WWL if MCoC is not implemented.

Recommendation(s)

- Accept the contents of this report
- Support maternity service in delivery of transformed model of care.
- National guidance requires quarterly monitoring of this plan – agree for return of plan to board on a quarterly basis for review

Report

All Trusts are instructed to:

- **Continue with MCoC teams already in place and roll out new teams as appropriate:**
  Currently WWL have 2 MCoC teams in place but due to ongoing midwifery vacancies the intrapartum element of these teams is suspended, we are out to recruitment and will reinstate these 2 teams to full MCoC models at the earliest opportunity. Recruitment is ongoing and our current vacancy is approximately 14, midwives across the service , inclusive of management roles, however there has been successful recruitment to 5 of these posts with staff due to commence in post in March / April 202.2 Once the remaining vacancies are filled and the current sickness levels are reduced the intention is to implement further MCoC teams as per projection.

- **Undertake Birthrate plus assessment or equivalent to enable a baseline for the midwifery workforce:**

  Staffing levels, and skill mix are key elements of a safe and high-quality service. In maternity, workforce planning is unique as each care 'episode' spans around 6-8 months, within both hospital and community settings, and involving a series of scheduled and unscheduled care and often involving unexpected inpatient admission as well as the birth itself.
  Birthrate Plus was undertaken in March 2020 and used in conjunction with the national continuity tool to provide a baseline of staffing requirements for MCoC**.**
  This information has been used to develop our Trust staffing papers the latest of which has been submitted to board and provides a template for our staffing action plan.(this is also attached as appendix A)

- **Prioritise women most likely to experience poorer outcomes, Ethnic Minority women, women from the most deprived areas. This includes development of enhanced model of MCoC.**

  WWL intend to build upon our current enhanced offer of MCoC (Daisy Team), with a view to having a second team to reach our most vulnerable women. With the implementation of full MCoC to all our eligible women all MCoC teams will have a mixed caseload of low and high-risk women which includes medical and social complexities.

- **Develop the ability to measure progress electronically and report it to the Maternity Service Data Set**

  Outlined further in the plan is our intention to utilise the new role of Digital Midwife to improve our Maternity Information System, data quality, data capture and data reporting.

DEVELOPING A PLAN
The WWL plan (as per NHSEI full scale guidance) includes the following information:

- **Number of women expected to receive MCoC**

Modelled on 2424 (Apr 20-Mar 21) women eligible for MCoC								
Out of Area Bookings	750	750	750	750	750	750	750	750
Out of Area Births	120	120	120	120	120	120	120	120
Non CoC Bookings	2,104	1,728	1,440	1,152	864	576	288	0
CoC Bookings	320	696	984	1,272	1,560	1,848	2,136	2,424
In area Births	2,424	2,424	2,424	2,424	2,424	2,424	2,424	2,424
% CoC	13%	29%	41%	52%	64%	76%	88%	100%

- **Staffing levels and recruitment plans: see Appendix A**
- **Provisional time scales: Please note that each implementation point will be dependent on appropriate staffing levels being reached: See Appendix B**

How MCoC teams are established and comply with national principles

Teams within WWL will reflect the national principles of MCoC this will be provided by midwives organised in teams of 8 (headcount) or fewer. Each midwife will aim to provide antenatal, intrapartum and post-natal care to approximately 36 women per year with support from the wider team.
At WWL we propose that the majority of our MCoC teams will be a maximum 8 headcount. The Continuity of Carer teams will be geographically located, taking on mixed risk women from that location. Teams will be made up of band 5 and band 6 midwives. A band 7 midwife will support the teams. The band 7 midwife will have an overview of the team and its functionality.

The team of midwives will maintain close working relationships with the obstetric team, the safeguarding team and the midwifery management team, alongside inpatient/outpatient service leads.
Each midwife within each team will aim to recruit 36 women per annum. The team will hold weekly meetings to ensure referrals are managed appropriately, to co-ordinate activities, encourage reflection and learning and to enable timely resolution of any issues that may arise.
Each midwife within the team will be available to provide labour and delivery care on a rota basis to cover the service and ensure there is someone available from that woman's team to provide intrapartum care at any given time.

As the teams develop the focus will be on women from Ethnic minorities and women from the most deprived areas within the borough The exception to this will be teams who are currently organised to care for the most vulnerable women, at the present time we have the Daisy Team who provide care for our most vulnerable women (see appendix C for

model and referral criteria). Due to the complexities of care for these women the midwives on this team carry a reduced caseload of 1:20.

Each MCoC team will have a linked obstetrician who will provide support for the midwives, the obstetrician is not responsible for each woman's individualised care plan (every woman who is not low risk will have a named obstetrician). WWL's vision for the link obstetrician is to provide overarching support for the midwives within the team, this may be facilitated by email, face to face meetings, telephone or setting up of a social media platform, which will enable the midwives and obstetricians to have open communication with each other, facilitating a multi-disciplinary team approach.

WWL's vision is for all staff to feel involved in actively achieving MCoC. There have been multiple staff engagement sessions which have culminated into a formal HR Consultation process due to be rolled out in the new year to the midwifery staff to ensure all areas of the midwifery service are involved in the building and provision of MCoC and that staff interests are fairly represented with the inclusion of review of existing and proposed renumeration and on call arrangements. Further to this we have and continue to ensure co-production of MCoC plans with the CCG and the MVP.

How rollout will be prioritised for those most likely to experience poorer outcomes.

Within the Greater Manchester Maternity footprint WWL have one of the highest overall rates of substantial levels of deprivation, safeguarding and high levels of poor perinatal mental health. WWL focus to date has been to roll out our first MCoC team within an area identified as an area with high levels of vulnerability and were women have access to a neighbouring provider.
The second MCoC team built on the existing Integrated Health Team, which focused on the top 2% most vulnerable women and families within the borough, the development of this team allowed for expansion of numbers of the women reached. WWL vision is to build on these initial models of care and expand them as per projection.
With the appointment of a Digital Midwife, the service is working on workflows which will identify from the Maternity Information System (MIS) the women who are more likely to experience poorer outcomes, including women and families from ethnic minority backgrounds and those residing within the most deprived areas of the borough. The next MCoC teams introduced will be prioritised to these areas of high deprivation and will include women from ethnic minority backgrounds.

How care will be monitored locally using MSDS

All MCoC teams will have in place regular audit and monitoring processes to ensure quality of care, this will feed into the established maternity services quality surveillance, audit and governance processes. Reports will be generated from the MIS where possible to reduce the burden of Midwives undertaking manual audits , however this is very reliant on good data entry and completing all care episode within the MIS , Data quality will continue to be monitored through the Maternity Service Data Set (MSDS) submissions. Regular audit of activity and outcomes of all MCoC and core teams will continue to be facilitated in conjunction with the maternity governance team and digital midwife. Reporting any adverse outcomes and embedding learning within the MCoC teams and wider maternity service .

A standard operating procedure will be developed for the MCoC teams, clearly outlining the pathway and model of care, which will be inclusive of the requirements for Personalised Care and Support plans (PCSPs)
With the support of the Clinical Director, we aim to facilitate linked obstetricians for all MCoC teams as they are introduced with regular team meetings to ensure multi-disciplinary communication and problem solving within our MCoC.

WWL intend to address the 3 steps needed to improve data quality by :

- **How will WWL evidence how MCoC will be measured and the key data requirements?**

WWL will use the technical annex (definitions for maternity service data set measures) and will continue monthly submissions to the national data bases .
Digital Midwife now in post who will facilitate and lead on the digital prioritisations as outlined within the Maternity Transformation programme.

- **How will WWL ensure the capability of the maternity information system (MIS)?**

WWL will continue to work with our MIS supplier to ensure we can record and submit the requisite data items to MSDS monthly. WWL Maternity Services has submitted their digital maturity assessment in conjunction with IT, BI and Digital leads within the Trust. Additionally, WWL HAVE submitted a bid to obtain National funding to provide fully integrated care records for maternity patients (electronic records for women) and upgrades to the current MIS to reduce the reliance on paper records.

- **How will WWL embed good data practice into business as usual?**

WWL will undertake regular review and audit of data input, this will build on existing governance procedures. The group will be led by the Head of Midwifery who will oversee the work of the digital midwife, who in turn will work with the data submitters. This group will identify ongoing consistent data quality and reporting, undertake analysis to identify gaps in consistencies or inaccuracies in data submission, this will ensure the provision of MCoC can be evidenced.

Summary.

MCoC Implementation has been limited here at WWL due to the existing challenges with midwifery establishment, and the challenges associated with bringing about wholescale change in midwifery staffing models. It is now recognised that all services need to be fully established to enable safe care before MCoC is implemented at scale as women will only be able to experience true MCoC in a well-established service.
Due to the ongoing national staffing issues across maternity services and the difficulties providers are facing with recruitment and retention, clear guidance has now been produced for the phased roll out of MCoC, which clearly states that the building blocks should be in place by March 2022 and teams are rolled out as appropriate when establishments allow.
The Consultation with staff as agreed by staff side and HR representatives will be commenced when the staffing establishment allows. The consultation paper will be shared with staff in order that they are aware of the process and plans going forward for implementation, with the 60 day consultation process formally commencing once the required numbers of staff are in place across all areas of the service

Trust Boards are requested to review and agree the local plans which will be submitted to the LMS in January 2022.

Appendix A
Staffing Plan for MCoC

Ward / Department		Band	Current Budgeted WTE	WTE Required at 31%	WTE Required at 42%	WTE Required at 54%	WTE Required at 65%	WTE Required at 77%	WTE Required at 88%	WTE Required at 100%
Delivery Suite	Shift leader	7	5.38	5.38	5.38	5.38	5.38	5.38	5.38	5.38
	HDU Team	7/6	5.38	5.38	5.38	5.38	5.38	5.38	5.38	5.38
	Core Midwives	6/5	5.38	5.38	5.38	5.38	5.38	5.38	5.38	5.38
	Induction Labour Bay	6/5	5.38	5.38	5.38	5.38	5.38	5.38	5.38	5.38
	Rotational M/W	6/5	5.38	5.38	5.38	5.38				
	Rotational M/W	6/5	5.38	5.38	5.38					
	Rotational M/W	6/5	5.38	5.38						
	Rotational M/W	6/5	5.38							
Delivery Suite Total			**43.04**	**37.66**	**32.28**	**26.90**	**21.52**	**21.52**	**21.52**	**21.52**
Maternity Ward	Rotation 5/6	6	5.38	5.38	5.38	5.38	5.38	5.38	5.38	5.38
	Core Midwives	6	8.07	8.07	8.07	8.07	8.07	8.07	8.07	8.07
Maternity Ward Total			**13.45**	**13.45**	**13.45**	**13.45**	**13.45**	**13.45**	**13.45**	**13.45**
Elective C- Section	Elective C-Section	**5/6**	**1.46**	**1.46**	**1.46**	**1.46**	**1.46**	**1.46**	**1.46**	**1.46**
Elective C- Section Total			**1.46**	**1.46**	**1.46**	**1.46**	**1.46**	**1.46**	**1.46**	**1.46**
Triage	Triage	6	7.06	7.06	7.06	7.06	7.06	7.06	7.06	7.06
Triage Total			**7.06**	**7.06**	**7.06**	**7.06**	**7.06**	**7.06**	**7.06**	**7.06**
DAU	DAU	6	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
DAU Total			**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**
Ante Natal Clinic	Ante Natal	6	7.10	7.10	7.10	7.10	7.10	7.10	7.10	7.10
Ante Natal Total			**7.10**	**7.10**	**7.10**	**7.10**	**7.10**	**7.10**	**7.10**	**7.10**

Infant Feeding Team	Infant Feeding Team	6	1.88	1.88	1.88	1.88	1.88	1.88	1.88	1.88
Infant Feeding Team Total			**1.88**	**1.88**	**1.88**	**1.88**	**1.88**	**1.88**	**1.88**	**1.88**
Community	Out of Area Births	6	7.65	7.81	7.81	7.81	7.81	7.81	7.81	7.81
	In Area Births 1:98	6	20.59	17.63	14.69	11.76	8.82	5.88	2.94	0.00
	In Area Births 1:96	6								
Community Total			**28.24**	**25.44**	**22.50**	**19.57**	**16.63**	**13.69**	**10.75**	**7.81**
Continuity of Care Teams	Team 1- Daisy Team 1.20	7/6	7.50	7.50	7.50	7.50	7.50	7.50	7.50	7.50
	Team 2 (1:36)	6/5	8.00	8.00	8.00	8.00	8.00	8.00	8.00	8.00
	Team 3 (1:36)	6/5		8.00	8.00	8.00	8.00	8.00	8.00	8.00
	Team 4 (1:36)	6/5			8.00	8.00	8.00	8.00	8.00	8.00
	Team 5 (1:36)	6/5				8.00	8.00	8.00	8.00	8.00
	Team 6 (1:36)	6/5					8.00	8.00	8.00	8.00
	Team 7 (1:36)	6/5						8.00	8.00	8.00
	Team 8 (1:36)	6/5							8.00	8.00
	Team 9 (1:36)	6/5								8.00
Continuity of Care Teams Total			**15.50**	**23.50**	**33.50**	**39.50**	**47.50**	**55.50**	**63.50**	**71.50**
Management	Delivery Suite	7	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Maternity Ward	7	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Ante Natal	7	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50
	Community	7	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
	Team 1- Daisy Team	7	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50

	Team 3 Onwards	7		2.00	2.00	2.00	2.00	2.00	2.00	2.00
Management Total			**5.00**	**7.00**	**7.00**	**7.00**	**7.00**	**7.00**	**7.00**	**7.00**
Specialist Midwives	Bereavement Midwife	7	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	CTG Champion	7	0.40	0.40	0.40	0.40	0.40	0.40	0.40	0.40
	Digital Midwife	7	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Governance and risk midwife	7	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Low Risk Lead Midwife	7	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Perinatal Mental Health Midwife	7	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Preceptorship Midwife	7	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Practice Development Midwife	7	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Quality and safety midwife	7	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	SBL champion	6	0.40	0.40	0.40	0.40	0.40	0.40	0.40	0.40
	3RD Trimester scanning	6	0.70	0.70	0.70	0.70	0.70	0.70	0.70	0.70
	Screening Midwife	6	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60

	Screening Midwife	6	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60
	Smoking Cessation Midwife	6	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Specialist Midwives Total			**11.70**	**11.70**	**11.70**	**11.70**	**11.70**	**11.70**	**11.70**	**11.70**
Managerial Roles	Director of Midwifery	8D	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	HOM	8C	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Matron	8a	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Matron	8a	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Head of Governance	8b	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Total Managerial Roles			**5.00**	**5.00**	**5.00**	**5.00**	**5.00**	**5.00**	**5.00**	**5.00**
Grand Total			**140.43**	**142.25**	**141.93**	**141.62**	**141.30**	**146.36**	**151.42**	**156.48**
Agreed Budget			**141.43**	**141.43**	**141.43**	**141.43**	**141.43**	**141.43**	**141.43**	**141.43**
Staff in Post			**127.55**							
Current Shortfall based on 20% uplift			**13.88**							
Additional WTE Required for Continuity				**0.18**	**0.50**	**0.81**	**1.13**	**(3.93)**	**(8.99)**	**(14.05)**
Additional 3% for 25% uplift			**(5.81)**	**(5.89)**	**(5.87)**	**(5.86)**	**(5.85)**	**(6.06)**	**(6.27)**	**(6.48)**
Additional WTE Required for CoC with 25% uplift			**(3.81)**	**(5.71)**	**(5.37)**	**(5.04)**	**(4.72)**	**(9.99)**	**(15.25)**	**(20.53)**

Appendix B
Provisional Timescales for Implementation of MCoC

Phase 1	**Current- March 2022**	**2 MCoC teams (Meadow and Daisy): recruit to vacancies to reinstate intrapartum element of MCoC**	**2 x MCoC teams**
Phase 2	**December 2021-May 2022**	**Staff formal consultation period: includes 12 weeks' notice period to staff**	**2 x MCoC teams**
Phase 3	**June 2022**	**Launch of next MCoC team: evaluate, review staffing**	**3 x MCoC teams**
	November-March 2023	**Launch of next MCoC teams, 1 at a time; evaluate, review staffing**	**To increase to 6 x MCoC teams (65% MCoC) with current staffing establishment.**
	March 2023 building blocks in place to implement full MCoC as default model of care for women choosing to birth at WWL	**Further MCoC teams, 1 team at a time dependent on staffing, evaluation and funding for additional staff**	**9 x MCoC (100% MCoC)**

NB: This is dependent on appropriate staffing numbers/vacancies and funding. Timings are subject to review and change, dates provided are an example, following each stage, evaluation will be required.

Appendix C
Daisy Team

In May 2021, WWL launched its second CoC team. This team was developed to build on the work of the Integrated Health Team (Public Health Midwives) and the Specialist Midwife for Substance Misuse. The new model is for women who are classed as the most vulnerable (see criteria below), we have developed a new team of midwives, MSW's and administrative support which we allow sufficient midwives and maternity support workers to increase capacity (previous capacity was for 75 for IHST and approximately 25 for substance misuse), the team will provide a full continuity model of carer which includes Intrapartum provision for this group of women. We have appointed a total of 8 midwives to this team, the team have 2 MSW's and a new full time administrative clerk has also been recruited.

This team will be working in close partnership with the Health visiting team, Perinatal Mental health Teams and are newly appointed Perinatal Mental Health Midwife and outside agencies such as social services, 'We are with you' Drug and Alcohol service, Start-well and the local authority support services.

The caseload for this team will be 1:20 with a reduced caseload for the Team manager. A maximum of 160 women is suggested for this team.

Daisy Team referral criteria: Not exclusive and will be used with a traffic light system (Red, Amber, Green)

Significant mental health

Significant substance abuse

Significant domestic abuse/domestic violence

Teenage Pregnancy 18 and under

Previous CSE/Child drugs exploitation

Women from a BAME background with additional risk factors (medical/social)

Complex safeguarding: includes care leavers, risk of removal at birth, child protection plans

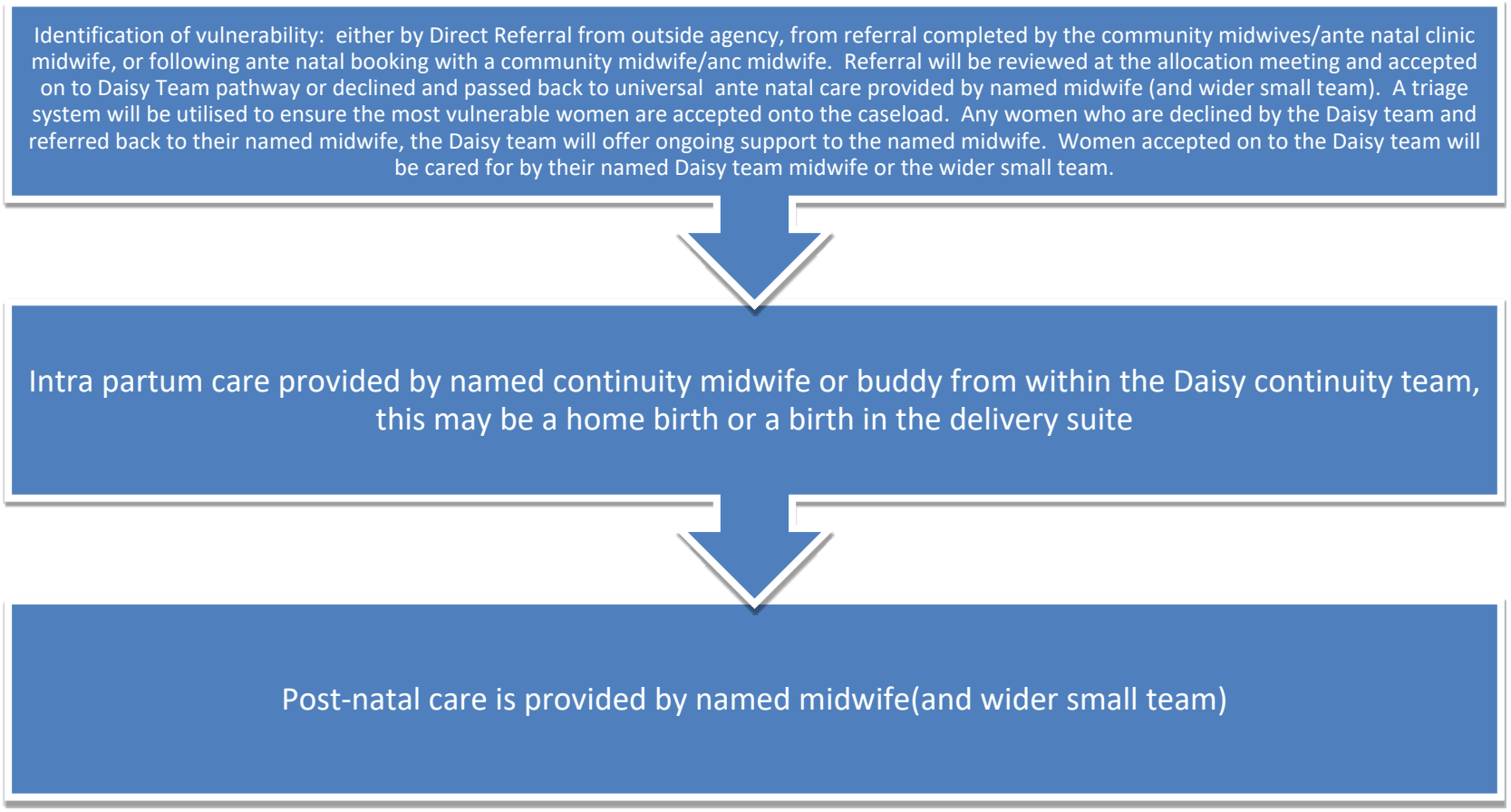
Additional support from vulnerable team in conjunction with community midwife

Teenager's aged 19 if additional risk factors

Learning difficulties/disabilities

Low/medium level: mental health, substance misuse, domestic abuse/domestic violence

Adverse childhood experiences



- This team have a caseload of 1:20 and allocation of women is by referral and triaging.
- Birth availability rostering. This team have a more structured off duty to reflect the nature of the work being predominantly in office hours.
- Named midwife for each woman
- An aim to deliver continuity in the ante-natal, intrapartum, and postnatal periods.

Appendix D

Action Table for MCoC

Task details	To be completed by	Comments	RAG rating
Linked obstetrician	March 2023	Each team to be allocated a named link obstetrician	
Staff Engagement	March 2022	Consultation paper	
		Webinar from National Lead	
		Roadmap	
		Drop in sessions through whole maternity service	
		Zoom sessions	
		Task and Finish group	
		Co-Production meeting with CCG and MVP	
Staffing Plan for MCoC	November 2021	Paper to Trust board Dec 21	
		Paper to CCG and MVP for co-production	
		Paper to LMS Jan 22	
Provisional timescales for implementation of MCoC	November 2021	Paper to Trust Board Dec 21	
		Paper to CCG and MVP for co-production	
		Paper to LMS Jan 22	
Identification of need		Digital Midwife to review and identify MIS to support MCoC: Ethnicity and Decile as a priority	
SOP for MCoC teams		Matrons	
Data Quality	March 2022	Digital Midwife (technical annex resource B)	
		Regular meetings with MIS and updates facilitated.	
		Digital maturity assessment	
		Project group: data quality and reporting processes to be identified	

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Mortality Review: Learning from Deaths Report
Presented to:	Board of Directors
On:	2nd February 2022
Presented by:	Dr S Arya
Prepared by:	Alison Unsworth, Clinical Audit and Effectiveness Manager **Contributors:** Dr M Farrier, Associate Medical Director Sarah Howard, Bereavement Midwife Lesley Timperley, Clinical Lead/ Community Learning Disability Nurse Andrew Barlow, Head of Governance, Community Division Carrie McManus, Head of Patient Safety and Improvement
Contact details:	Sanjay.Arya@wwl.nhs.uk

Executive summary

The purpose of this report is to provide information regarding Mortality Reviews required by the Learning from Deaths Guidance published by the National Quality Board. The information contained within this report relates to data from Q3 2021-2022:

- Total number of deaths: 393
- Total number of deaths reviewed: 256 (65%)
- Total number of potentially preventable deaths: 0
- Total number of patients submitted to StEIS: 1
- Total number of patients with Learning disabilities submitted to LeDeR: 8 (3 within the acute Trust)
- Total number of Maternal Deaths, Still Births and Child Deaths (reported to MBRACE-UK): 2
- Total number of deaths in community recorded via Datix: 2
- Total number of Prevention of Future Deaths Notices: 0
- Current SHMI: 104.87 (Within expected level)
- Current HSMR: 89.30 (Within expected level)

Link to strategy

- Patients

The WWL Way

- Performance

Risks associated with this report and proposed mitigations

None known

Financial implications

None known

Legal implications

None known

People implications

None known

Wider implications

None known

Recommendation(s)

The group is recommended to receive the report and note the content.

Mortality Review: Learning from Deaths Report
2021 – 2022 Quarter 3

1.0 Introduction

In December 2016 a report from the Care Quality Commission (CQC) *'Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England'* found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements may be missed. In March 2017 the National Quality Board published National Guidance on Learning from Deaths, a framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and learning from deaths in care.

The guidance advised that Trusts were required to publish their policy and approach to Learning from Deaths.

The guidance also advised that Trusts are required to collect specified information on deaths and publish on a quarterly basis. The quarterly reports should be scheduled on the agenda of public Board meetings. The report should include:

- The total number of the Trust's inpatient deaths (including Emergency Department deaths for acute Trusts);
- Deaths subjected to review: Trusts are required to provide estimates of how many deaths were judged more likely than not to have been due to problems in care.

The purpose of this report is to provide the Trust with information regarding Mortality Reviews required by the Learning from Deaths Guidance, outlined above.

2.0 Total Number of Deaths (By Quarter)

Quarter	**2021 - 2022**		**2020 - 21**		**2019 - 20**	**2018 - 19**
Chart 1	Inpatient	A&E Deaths	Inpatient	A&E Deaths	Total (A&E deaths not included)	Total (A&E deaths not included)
Quarter 1	256	35	443	41	312	293
Quarter 2	297	38	261	23	270	271
Quarter 3	348	45	549	47	330	286
Quarter 4			387	39	310	343

2.1 Length of Stay

In the 348 inpatients who died, 67 died within 0 to 1 days of admission (18%).

2.2 COVID Cases

In Q3 2021 -2022, there were 12 patients with a COVID positive result who died.

Chart 2 below shows the number of COVID cases over from the start of the COVID pandemic in March 2020. This information is derived from information collated by the Clinical Audit and Effectiveness team. It includes in-patients with a confirmed COVID-19 positive result.

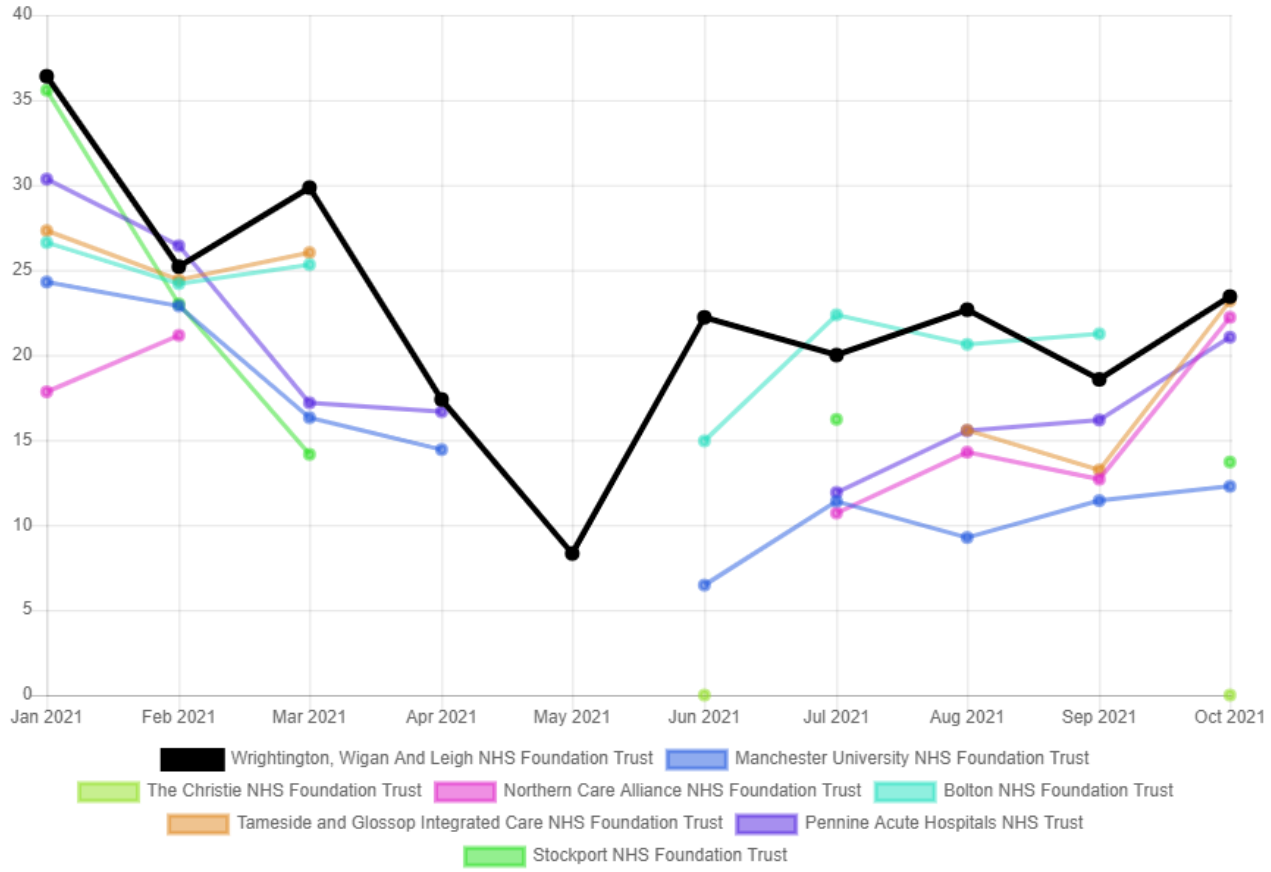
The percentage of deaths in the third phase is calculated from those with a known outcome, which therefore excludes any current inpatients.

Chart 2	Total	17th Mar 2020 – 31st August 2020	1st Sep 2020 – 30th April 2021	1st May 2021 – 17th Jan 2022
Number of Cases	3343	568	1794	981
Deaths	873	246 (43%)	477 (26%)	150 (17%)
Deaths on readmission	68	6	56	6
Discharges	2327	322	1317	688

2.3 COVID cases: National Comparison

Chart 3 shows the crude in-hospital mortality rate compared nationally using clinical coding, primary diagnosis. In cases where the number of cases is lower than 5, numbers are censored, with the exception of our own Trust:

Chart 3:



3.0 Deaths Subjected to Review

The Corporate Mortality Review Team, led by Dr Martin Farrier, Associate Medical Director, review the deaths of all patients who are not on the IPOC (Individualised Plan of Care) and those that have died in the Intensive Care Unit. Review of any patients identified for further analysis by others is also carried out. Certain patients on the IPOC are also reviewed. An in-depth review does not take place if there are no clinicians present.

In Q3, 256/393 65% of all deaths were reviewed and concluded the following:

3.1 Potentially Preventable Deaths

There were 0 potentially preventable deaths noted.

3.2 Themes/Learning

Themes identified during the corporate mortality review are:

- Missed CVA on MRI scan
- Patient who is admitted in arrest having not been able to get a GP appointment
- Patient awaiting colonoscopy for GI related death. There is a possibility that the colonoscopy may potentially have altered the outcome had it been done in a more timely way
- Patient who died in the Emergency Department after 20 hours
- Patient in heart failure treated as pneumonia.

The above themes/learning are shared in the weekly deaths audit circulation email. Cases where there are concerns are shared with ESG so that organisational learning can be progressed.

4.0 External Reporting

4.1 Unexpected Deaths Reported to STEIS in Q3 2021 -22

There was one death reported to StEIS in Q3 2021 – 22:

- Catastrophic Fall on CAU. Patient sustained a subdural haematoma following an inpatient stay.

4.2 Deaths of patients with a learning disability (reported to Learning Disabilities Mortality Review Programme - LeDeR)

The deaths of patients who are formally diagnosed with a learning disability and on the learning disability register should be referred to LeDeR. To date the Trust has not received any recommendations from LeDeR.

In Q3, the Trust reported 8 deaths to LeDeR. 3 of these died in the acute Trust at WWL

The LeDeR programme has been commissioned by NHS England to support local areas in England to review the deaths of people with a learning disability to:

- Identify common themes and learning points, and
- Provide support to local areas in their development of action plans to take forward the lessons learned.

All patients who died in the acute Trust were reviewed by the corporate mortality review team. No issues were identified.

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

The Trust had 0 Maternal Deaths in Q3 2021-2022, 2 stillbirths and 0 Neonatal death.

The 2 Stillbirths this quarter both occurred in December:

- A 36+ 3 gestation previous emergency LUSCS no other risk factors within this pregnancy. Fetal growth restriction confirmed at the birth of the baby.
- A 35 + 3 gestation with risk factors of raised BMI and E-cig user on the serial scan pathway.

Both cases are being reviewed as per recommendations from MBRACE using the Perinatal Mortality Reporting Tool. Awaiting placental histology reports from RMCH and cytogenetics. Both babies Parents' declined Post-mortem.

5.0 Community Deaths

There have been 2 community deaths reported via Datix in Q3 2021/2022 who died outside the acute Trust.

- 2 cases of child deaths who sadly died in other hospitals

6.0 Prevention of Future Deaths Notices

There have been 0 Prevention of Future Deaths Notices (Regulation 28) issued by HM Coroner.

7.0 SHMI (Summary Hospital Level Mortality Indicator) (Deaths in hospital and deaths 30 days post discharge) and HSMR (Hospital Standardised Mortality Rate) (Deaths in hospital only)

The Trust has recently moved from using Dr Foster Healthcare information software tool produced by Telsta to HED (Health Care Evaluation) Healthcare information tool which is owned and produced by Birmingham University Hospitals. This still calculates HSMR and SHMI using the same methods.

7.1 SHMI

SHMI calculated data using NHS digital SHMI rolling 12 months data is 104.87 for the time period October 2020 to September 2021.

The table below shows the previous SHMI figures for the rolling 12 months from November 2019. It should be noted that COVID 19 is not included in the figures.

Chart 4	**Indicator Value**	**Number of Discharges**	**Number of Observed Deaths**	**Number of Expected Deaths**
Wrightington, Wigan And Leigh NHS Foundation Trust				
Nov 2019 - Oct 2020	118.9	38,271	1,562	1,313.67
Dec 2019 - Nov 2020	116.61	36,819	1,455	1,247.71
Jan 2020 - Dec 2020	117.01	35,972	1,394	1,191.35
Feb 2020 - Jan 2021	117.41	35,182	1,334	1,136.20
Mar 2020 - Feb 2021	117.16	34,826	1,302	1,111.28
Apr 2020 - Mar 2021	112.25	35,402	1,252	1,115.34
May 2020 - Apr 2021	109.7	37,135	1,282	1,168.60
Jun 2020 - May 2021	107.55	38,447	1,295	1,204.07

Jul 2020 - Jun 2021	108.26	39,333	1,324	1,222.99
Aug 2020 - Jul 2021	106.69	39,633	1,302	1,220.34
Sep 2020 - Aug 2021	104.5	39,607	1,267	1,212.46
Oct 2020 - Sep 2021	104.87	39,507	1,274	1,214.79

The chart (5) below shows the SHMI position of WWL when compared to local peers (latest data to September 2021). WWL is the black line.

Chart 5

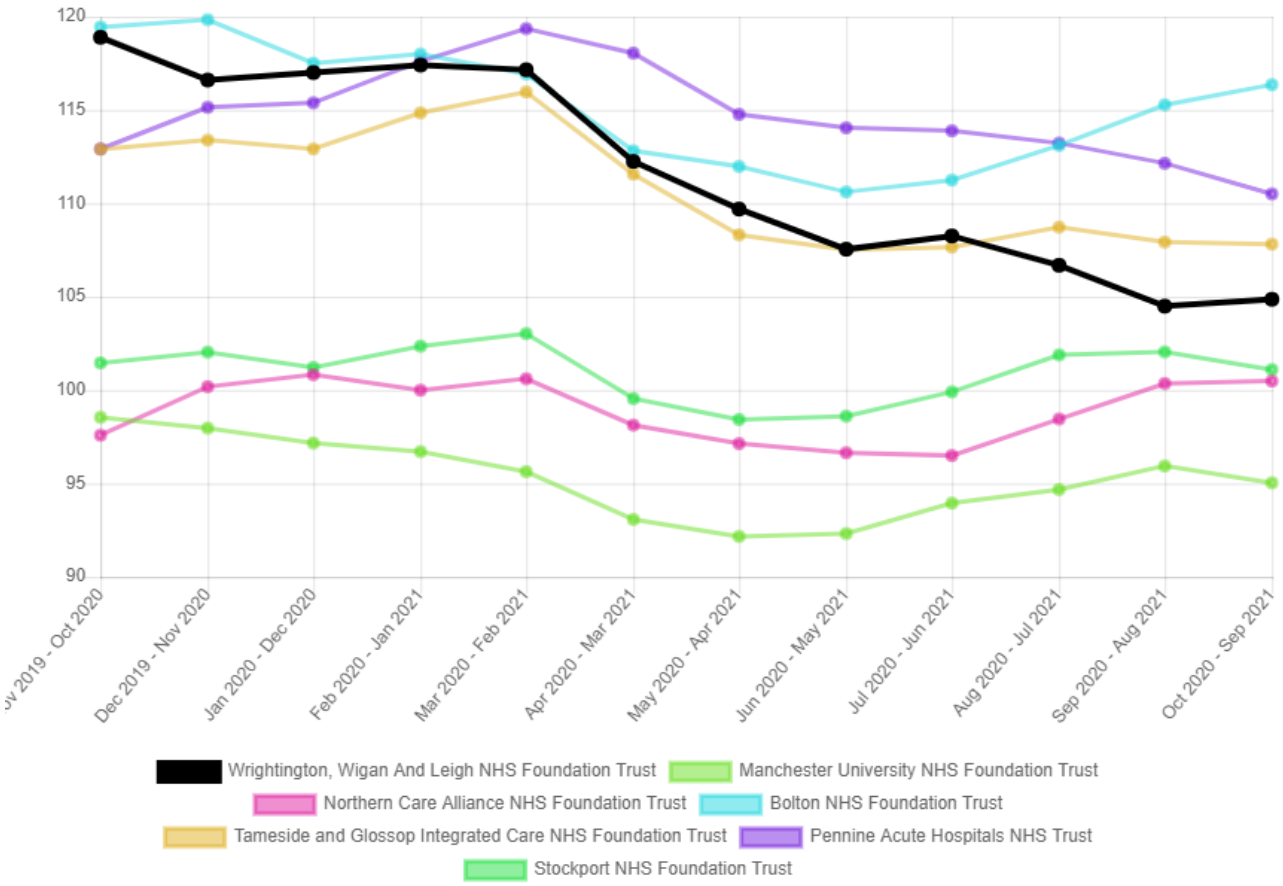
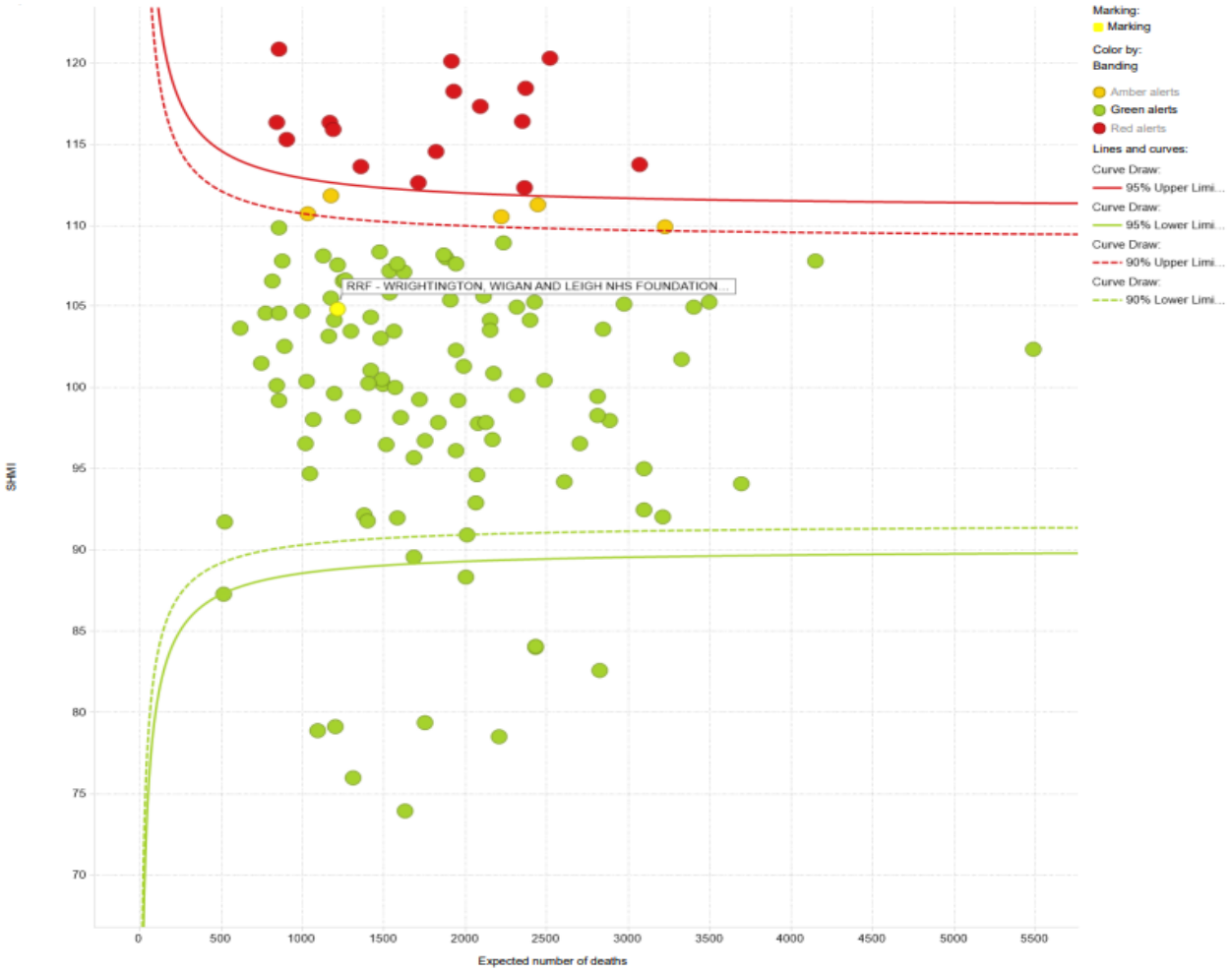


Chart 6 shows the national position of WWL when compared nationally. WWL is currently within the expected parameters.

Chart 6: SHMI



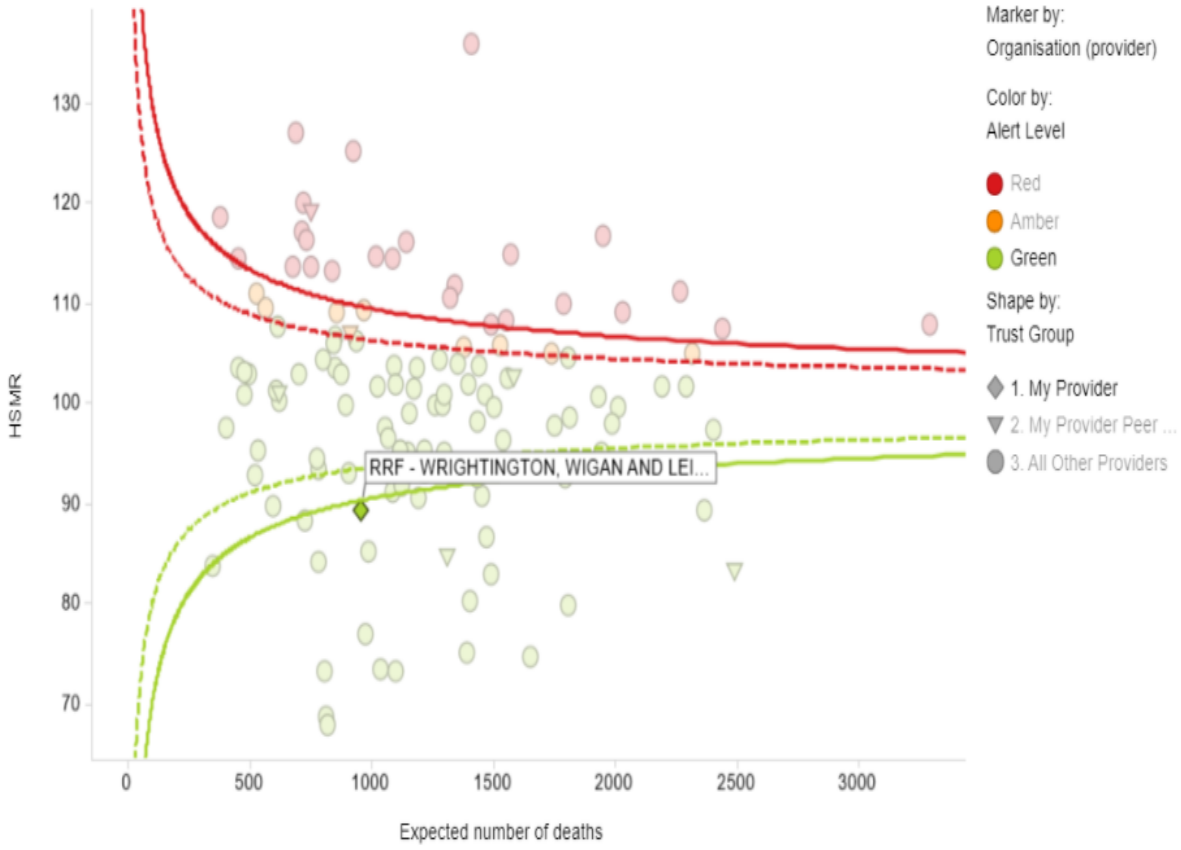
There are no diagnostic groups currently alerting on SHMI/NHS digital.

7.2 HSMR

The current HSMR is for the rolling 12 month period of November 2020 to October 2021 using HED is 89.3 which is below the national benchmark of 100. The previous reported figure for October 2020 to September 2021 using HED was 90.13.
It should be noted that patients with COVID-19 are not included in the figures.

The chart below (chart 7) shows the HSMR position for WWL when benchmarked nationally.

Chart 7: HMSR


HSMR
130
120
110
100
90
80
70
0
500
1000
1500
2000
2500
3000
Expected number of deaths
RRF - WRIGHTINGTON, WIGAN AND LEI...
Marker by:
Organisation (provider)
Color by:
Alert Level
Red
Amber
Green
Shape by:
Trust Group
1. My Provider
2. My Provider Peer ...
3. All Other Providers

Agenda item: [29]

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	WWL M9 Balanced Scorecard
Presented to:	Board of Directors
On:	2 February 2022
Presented by:	Director of Strategy & Planning
Prepared by:	Data, Analytics and Assurance
Contact details:	BI.Performance.Report@wwl.nhs.uk

Executive summary

This paper is an interim report as Data, Analytics and Assurance continue to automate the production of a Balanced Scorecard with supporting commentary. Work is in progress to collect, process and report some of the newly defined Quality & Safety metrics.

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

Link to strategy
Patient
Partnership
Workforce
Site and Service

The WWL Way

Risks associated with this report and proposed mitigations

Financial implications
None currently highlighted.

Legal implications
None identified.

People implications
None identified.

Wider implications

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

Report: M9 WWL Balanced Scorecard: December 2021

QUALITY & SAFETY

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

ACTIVITY & EFFECTIVENESS

	Month	ON/OFF Track	Why?
A&E Performance (Single)	M09	Off Track	67.25% M09, 78.72% YTD; Target 95%
Cancer Performance (Grouped)	M08	Off Track	3 / 7 in month, 2 / 7 YTD; Metrics Off Track
RTT Performance (18 Weeks)	M09	Off Track	60.09% M09, 61.85% YTD; Target 92%
RTT Performance (52 Weeks)	M09	Off Track	1826 patients waiting 52+ weeks (157 Waiting 104+ weeks)
Diagnostics Patients waiting under 6 weeks	M09	Off Track	71.60% M09, 80.44% YTD; Target 99%
Recovery plan - NHS E/ I	M09	Off Track	77.00% M09
Recovery plan - WWL	M09	On Track	112% of 2019 Activity; Target 90%

PEOPLE

	Month	ON/OFF Track	Why?
Employment Essentials			
Vacancy Rate	M9	Off Track	9.64% M9, 9.21% M8, 7.27% M7, Target 5.0%
Number of active Employee Relations cases (disciplinary, grievance, dignity at work, performance)	M9	On Track	18 M9, 18 M8, 20 M7
Time to Hire- vacancy authorisation granted to start date (average days)	M9	Off Track	74.3 M9, 66.9 M8, 59.8 M7 - Target 51 days
Rate Card Adherance- % adhering to rate card	M9	Off Track	52.8% M9, 70% M8, 57.4 M7 - Target 85%
E-rostering- % rosters approved within 6 weeks	M9	Off Track	54% M9, 38% M8, 57% M7, Target 90%
Trust % Turnover	M9	On Track	9.34% M9, 9.16% M8, 9.08% M7, Target 10%
Your Voice Matters			
Your voice engagement score	Q2	Off Track	*3.91 Q2, 3.9 Q1 3.8 Q4, Target 4*
Your voice response rate	Q2	Off Track	*17.1% Q2, 16% Q1 18.0% Q4, Target 50%*
Your voice Wellbeing score	Q2	Off Track	*3.22 Q2, Target 4*
Learn and Grow			
Mandatory Training over rolling 12 months	M9	Off Track	89.8% M9, 90.0% M8, 90.0% M7, Target 95%
PDR`s over rolling 12 months	M9	Off Track	73.4% M9, 73.1% M8, 72.9% M7, Target 90% NB. Excludes M & D Staff
Steps for Wellness			
Sickness Absence	M9	Off Track	7.71% M9, 6.72% M8, 6.63% M7 Target 4%
Special Leave Infection Precaution	M9	On Track	2.02% M9, 1.47% M8, 1.53 M7

FINANCE

Financial Position (£000s)

	In Month			Year to Date			H1	H2	Full Year
	Actual £000's	Plan £000's	Var £000's	Actual £000's	Plan £000's	Var £000's	Plan £000's	Plan £000's	Plan £000's
Income	38,366	38,202	164	346,518	338,490	8,029	221,052	232,040	453,092
Expenditure	(36,791)	(37,012)	221	(335,460)	(327,773)	(7,687)	(213,908)	(224,896)	(438,803)
Surplus / Deficit	216	(0)	216	(98)	(70)	(29)	(70)	0	(70)
Cash Balance	48,884	34,409	14,475	48,884	34,409	14,475	34,321	41,482	41,482
Capital Spend	1,207	700	(507)	9,526	8,909	(617)	6,302	4,720	11,022

Reported position : M09

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

M9 WWL Balanced Scorecard Commentary: December 2021

QUALITY & SAFETY

Board are asked to note that further work is being undertaken to further strengthen the quality safety and patient experience metrics within this report.

Patient Safety (Safe)

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

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

Clinical Effectiveness (Effective)

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

Patient Experience (Caring)

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

ACTIVITY & EFFECTIVENESS

Summary:

The Trust is operating at a heightened level of escalation. The pressure on urgent care remains significant with long waits to be seen and for admission. Capacity is the primary reason but sickness amongst medical and nursing staff is also a contributory factor.

Although overall admissions are not increasing, bed occupancy levels on the acute site are consistently at 100% triggering escalation of additional areas as part of the Trust's full capacity protocol. The number of people no longer receiving on-going medical care but unable to leave hospital has reached unprecedented levels due to the care home sector closed to admissions due to covid outbreak response. The impact this time round is on the General and Acute bed base due to the larger volume of people testing positive with less severity of illness. Predicting the Omicron peak is difficult, but it is expected to occur sometime

Several mitigations are in place, redeployment of staff to open surge capacity at Leigh ahead of schedule, super surge capacity on the Wrightington site, development of ambulatory models including surgical and medical same day emergency care and investment in Virtual wards. The Trust continues to work with the locality on ensuring risk assessment guidance in care homes Greater Manchester took a very difficult decision at the start of January to pause some non-urgent elective activity due to the rising impact of covid. WWL supported this decision to keep people safe, maintain the best infection support measures under the circumstance and ensure staff were deployed to where they are needed the most.

Oversight and scrutiny remain strong, Greater Manchester Gold Command moved to 7 days per week, twice daily Wigan system level calls continue and weekly Director of Public health Board meetings take place.

Scheduled Care

The Trust continues to ensure there is a focus on patient safety across all services according to agreed clinical priorities. Although December saw a continuation in the reduction of 52-week breach patients and a halt in the growth in 104-week breaches for the first time since March 2021, the position will deteriorate in Month 10 given the decision to pause the elective

Unscheduled Care

Daily A&E attendances remain at full capacity levels and significantly higher than pre pandemic demand with yet another sharp rise in patients waiting over 12 hours from arrival in A&E as it becomes increasingly difficult to discharge patients, in Dec there was 923 patients compared to just 53 in Apr 21.

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

PEOPLE

Employment Essentials:

ESR project team appointed and now co-leading the joint roll out of Empactis, ESR hierarchy updates and E-roster to support the availability of staff absence and availability data.

Fast tracking of recruitment and staff deployment with the introduction of the pre-employment check risk assessment form. Will remain in operation during the escalation period only and those working with patients will work fully supervised at all times.

Kickstart scheme has been used to ward helper, fall sitter and admin roles.

Joint work with Indeed and an HCA recruitment event to support clinical recruitment in key escalation areas.

Steps 4 Wellness:

SOS rooms are now operational at Wigan, Wrightington and Leigh. The uptake of these has so far been slow – their usefulness will remain under review, and resource allocated elsewhere if appropriate

Normal wellbeing activity has been shifted to virtual where possible

Referrals to the psychological support service have been significantly higher than pre-Christmas – services are being reprioritised to highest clinical need and those from areas of key clinical importance (e.g. supporting VCOD)

Recruitment has started to the new roles enabled by the successful business case.

Learn and Grow

Until 31st March mandatory training requirements have been relaxed except local fire, resus, IPC and safeguarding, which must be prioritised. Link to pay progression for this period has also been removed.

10 new clinical Kickstarters have been recruited to ward helper roles to support in key clinical areas where resource has been stretched. Clinical Kickstart recruitment is ongoing.

Your Voice

Culture programme framework launched although leadership development aspects of the Culture programme currently on pause

Leadership support circles have started, with the first sessions running next week. Request that ETM disseminates these

FINANCE

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

The Trust is reporting a surplus of £0.2m in month 9 and a break-even position year to date.

The Trust is forecasting to deliver the break-even year-end outturn plan agreed with GM & NHSE/I.

Cash is £48.9m at the end of month 9 which is £14.5m above the plan.

Capital expenditure is £9.5m year to date which is £0.6m more than planned.

The Capital Delegated Expenditure Limit (CDEL) for the Trust has been increased from £10.5m to £16.8m for this financial year.

Please see the monthly finance report for further commentary.

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

Agenda item: [30]

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Monthly Trust Financial Report – Month 9 (December 2021)
Presented to:	Board of Directors
On:	2 February 2022
Presented by:	Ian Boyle [Chief Finance Officer]
Prepared by:	Senior Finance Team
Contact details:	E: David.A.Hughes@wwl.nhs.uk

Executive summary

	In Month			Year to Date		
	Actual £000's	Plan £000's	Var £000's	Actual £000's	Plan £000's	Var £000's
Income	38,366	38,202	164	346,518	338,490	8,029
Expenditure	(36,791)	(37,012)	221	(335,460)	(327,773)	(7,687)
Financial Performance	212	(1)	212	(31)	(0)	(31)
Cash Balance	48,884	34,409	14,475	48,884	34,409	14,475
Capital Spend	1,207	700	(507)	9,526	8,909	(617)

Key Messages:

- The Trust has agreed a balanced budget with NHSE/I and the Greater Manchester system for the second half of the 2021-22 financial year.
- The block contract and system top up funding arrangements have been extended to the end of the financial year, as national tariff remains suspended.
- In month 9, the Trust reported a surplus of £0.2m. The Trust is reporting a break-even position year to date.

The WWL Way

- Cash is £48.9m at the end of Month 9.
- Capital spend is £1.2m in month and £9.5m year to date.

Title of report:	The Guardian Service - Freedom to Speak up Report
Presented to:	Board of Directors
On:	2 February 2021
Presented by:	
Prepared by:	Natalie Morgan
Contact details:	Tel: 07732496588 // natalie.m@theguardianservice.co.uk

Executive summary

This report covers the provision of service from 1st October 2021 to 31st December 2021 – Q3. The purpose is to give insight into the progress of the service since The Guardian Service going live on the 1st October 2021 and to provide an overview of the emerging themes. The report also provides some early recommendations based on the concerns received. Appendix A provides the details for this period.

Link to strategy

A culture of psychological safety is a core component of the 2030 strategy, as it underpins patient and staff safety. It also provides the bedrock of a learning organisation that supports innovation. The FTSUG is a core role in helping us to create this organisational culture, providing an alternative route for colleagues to raise concerns and to provide assurance that these critical issues are reviewed and addressed. Having an independent service to support FTSU indicates that the Trust acknowledge the importance of the Freedom to Speak up Guardian role and the positive impact on having an independent listening support can bring to staff and a commitment to culture improvement.

Risks associated with this report and proposed mitigations

Notwithstanding that WWL had appointed an internal FTSU Guardian, it was perceived that this service was not sufficiently resourced to meet the needs of the organisation. With the appointment of an external FTSU Guardian who is part of a national organisation, staff now have access to a 24/7 service to raise their concerns. With the Guardian not being a member of the Trust nor the NHS, staff are more likely to come forward with their concerns with their anonymity being protected where requested. The FTSU Guardian, having access to all managers, senior leaders and board members can escalate concerns to an appropriate conclusion.

Financial implications

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

Legal implications

There is a requirement following the Francis report that every Trust has a FTSU service in place and this enables staff members to safely raise concerns, in the knowledge that they will be listened to and actions agreed and taken to resolve / address the issue.

Failing to handle FTSU cases appropriately can result in claims at Employment Tribunal under the Public Interest Disclosure Act (1998).

People implications
A resilient and robust FTSU service, where actions are owned and delivered against, is essential for an organisational culture underpinned by psychological safety.

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

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

Appendix A

Purpose of the paper

This report covers the provision of service from 1st October 2021 to 31st December 2021 – Q3. The purpose is to give insight into the progress of the service since The Guardian Service going live and to provide an overview of the emerging themes. The report also provides some early recommendations based on the concerns received.

Content

1. Assessment of Issues

Total number of concerns raised to Freedom to Speak Up Guardian	**20**
Themes	
Patient Safety / Quality	1
Management Issues	6
Systems and Processes	3
Bullying and Harassment	8
Discrimination / Inequality	0
Behavioural / Relationship	2
Other	0
Why use the Guardian Service	
Fear of damage to career	0
Fear of losing job	2
Fear of Reprisal	9
Believe they would not be listened to	5
Believe the organisation would not take action	2
Have Raised Concern but have not been listened to/nothing done	2
Confidentiality	
Keep it confidential within the Guardian Service Remit	3
Permission to escalate with names	5
Permission to escalate anonymously	12

No. of concerns raised

Detailed below are the number of concerns raised across the trust for Quarter 3 (1st October 2021 to 31st December 2021) and a comparison to Quarter 2 (1st July 2021- 30th September 2021) prior to the Guardian Service commencement,

Date	Number of concerns
Q3	20
Q2	1

17 concerns were escalated to the Trust within this period, all of which were responded to within the agreed RAG Protocol timeframe.
From the 20 cases raised within this period moving into Q4, 8 cases remain open and 12 have been closed with permission of the staff member as a result of outcomes being achieved.

Open cases are actively monitored, and regular contact is maintained by the FTSUG with staff members. Cases can remain ongoing for a period, where staff require either ongoing support and guidance from the FTSUG in tackling situations informally or emotional support in situations where they have not built up the resilience to take action for themselves. Where setbacks or avoidable delays are experienced in the progress of cases, these would be raised in regular monthly meetings.

The number of emails, telephone calls and face to face visits engaged by the FTSUG in responding to concerns are as follows:
Email – 59 Telephone – 58 Face to face – 2

There are often multiple contact points for every concern raised, therefore the numbers do not directly correlate with the number of concerns raised.
The FTSUG encourages face to face meetings, with additional follow up meetings which can be conducted by telephone. Further contact can be made with the FTSUG via email.

Themes

Bullying and Harassment
Concerns raised under the theme of bullying and harassment accounts for 8 cases emerging as the highest theme within the Trust. The concerns that have been raised under this category have been escalated due to their thematic nature to the CEO, with a meeting scheduled for January 2022.

Management Issues
Management Issues account for the 2nd largest portion of cases that have been raised with the FTSUG in the period. 6 concerns have been raised under this theme. These were raised within the context of.

Communication:
- General quality of management communication with staff.
- Hostile communication being used by managers.
- Managers not listening to staff concerns, or service improvement suggestions.

Working Environment:
- Creating hostile working environments
- Management decision-making perceived to be unfair.

Interpersonal Issues:
- Breakdown of trust between staff & managers
- Insensitivity towards staff concerns & issues.

The Guardian has supported staff to raise and take forward their own management concerns. This involves helping them to formulate e-mails to Managers about their situation in the workplace. The Guardian also assists with verbal communication and preparation for staff attending informal meetings with subjects of their concern to discuss how they are being treated.
Concerns of this nature have also been escalated to Divisional Directors which has contributed to learning and development opportunities being identified within the areas of concern and sessions with the learning and development team scheduled. With HRBP involvement, managers have been provided with support and guidance with formal processes and procedures.

Systems and Process
Concerns about systems and process were associated with clarity and communication around processes.

When discussing their experience staff reported that they received no management of expectations or given any understanding of timeframes for investigations or outcomes of procedures, no feedback once an outcome had been received and barriers of understanding relating to specific procedures.

Escalation of the concerns under this category resulted in communication being issued cross departmentally to staff to provide clarity relating to a specific process. Also, staff members received updates and feedback following requests into HR.

2. Potential patient safety or workers experience issues

All staff who contact The Guardian Service are advised that patient and staff safety concerns entailing an immediate risk of harm are escalated immediately, with assurance being given to staff of their anonymity should they wish to remain anonymous.

One concern under this heading was reported in the period from 1st October 2021 to 31st December 2021.

The concern related to the reopening of decommissioned wards including inadequate staffing and equipment to operate these wards effectively. The concern was escalated to Matron and subsequently the Divisional Director of Nursing and AHP with feedback received those concerns had been reviewed and measures had been put in place to ensure wards are reopened with the correct staff and equipment which was to be managed by Matron. The staff member confirmed that they had received feedback directly from the Divisional Director and was satisfied with the outcome the case was closed. The guardian has requested that the staff member provide feedback back into the Guardian Service once the impact of the action has had enough time to be measured – to be followed up in January 2022.

3.Action taken to improve FTSU culture

The Trust has taken active steps to ensure that staff feel safe to raise concerns and to view speaking up as "business as usual" and has supported the FTSUG in getting the message across. This is evident in the increased level of concerns raised.

The following are some of the ways in which the FTSUG and WWL are working to improve the Speak up Culture.

- The FTSUG attends monthly catch-up meetings with the Director of Workforce to talk through emerging themes and issues with an aim to resolve barriers where they exist. Names of staff are not mentioned in keeping with the confidentiality nature of the service.

- The FTSUG attends monthly activity catch up meetings with CEO and FTSU NED to discuss themes and cases. No individual can be identified by the reports therefore maintaining staff members' confidentiality.

- The FTSUG attends a wide range of meetings and events to brief staff about the service to further encourage a speaking up culture and actively seeks engagement throughout the trust to raise awareness to all staff groups. FTSU is promoted as a positive service where ideas and suggestions can be raised as well as concerns.

- The FTSUGs contact information is promoted within the 'Speaking Up' and Listening Up' Training modules available within the Trust online training platform.

- The FTSUGs contact information has been promoted via the comms team within the Trust newsletter, Intranet, Social media platforms and with posters and postcards distributed throughout all Trust sites.

- Feedback from staff members utilising The Guardian Service advise that the independent nature and impartiality of the service have influenced them to speak up and although fear of reprisal is the leading reason for coming to the service, the ability to have concerns escalated anonymously provides them with confidence.

- Detriment is a major concern associated with speaking up and has a huge influence on FTSU culture. FTSUG will not close cases without approval of the staff member. The staff member is encouraged to keep the lines of communication open with the FTSUG throughout their case and following closure. Any perceived detriments should be advised to the FTSUG.

4.Learning and Improvement

- The FTSUG attends fortnightly Guardian Service meetings with other GSL FTSUGs where difficult concerns raised are discussed and learning is embedded via shared good practices. Reflection on practice informs continual learning.

- The FTSUG attends the meetings and events organised by the NGO. This includes fortnight catch up meetings with NGO London region FTSUGs. This, in addition to the NGO Bulletins, enables Guardians to stay abreast of developments in the field which in turn support handling concerns effectively.

- The FTSUG receives continual Training and development for instance, Mental Health First Aider and support activities are undertaken such as Resilience training and they attend Therapeutic Coaching Sessions.

5. Recommendations

- The FTSUG recognizes that there are barriers to effective communication and the exchange of feedback between parties occasionally, which can impact adversely on the quality of relationships between the parties going forward. In the instance of lengthy investigations measured contact should be made with staff to provide an understanding of progress. Sometimes being aware that things are still being done can go a long way for staff moral and in enabling them to continue to work effectively.

- Managers, heads of department and others with a staff management responsibility are to be encouraged to invite the FTSUG to team meetings, training events or any other event where staff can meet the FTSUG and understand the service on offer and the support that they can be given.

- Communication of the FTSU service should be ongoing and the FTSUG will continue to work with comms to refresh and keep information updated.