Board of Directors - Public Meeting

Wed 03 August 2022, 13:15 - 16:15

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Agenda

13:15 - 13:16
1 min

11. Declarations of Interest

Information *Mark Jones*

13:16 - 13:18
2 min

12. Minutes of Previous Meeting

Approval *Mark Jones*

12. Minutes - Public Board - 8 June 2022.pdf (12 pages)

13:18 - 13:33
15 min

13. Chair's Opening remarks

Information *Mark Jones*

Verbal Item

13:33 - 14:03
30 min

14. Patient Story

Discussion *Rabina Tindale*

Verbal

14:03 - 14:23
20 min

15. Chief Executive's report

Information *Mary Fleming*

15. Board Report_CEO_August 2022_FINAL.pdf (4 pages)

14:23 - 14:58
35 min

16. Committee chairs' reports

Information *NEDs*

16.1. Audit

Ian Haythornthwaite

16.1. AAA Audit - June 2022.pdf (1 pages)

16.2. Finance and Performance

Alison Tumilty

16.2. AAA F&P - May 2022.pdf (2 pages)

16.3. People

Lynne Lobley

16.3. AAA _ People - 22 Jun 2022.pdf (2 pages)

14:58 - 15:08
10 min

17. Board assurance framework

Discussion *Paul Howard*

17. BAF Report August 2022 Board.pdf (26 pages)

15:08 - 15:28
20 min

18. Integrated performance report

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

18. Board of Directors M3 2223 Scorecard.pdf (4 pages)

15:28 - 15:43
15 min

19. Review of well-led action plan

Discussion *Paul Howard*

19. Well-led action plan - Aug 2022.pdf (12 pages)

15:43 - 15:58
15 min

20. Learning from deaths report

Discussion *Sanjay Arya*

20. Mortality Report - Learning from deaths Q1 22-23 V1. Final.pdf (8 pages)

15:58 - 16:13
15 min

21. Consent Agenda

Information

21.1. Finance Report

21.1Trust Financial Report 22-23 June month 3 Public.pdf (2 pages)

21.2. GOSWH report

21.2. Cover report - guardian of safe working Aug 2022.pdf (2 pages)
21.2. GOSWH QTR 4 report June 2022.pdf (7 pages)

21.3. Freedom to Speak up Mid-Year report

21.3. WWL FTSU Report 6 month Oct 21-March22.pdf (9 pages)

21.4. IPC board assurance framework

21.4. IPC BAF for Trust Board 3.8.22.pdf (8 pages)

21.5. SID appointment

21.5. SID appointment.pdf (2 pages)

16:13 - 16:15
2 min

22. Date, time and venue of next meeting

Information *Mark Jones*

Wednesday 05 October 2022, 13:15pm, THQ Boardroom

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

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

HELD IN PUBLIC ON 8 JUNE, 1:30PM

BY VIDEOCONFERENCE

Present:	Mr M Jones	Chair (in the Chair)
	Mr S Nicholls	Chief Executive
	Prof S Arya	Medical Director
	Prof C Austin	Non-Executive Director
	Mrs A Balson	Director of Workforce
	Mr I Boyle	Chief Finance Officer
	Lady R Bradley	Non-Executive Director
	Ms M Fleming	Deputy Chief Executive
	Mr I Haythornthwaite	Non-Executive Director
	Mr P Howard	Director of Corporate Affairs
	Mrs L Lobley	Non-Executive Director
	Mr R Mundon	Director of Strategy & Planning
	Ms R Tindale	Chief Nurse
	Mrs F Thorpe	Non-Executive Director
	Mrs A Tumilty	Non-Executive Director
In attendance:	Mr P Apter	Physician Assoc Lead for Surgical Ambulatory Care
	Mrs D Alicehajic-Becic	Consultant Pharmacist, Frailty
	Mrs L Braley	Divisional Dir of Operations, Community Services
	Dr M Farrier	Associate Medical Director
	Mrs N Guymer	Deputy Company Secretary (minutes)
	Mr J Williamson	Member of the Public

The Board reconvened following an adjournment.

72/22 Declarations of interest

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

73/22 Minutes of the previous meeting

The minutes of the previous meetings held on 30 March and 6 April 2022 were **APPROVED** as a true and accurate record.

74/22 Action log

The Board accepted that both of the actions due had been completed.

50/22 - Maternity dashboard

The requirements set out had been included in the report provided.

52/22 - Staff survey report

The Chief People Officer advised that the views of staff who had not participated in the staff survey will be ascertained through use of staff stories at Board and sub committees as well as the increase in the number of walkabouts conducted by Board members across all trusts sites and departments. The Board accepted the update.

75/22 Chairs opening remarks

The Chair welcomed members of the public to the meeting. He noted that some members of WWL's Shadow Board were present and explained that these colleagues are taking part in a practical development exercise, they had their first meeting yesterday and positive feedback had been provided by their Non Executive Chair.

He noted that himself and two other Non Executives had attended a workshop the previous day with the Chair of the Provider Federation Board, and emphasised the understanding amongst those present around the emphasis now placed on collaborative working, rather than competition.

The Board received and noted the update.

76/22 Staff story

The Chief People Officer introduced Physician Associate Lead for Surgical Ambulatory Care, Mr P Apter, following them sharing their experiences with her on a wellbeing walkabout. She described how the creation of new roles have been used to address some of the difficulties in staffing identified throughout the pandemic. The Board appreciated how this evidences the support that WWL provide for staff to work up to become fully licenced to practice to ensure that they can operate to the full remit of their training and expertise.

Mr P Apter described how he began working with the Trust a short time ago and how he had felt welcomed and supported. He described some difficulties with a colleague who was a nurse practitioner being told by the radiology governance team that she was unable to prescribe ionising radiology until having completed an additional training module, to be written by the Trusts. This was despite her many years of experience, cumulatively, more than a foundation year trainee doctor, who would be able to prescribe this. He had faced similar challenges himself and he and his colleague both felt upset and frustrated by the lack of understanding of their roles, around what training they have had already and what they are regulated to be able to do.

The Deputy Chief Executive noted the difficulties faced by her colleagues and queried whether there is a forum where Advanced Nurse Practitioners and Physicians Associates can raise and discuss such issues. Mr P Apter was unsure of this.

The Medical Director and Chief Nurse did not think that such forums existed and agreed to consider the need for these to be established and to facilitate this if considered that it would be of benefit to the staff group concerned.

ACTION: Medical Director & Chief Nurse

Mrs F Thorpe asked where these types of role fit in with WWL's strategic workforce plan.

The Chief People Officer noted the need for a strategic medical workforce plan to be put in place. This programme of work will commence urgently, lead by the Associate Medical Director and Divisional Medical Director for Surgery and will be hoped to incorporate all of these types of alternative roles.

The Chief Nurse highlighted that advanced nurse practice is contained within the nursing workforce strategy.

The Chief Executive expressed a keenness to be at the forefront of innovation in developing a new type of workforce, despite practical challenges. He noted that the plan described would be carried forward, overseen by the People Committee.

The Chief People Officer and Medical Director agreed to consider whether a wider scope of practice might be possible for Advanced Nurse Practitioners and Physicians Associates at WWL and to ensure that these roles are factored into the medical workforce plan.

ACTION: Medical Director & Chief People Officer

Mrs L Lobley asked how WWL can attract more physician associates to work with them.

Mr P Apter explained that job descriptions are often very broad and open to interpretation, leaving himself and colleagues unclear as to what their role and responsibilities will be, he suggested that more tailored job descriptions would assist this and noted how well Southport and Ormskirk NHS Foundation Trust have done in filling gaps in rotas by using physician associates.

The Board thanked Mr P Apter for attending the meeting to provide the patient story.

Mr P Apter left the meeting.

77/22 Chief Executive's report

The Chief Executive began by thanking all of the staff who worked over the Queen's Platinum Jubilee bank holiday weekend. He congratulated wards with the progress made on the ASPIRE programme and that this would be expanded to both the community and outpatient services in the coming months. He highlighted that it was NHS sustainability day and was pleased to report how well WWL's 'Green Plan' strategy is being supported by colleagues, through initiatives such as the first Trust-wide sustainable travel competition and the work of the catering team in their endeavours to use locally grown produce where possible. He highlighted that the Trust has now set out clear strategies around research and innovation as well as information management and technology and that WWL is the first NHS organisation in the UK to be awarded the Excellence in Informatics Level 3 accreditation by the Informatics Skills Development Network.

He recalled a recent visit to the trust's Thomas Linacre Centre building and the positive mood and friendliness of staff that he had experienced during his visit.

He advised that colleagues from the National Hospital Only Discharge Team had recently visited the Trust and had fed back on how integrated WWL are as an organisation and that their work done to improve discharges will be showcased nationally for role modelling.

The Board received and noted the update.

78/22 Committee Chairs' reports

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

(a) Audit Committee

Mr I Haythornthwaite, Chair of the Audit Committee reported positively around how fast the current limited assurance reports had been turned around by the responsible Executive Leads.

Lady R Bradley noted the limited assurance report received in respect of private patients and overseas visitors. She reported back on discussions had the previous day at the Shadow Board meeting and queried how important private patients are to WWL.

Mr I Haythornthwaite advised that the Audit Committee are not concerned with the role of private patients within the Trust as a whole but rather, with the processes for ensuring that adequate controls around private patients are in place.

The Chief Finance Officer added that the private patient strategy is currently being rewritten but noted that the Trust must take care to ensure that this does not impact on NHS work. Although an additional funding stream may help financial recovery, this would not be to the detriment of NHS work. He summarised the audit's findings, that one person based on one site capturing private patient activity and associated payment was not enough but that, in line with recommendations, this activity will now be taken on by the finance team.

Mrs A Tumilty queried whether in previous months the Committee has looked at the risk management strategy and been provided with assurance around this.

The Director of Corporate Affairs affirmed that the Committee has been involved in revision of the strategy and that it's workplan has been revised to ensure much more focus on risk, including a biannual deep dive in to corporate risks scored at 15 or above on the risk register.

The Medical Director was supportive of private patient work and highlighted the positive reputational effect that this has had for the Trust in previous years.

(b) Quality and Safety Committee

Mrs F Thorpe, Chair of the Quality and Safety Committee noted the focus of the last meeting as being centred around patient experience and on closing objectives from the previous financial year, with many of these having been exceeded.

The Chief Executive queried what may be responsible for the increase in colostrum difficile.

The Chief Nurse advised that herself and the Medical Director would soon meet to discuss how the levels of this type of infection can be reduced, it was noted that this is influenced currently by the longer length of stay which many patients are having.

(c) Finance and Performance Committee

Mr A Tumilty, Chair of the Finance and Performance Committee, provided a summary of the report which had been provided in advance of the meeting. She highlighted the challenges to the delivery of the Trust's financial plan, being mainly agency overspend and delivery of cost improvement initiatives (CIP). She advised that herself and chair of the People Committee would meet to discuss the former and that the Committee will be closely reviewing the 'rapid meetings' which have been monitoring CIP at the operational level. She noted that post investment approvals would also be reviewed by the Committee going forwards to ascertain whether business cases approved by the Committee are achieving what they promised.

The Board received and noted the updates provided.

79/22 Board assurance framework

The Chair summarised that the document provided addresses the corporate objectives and key risks to their delivery. The Director of Corporate Affairs noted that sessions had been attended by both Executive and Non Executive Directors, where they had been advised around the rationale and process for updating the document. He thanked Executive Directors for their input in updating the document prior to the meeting.

Mrs A Tumilty queried how the primary risk set out in relation to CO1 threatens achievement of the objective. The Medical Director noted that early discharge can be a risk to increased mortality, due to the inability for patients to be monitored.

It was noted that the Chief People Officer had been out of the office unexpectedly the previous week and therefore the 'People' risks had not been updated. It was also noted that many of the finance risks have also been transferred over from the previous year's document and that several statements need to be rephrased to make them more relevant.

Mr I Haythornthwaite noted the need to more clearly quantify risk.

The Director of Corporate Affairs noted that monthly meetings between the Executive Directors and Head of Risk now take place and agreed to feed back that risks must be more accurately articulated. He added that most risks still require alignment to the corporate objectives and this will be completed by the next meeting.

ACTION: Director of Corporate Affairs

The Board received and noted the update.

80/22 Safe nurse staffing report

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

Prof C Austin noted the Trust's current split of vacancies at different bands and asked how reliant WWL are on external recruitment to fill band 5 roles, which are in the main for qualified nurses. She emphasised the need for the Trust to ensure that proper succession planning is in place so that junior band 5s have access to the right education and facilitators to help supervise them to progress into more senior roles.

The Deputy Chief Executive noted the need for triangulation between patient harms and staffing numbers so that the Board can be confident that the decision on nurse staffing ratios made specifically by WWL should still stand.

Mrs A Tumilty asked how WWL will deal with the national issue of midwife shortages.

The Chief Nurse noted that this was hoped to be mitigated through international recruitment but that it will take time for the focus to become more specific, given the current pressures and the need to fill vacancies across many different areas of service.

Queries were raised as to the purpose of the Board receiving the report and whether it had been reviewed by any sub Board Committees in the first instance. It was noted that the report is nationally mandated for Board review although it was agreed that the Chief Nurse should consider, with Non Executive input, whether it may first be considered by any sub Committee moving forwards and whether it may be included on the consent agenda routinely.

The Chief Executive agreed that some nationally mandated reports may need to be reconsidered for adding to the consent agenda or routed through committees first.

ACTION: Chief Nurse

The Board received and noted the report provided.

81/22 Maternity dashboard

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

Mrs F Thorpe commented that the report provides a clear example of how national expectations do not match up with the resources available for Trusts generally.

The Chief Executive noted that the line between planning and what is nationally mandated must be considered by Committees, although was pleased that WWL's internal governance procedures are operating as they should be.

Mrs A Tumilty queried what measures WWL are putting in place to address problems identified with staff culture and patient views as this was a common problem described by women who took place in the reviews but is not addressed within the

report. The Chief Nurse noted that work in this respect is being picked up through other initiatives which are ongoing but not described within the report. The Trust's clinical ward accreditation scheme 'ASPIRE' will be expanded to address these areas, as well as human factors and it is hoped that this will ensure that every nurse who begins work with WWL goes through that training.

The Board considered the format of the report, noting that its provision to the Board is nationally mandated. They agreed that the report should clarify what the Board needs to be assured around – progress against the Ockenden recommendations and continuity of care were highlighted as key – and suggested that the bulk of this report may sit as appendices, with assurance provided by the main body and executive summary.

The Director of Corporate Affairs advised that, as noted in review of the 'well led' plan, report author training for those writing for assurance committees has now begun and focuses on ensuring that reports are set out as the Board had been describing.

The Board received and noted the report provided.

82/22 Q4 2021/22 learning from deaths report

The Medical Director provided a summary of the report provided.

Prof C Austin queried the 11% of patients who died within one day of admission and asked how this figure may be reduced. The Medical Director advised that the weekly report shows that patients who have chosen to stay residing in care homes or their own homes are still being brought in by their carers. WWL will take forward work with primary care colleagues to help to provide support for carers and reduce the need for patients to be brought in at crisis point.

Mrs F Thorpe queried whether the themes and learning show ongoing and recurring issues or whether these have only been evidenced in a few cases.

The Medical Director advised that these concern individual cases and appreciated the need to change the terminology going forwards to make this more apparent.

Mr I Haythornthwaite queried what it means where a patient has COVID-19 included on their death certificate and whether at some point, this will cease to be recoded.

The Medical Director explained that on death, any contributory factor must be noted, where the clinician thinks this is relevant, even if it is not the main or sole cause of death. Some patients deaths may largely be non related to COVID-19 but where they have tested positive at the time of their death, this was recorded. It was agreed that, in the same way that infection control guidance is being reduced, at some point in the future the presence of COVID-19 may be less relevant and may therefore be recorded less where appropriate.

The Board received the report and noted its content.

83/22 University teaching hospitals update

The Medical Director presented the paper that had been circulated in advance of the meeting and set out the organisation's progress against the strategic priority of becoming a University Teaching Hospital. He highlighted the two elements of the research related requirement which the Trust are struggling to fulfil. He explained that the Trust had written to the University Hospital Association to request a reduction in the number of joint appointments required to allow them to achieve university hospital status and that an email had been received that morning from the University Hospital Association, advising that they are unwilling to reduce this. However, he was optimistic that the amount of research capacity funding required in respect of the second unfulfilled criterion would be easily achieved.

The Chief People Officer queried whether a benchmarking exercise could be conducted to compare WWL to other Trusts seeking to gain university hospital status, to support a case for a reduction in the number of joint posts required.

The Chair asked whether anyone was aware of other trusts in same position of struggling to achieve university status for similar reasons. Prof C Austin agreed to query this with other organisations that are going through the same process and continue ongoing discussions with the Medical Director around the matter.

The Medical Director advised that several hospitals with university status do not currently have 20 consultant staff with substantive contracts of employment with the relevant university.

Lady R Bradley queried whether there will be a cut off point at which the University Hospital Association will preclude WWL from continuing to pursue this aspiration.

The Board queried whether the approach taken could be seen as elitist and were supportive of WWL's pursuit of university status, since this would be of benefit to the NHS overall, however, they agreed that, should the status not be achieved within the next year, WWL should no longer invest resource in pursuing it.

The Board received the report and noted its content.

84/22 Review of well led action plan

The Director of Corporate Affairs noted the recommended closure of four actions and advised that the rest are on track to be closed on time, before the end of the financial year. He proposed that these be considered in Q4 when Deloitte would return to review progress.

Mrs L Lobley noted that the Integrated Care System will soon come into existence and suggested that Deloitte are asked to provide assurance to WWL that this does not change their position in terms of progress and how well the 'well led' CQC key line of enquiry requirements are adhered to.

The Board received the report, noted its content and **APPROVED** closure of recommendations 2,3, 6 and 8.

85/22 Q4 2021/22 complaints report

The Chief Nurse provided a summary the report which had been circulated in advance of the meeting.

The Chair queried the average response time for patient complaints.

Lady R Bradley noted that the Shadow Board has shared similar concerns the previous day. She highlighted and was pleased to see the high number of compliments received.

The Chief Nurse advised that much of the time responses can take up to 90 days which is why a task and finish group has been set up to ensure focus is placed on reducing this.

Mrs F Thorpe noted that the annual report to the Board should take a much more high level view than that provided here.

It was **AGREED** that future quarterly updates would be provided via the Quality and Safety Committee, with the Board only to receive an annual report. The Board received the report and noted its content.

86/22 Infection control board assurance framework

The Chief Nurse presented the report which had been circulated in advance of the meeting, noting that the framework had been provided due to Board oversight of the same being nationally mandated.

The Chief Executive noted that as the pandemic subsides, this paper will be more appropriate to be included on the consent agenda, as long as it is required to be provided. It was agreed that it would be included here moving forwards.

Lady R Bradley noted need to consider the implication of less mask wearing and to take forward as much learning as possible from over the pandemic period.

The Board received the report and noted the change in infection control risk focus, outlined therein.

87/22 Integrated performance report

The Deputy Chief Executive provided a supplementary update to the score card provided. She noted that although WWL did not deliver on their elective plan target this month, one or two planning assumptions will remain the same as the divisional team are confident that the Trust will recover to the desired level. She advised that colleagues from the National Hospital Only Discharge Team had recently visited the Trust and had fed back on how integrated WWL are as an organisation and that this behaviour will be showcased nationally for role modelling.

The Chief People Officer noted that although several 'People' measures show that WWL are off track, these are being measured against the ultimate target and not in line with the expected improvement trajectories

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

88/22 Consent agenda

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

1. THAT the finance report be received and noted.

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

3. THAT the self certification against the Trust's provider licence condition FT4, be **APPROVED** as presented and **DIRECTED** that the statement be published on the website.

4. THAT the risk appetite statement be **APPROVED** as presented for implementation from 1 July 2022.

5. THAT the update on cyber security be received and noted.

89/22 Questions from members of the public

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

90/22 Date time and venue of the next meeting

The next meeting of the Board of Directors will be held on 3 August 2022, 12.15 to 4.15pm, in the Boardroom at Trust Headquarters.

Action log

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
8 Jun 2022	76/22(a)	Staff story	Consider whether a forum exists, or should be established, for Advanced Nurse Practitioners and Physicians Associates, if likely to benefit this group	Medical Director and Chief Nurse	TBC	Verbal update to be provided.
8 Jun 2022	76/22(b)	Staff story	Consider whether a wider scope of practice might be possible for Advanced Nurse Practitioners and Physicians Associates at WWL and to ensure that these roles are factored into the medical workforce plan, overseen by the People Committee	Chief People Officer and Medical Director	TBC	Two PAs working at WWL are working with Medical director in preparing a scoping exercise to understand the roles/responsibilities/need for PAs at WWL. In addition a visit have been arranged to Trusts in the region where PAs have been used in more significant numbers than currently in post at WWL. The learning from the scoping exercise and visits will help inform our medical workforce planning process, which will include the role of PAs and ACPs. This will be included in a workforce plan that is aligned to the future operating model that is to be developed across the Wigan system.

8 Jun 2022	80/22	Safe nurse staffing report	i) Consider how patient harms can be triangulated with staffing numbers ii) Consider what governance channels the report should follow moving forwards	Chief Nurse	3 Aug 2022	Verbal update to be provided.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	03 August 2022
Presented by:	Deputy Chief Executive
Prepared by:	Director of Communications and Stakeholder Engagement
Contact details:	T: 01942 822170 E: anne-marie.miller@wwl.nhs.uk

Executive summary

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

Link to strategy

There are reference links to the organisational strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

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

Legal implications

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

People implications

There are no people risks associated with this report.

Wider implications

There are no wider implications associated with this report.

Recommendation(s)

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

Report

The collective hard work, dedication and expertise of our teams is continuing to drive excellent progress in our commitment to the elective recovery targets set by the Government, and I am delighted to say that we have met the target to eradicate 104-week waits for patients, proof that our Elective Recovery Plan is working. Despite this, waiting lists do continue to grow, but we are now working towards the next Government target of eliminating 78-week waits by March 2023, with particular focus on cancer and urgent treatments. Our surgical hub at Wrightington Hospital has played a huge role in our Elective Recovery Plan, not only for patients within the Wigan Borough, but for patients further afield in Greater Manchester, acting as an elective recovery hub for orthopaedics for the region. Our work at Wrightington has recently been highlighted in a report by the Royal College of Surgeons as an excellence example of how stand-alone hubs are vital in meeting waiting list recovery targets. The report is being used to make recommendations to the Government to support current surgical hubs and introduce more surgical hubs across the country. Wrightington has always had an international reputation for excellence in orthopaedics, and the level of high-quality service being provided to our patients is only acting to strengthen this reputation as a hospital of choice for orthopaedic services.

Another service continuing to flourish is our Virtual Ward. This model of care is providing huge benefits to our patients, by allowing them to access high quality care from the comfort of their own homes. It provides a wide range of positive impacts to patients, directly and indirectly, allowing patients to receive care in the most appropriate setting to them, whilst at the same time it frees up space within our hospitals for patients who do need a hospital bed. It was a pleasure to welcome members of the NHS England and Improvement team to come and see our Virtual Ward first hand at our Virtual Hub in Chandler House last month. I had the pleasure of joining Karen Downs, WWL's Clinical Quality Lead for Urgent Care Services, Community Division, and her team, to showcase this service to Dr Amanda Doyle (Director of Community and Primary Care), Tara Donnelly (Director of Digital Care Models), Breid O'Brien (Director of Innovation/Digital Health) and Sam Sherrington (Head of Community Nursing), all of whom highly commended the Virtual Ward and the great example of collaborative working across the Trust and the Greater Manchester Region.

WWL's understanding and use of data underpins successful services such as the Virtual Ward, and as part of our Digital Strategy 2022-2027, our aim is to ensure we have the best digital capabilities to equip our staff with the right skills and embed a 'digital first' culture to maximise the opportunity for our services to benefit from technology. One of the teams carrying out essential work to make this vision a reality is our Clinical Informatics Team. WWL became the first, and currently only, NHS Trust in the UK to receive Excellence in Informatics Level 3 accreditation, for which we must appreciate the outstanding efforts being made, and I must stress how important this type of accreditation is. We are moving quickly towards digitally enhancing healthcare for all and continually embracing innovation to shape our future, and the future of many thousands of people who use our services across the Wigan Borough and beyond.

We are making excellent progress in many areas, but there are still a number of operational challenges within our hospitals and the community. I must commend all our clinical and non-clinical colleagues who continue to meet the increasing demands on our services, and our Estates and Facilities, and wellbeing colleagues who worked hard to address the challenges caused by the weather conditions in order to support patients and staff. It must also be noted that our Emergency Department colleagues received high praise from the President of the Royal College of Emergency Medicine, Dr Katherine Henderson, in her recent visit, where she noted their impressive commitment to emergency care, despite the continuous challenges being faced.

Alongside our mission to stand up to the challenges we face, we will always keep patient safety and experience at the forefront of everything we do. A number of initiatives have taken place over the past two months to highlight this. Towards the end of July, WWL's Chief Nurse and Director of Infection Prevention and Control, Rabina Tindale, along with her senior nursing team, successfully launched the Hello My Name Is… campaign across the Trust. The campaign was co-founded by

the late Dr Kate Granger and her husband Chris Pointon and aims to inspire colleagues to provide truly person-centred and compassionate care to patients, highlighting the importance of medical professionals introducing themselves to their patients. This came not only from Kate's experience as a medical professional, but during a hospital stay in August 2013 with post-operative sepsis, where Kate observed that many staff looking after her had not introduced themselves before delivering care. Sadly, Kate passed away in 2016, but Chris continues to campaign for more compassionate care, and we were honoured to have him visit WWL and speak about the campaign during our launch activities.

The wellbeing of our staff has been and will always be a key priority for WWL, and I was proud to attend the official opening of our Wellness at Work Lounge on our Royal Albert Edward Infirmary site at the end of June. This dedicated space was developed in response to colleagues highlighting how much they value wellbeing support, alongside requests for changing facilities, a space to relax, make a brew and chat with other colleagues. It is important, especially for staff working long shifts, to have somewhere comfortable and well-equipped to take a break, and the Wellness at Work Lounge provides this. We are planning to look at providing similar facilities at our other sites and it is part of our ongoing investment into staff health and wellbeing.

Another commitment we have made to our staff is that of the 'real living wage'. Recognising the cost-of-living challenges facing us all, we have listened to and heard the financial concerns some colleagues are experiencing. WWL has committed to raising the hourly rate of pay of all our staff on Agenda for Change Band 1 and the entry point of Band 2 up to £9.90, that being the current 'real living wage' value this year. It is an investment in our people, and we believe that by ensuring our staff have the right pay and working conditions, it will enable them to provide the very best service to our patients and each other. This is also in line with our role as an anchor institution in the Wigan Borough, as WWL, alongside our partners at Wigan Council, has committed to pay the 'real living wage' this year, as part of our dedication to supporting colleagues and the economies of the local communities we serve. We are also exploring a number of other options, including supporting access to affordable food, uniform exchanges and easy access to benefit advice and guidance.

Further evidence of our influence and role as an anchor institution in the Wigan Borough came in mid-June, when I was privileged to attend the grand opening of the Centre for Advanced Technical Studies at Wigan and Leigh College, where our Education Skills Partnership with the College, Edge Hill University and Wigan Council was showcased. This partnership aims to improve opportunities for local people and develop their skills for employment in the future, with a focus on boosting education, health and economic prospects in Wigan. Our staff are actively involved in delivering real-world examples of health care to students within the dedicated ward facility on site, as well as using the building for training and development purposes. This is one of many shining examples of how we all work alongside each other for the benefit of our community and the people of the Wigan Borough.

It was also a matter of great pride that we recently hosted the Member of Royal College of Physicians Practical Assessment of Clinical Examination Skills Exam at the Thomas Linacre Centre at the start of July, which is a testament to our commitment to delivering high class education and training at WWL. Hosting such a prestigious examination is excellent recognition to our training practices and having high quality educators as consultants. I must thank Dr Abdul Ashish, Dr Imran Aziz and Dr Muhammad Ilyas for spearheading this, along with notable contributions from Specialist Nurses, a number of other consultants and colleagues from the Post Graduate Centre.

As well as important visitors to our sites over the past two months, we have observed some important dates in our calendar. At the beginning of June our teams worked incredibly hard to continue to provide high quality services in the face of an unprecedented four-day Bank Holiday over the Queen's Platinum Jubilee. As important as it was to colleagues to celebrate with decorations and activities for staff and patients on our wards in our departments, I must commend the collective effort made to ensure everything continued to run smoothly across our sites and

within our community. We have also celebrated the NHS' 74th birthday and the NHS collectively received the esteemed honour of the George Cross from Her Majesty the Queen in recognition of the courage, compassion and dedication of colleagues, past and present.

We are currently celebrating South Asian Heritage Month, a time to recognise and celebrate the work of our colleagues with South Asian Heritage. We are proud to have people of 64 different nationalities working with us, and of these, many are from South Asian countries, which is why we really want to take this opportunity to celebrate and learn about their heritage. Cultural and heritage celebrations such as this, along with recognition and awareness campaigns, play a big part in our Equality, Diversity and Inclusion (EDI) Strategy, in which it is our mission to positively influence our communities, increase diversity and accessibility, eliminate inequality and improve experiences for protected groups within our workforce and our patients. It gave me great pleasure to see the announcement regarding WWL's headline sponsorship of this year's Wigan Pride event, which takes place in 10 days' time on Saturday 13th August. We have a proud tradition of supporting the event, but to be Wigan Pride's first ever headline sponsor is a huge honour, and an excellent opportunity for us to continue to break down barriers for the LGBTQIA+ community when it comes to the accessibility of healthcare. I would like to thank our Director of Corporate Affairs and Executive Lead for LGBTQIA+, Paul Howard, for his work in driving this forward, and I hope to see many of our staff safely enjoying this event.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Audit Committee
Date of meeting:	14 June 2022
Chair:	Ian Haythornthwaite

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

ALERT
▪ At the time of writing KPMG had some outstanding matters to review to complete their audit of the accounts - any resulting changes will be reported to the Board, albeit this is unlikely.
ASSURE
▪ The annual report and accounts were presented and recommended for Board approval, with the going concern report and management representation letter. ▪ The counter fraud annual report was received. ▪ The final HOIA opinion annual report was received with substantial assurance.
ADVISE
▪ KPMG noted unadjusted differences in the annual accounts of £890k against a materiality limit of £9m. It was agreed that no changes will be made to the final accounts. ▪ The Committee reviewed the management representation letter and advise the Board to sign the same. ▪ The legal services annual report was received. ▪ The revised terms of reference were noted. ▪ The Committee received the minutes of its reporting groups.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
▪ No risks were discussed or identified.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	F&P Committee
Date of meeting:	25 May 2022
Chair:	Alison Tumilty

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

ALERT
▪ The key assumptions to support elective recovery are not being met – specifically G&A bed occupancy, cancer referral demand and covid occupancy level rates ▪ Waiting lists are growing. ▪ The board should be alerted around the month 1 financial position and CIP delivery at month 1 – significant gaps in the plan have been exacerbated by this.
ASSURE
▪ WWL are on track to deliver the 104 week wait target by the end of June 2022. ▪ The Hospital Only Discharge (HOD) Programme rating is now green, after the HOD team's second meeting with WWL. ▪ £7m IM&T capital spend was achieved – spent and receipted in time to ensure utilisation of funding. ▪ CIP plans: ▪ The responses to the MIAA report on improving processes and governance in this area have been actioned. ▪ 90% of the required savings have now been identified and additional QIAA panels set up to cope with this volume. ▪ Two rapid meetings have already taken place and feedback from the divisional on what the RAPID process feels like in practice has been positive. ▪ The Chair of the Q&S Committee reported on maternity and around the actioning of Ockenden recommendations, which was considered to provide adequate assurance
ADVISE
▪ Following the Chief Executive and his Deputy meeting with the Chief Executive and Director of Health Care from the Council, an update around system working was provided. The four areas of focus agreed were: 1) meeting with other system partners to explore market strategy for management of complex patients; 2) working together to address the immediate backlog of 'no right to reside' patients; 3) looking at costs currently being sustained to assess whether budgets can be pooled and demand moved as a system; 4) considering where demand in to the hospital can be influenced by focusing more on the wider out of hospital social care response.

- These are the areas system leaders have agreed to prioritise and will form part of the presentation to the National team leading discharge and flow when they return in the 6th June 2022.
- The Board must sign off the final financial plan including CIP plan by 8 June 2022 to meet NHSE/I deadlines.
- The Chair of the Q&S Committee reported on continuity of maternity care and noted that, in respect of the actions required to make improvements in this area, the team were unable to confirm where the extra costs required will be found at this stage.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- Waiting lists are growing.
- The BAF had not been updated fully – Executive Directors will be asked to update and review this document before it is provided for future meetings.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	People Committee
Date of meeting:	22 June 2022
Chair:	Lynne Lobley

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

ALERT

- The response rate to the Your Voice Survey (YVS) has improved by 6%, but remains low at 23%. The decision has been taken to reduce the frequency to bi-annual to allow for feedback and action on findings to demonstrate meaning in completion.
- The Guardian of Safe Working noted that exception reporting is being discouraged in the Surgical Division. Actions have been put in place to address this.
- The Workforce Race and Disability Equality Standard (WRES and WDES) reports still indicate recurring issues from previous reports. Issues with violence, bullying / harassment from other staff members are 4.4% higher for BME than white staff and the relative likelihood of issues progressing into disciplinary process and to appointment from shortlisting for BME staff was noted to be of concern. The agreed objectives and the enhancement of colleague diversity networks will be instrumental in addressing this, along with significant awareness raising and mainstreaming of equality, diversity and inclusion (ED&I) into everything we do.
- Appraisal and mandatory training compliance remains of concern. Divisional recovery plans have been requested for monitoring through monthly assurance meetings. Focus groups have taken place in June to inform the review of the appraisal process.
- Freedom to speak up processes continue to highlight bullying & harassment and management issues as the most consistent themes (12 concerns have been registered in respect of each out of the total 35 concerns raised). All cases are being managed and escalated in accordance with the KPIs and communication will be issued to clarify the role and expectations of the Guardian.

ASSURE

- The staff story illustrated the positive impact of WWL's fair and just culture in respect of avoiding unnecessary and inappropriate disciplinary processes.
- The People Dashboard has been revised to align to Our Family, Our Future, Our Focus, with a mixture of output and enabling measures. This will be cascaded for divisional assurance reviews. It also enables easier triangulation ad will become part of the interactive dashboard being developed by the business intelligence team.
- Freedom to speak up systems and processes are working well and there is a very low number of patient safety concerns. As a result of the positive feedback about the independence of the Guardian Service, the exit interview and stay discussion pilot will commence in July 2022.

- We are seeing significant improvements in the YVS with 11 of the 16 measures seeing statistically significant improvement. Compassionate leadership became a top three enabler for the first time. This demonstrates that the Our Family, Our Future, Our Focus is delivering and we should remain consistent in our approach.
- A staff side representative was present and contributed to the meeting showing good engagement with staff side.
- The WRES and WDES reports were signed off for national reporting, along with the workforce Equality Diversity and Inclusion (ED&I) objectives, with agreed priority programmes of action to be informed by the colleague diversity networks.
- The Committee was assured by the process and outcomes for annual nursing revalidation
- The audit and risk report gave good assurance that all corporate 'People' risks and audit reports are being appropriately managed and actioned
- The annual learning needs analysis (NA) has been completed. The NA and the talent for care strategy have been agreed in principle by the Executive Team, subject to business case approval.
- The apprenticeship plan for 2022-23 will see more than £1m of the apprenticeship levy used. This is a significant improvement and is indicative of how the perception of apprenticeships is improving.

ADVISE

- The frequency of the YVS will be reduced to biannual, to encourage a higher response rate and to allow time for actions to be implemented.
- The organisation will run EDS3 (Equality Delivery System) in shadow form this year, which will help embed ED&I within the organisation.
- Objectives are being established for the ED&I network groups, to aid progression of positive action to tackle ED&I issues highlighted within the WRES/WDES
- The new terms of reference for 2022/23 were accepted.
- The recruitment and retention report set out a comprehensive action plan to achieve a positive reduction nursing vacancies by October 2022.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- Risks associated with the delivery of Corporate Objectives, as set out in the BAF, were referenced throughout the meeting and through the papers considered by the Committee.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Board Assurance Framework (BAF) Report
Presented to:	Board of Directors
On:	03 August 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 framework to control the trust's key strategic risks.

Financial implications

There are no financial implications associated with this report.

Legal implications

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

People implications

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

Wider implications

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

Recommendation(s)

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

1. Introduction

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

1.2 The Board of Directors is responsible for reviewing the 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.

1.3 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. Risk Rating Matrix

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

RISK RATING (LIKELIHOOD x IMPACT)

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

Table 1

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

3. **Board Assurance Framework Review**

3.1 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.

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

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

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

6. Risks Accepted and De-escalated from the Board Assurance Framework since June 2022

6.1 The following risks have been accepted and closed since June 2022:

- Risk 1.2 (3266) SHMI - Primary and Secondary Care Pathway. Objective achieved.
- Risk 1.3 (3267) SHMI - Discharge and return to hospital. Objective achieved.
- Risk 2.2 (3269) Limited resources in relation to training & development for staff. Linked to 2.1
- Risk 8.1 (3284) Culture - Participation in the programmes. Objective achieved.
- Risk 9.3 (3288) Fairness and compassion - Locality-wide workforce EDI strategy. Linked to 9.2
- Risk 14.1 (3297) Elective Hub – Insufficient staffing for levels. Objective achieved.
- Risk 14.2 (3298) Elective Hub – Restricted amount of capital. Objective achieved.
- Risk 16.2 (3301) Partnership working - Locality-wide workforce EDI strategy. Linked to 9.3

6.2 The following risks have been de-escalated to the operational risk register since June 2022:

- Risk 2.3 (3270) No consultant cross-cover from Salford Royal for the AKI service
- Risk 2.4 (3271) AKI and sepsis services over a 5-day working week. Linked to 2.3
- Risk 3.2 (3323) Tissue Viability Team capacity
- Risk 13.1 (3294) Estates Strategy.

7. Review Date

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

8. Recommendations

8.1 The Board are asked to:

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

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Board assurance framework

2022/23

The content of this report was last reviewed as follows:

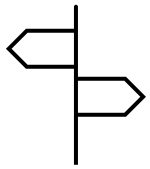
Quality and Safety Committee:	May 2022
Finance and Performance Committee:	July 2022
People Committee:	June 2022
Audit Committee:	June 2022
Executive Team:	July 2022

“ **assurance** (/əˈʃɔːrəns/) *noun*

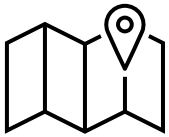
(In relation to board assurance) Providing confidence, evidence or certainty that what needs to be happening is actually happening in practice ”

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

How the Board Assurance Framework fits in

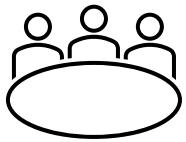


Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how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

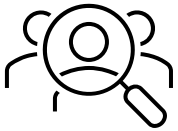


Corporate objectives: Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives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

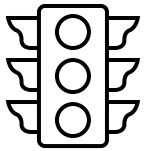
Board Assurance Framework: The board assurance framework provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains risks that are most likely to materialise and those that are likely to have the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



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



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



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

Understanding the Board Assurance Framework

RISK RATING MATRIX (LIKELIHOOD x IMPACT)

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

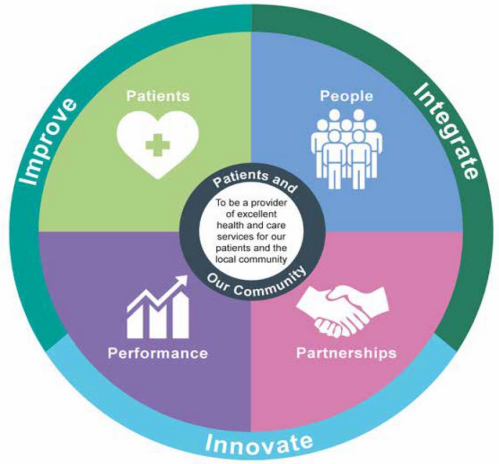
DIRECTOR LEADS

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

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

Our approach at a glance

Our Strategy 2030



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

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

FY022/23 Corporate Objectives

Patients

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

People

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

Performance

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

Partnerships

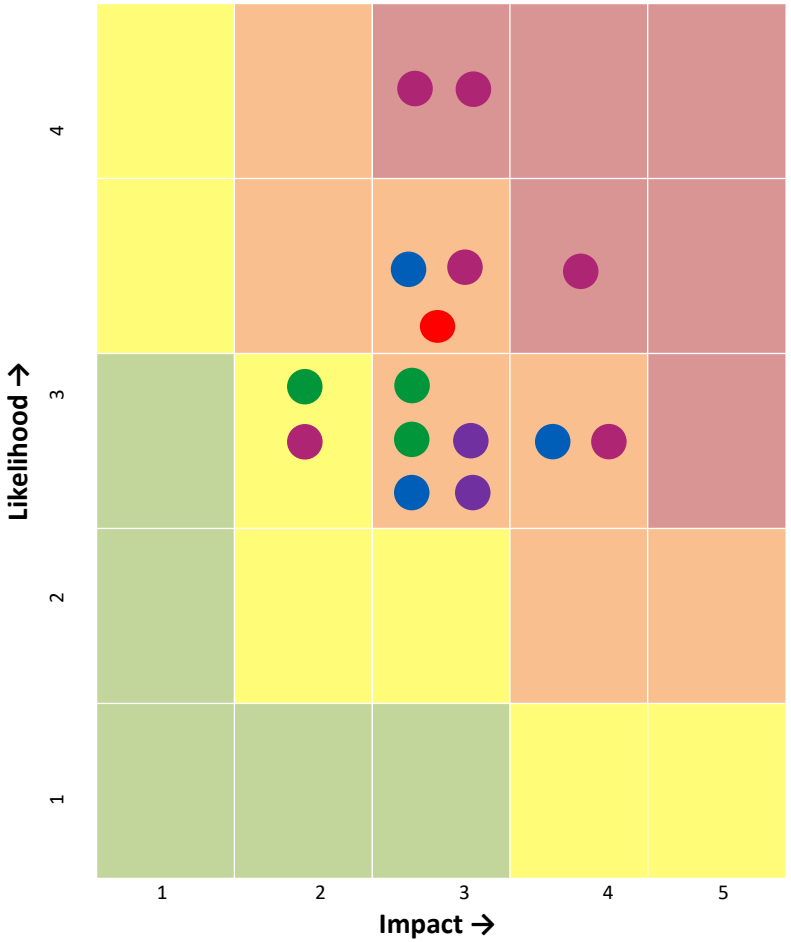
We will…
- Positively impact on the social and economic factors of our Borough
- Develop effective relationships within Wigan Borough and Greater Manchester for the benefit of our patients
- Make progress towards becoming a University Teaching Hospital

Risk management

Our risk appetite position is summarised in the following table:

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

The heat map below shows the distribution of all 14 strategic risks based on their current scores:



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

Patients

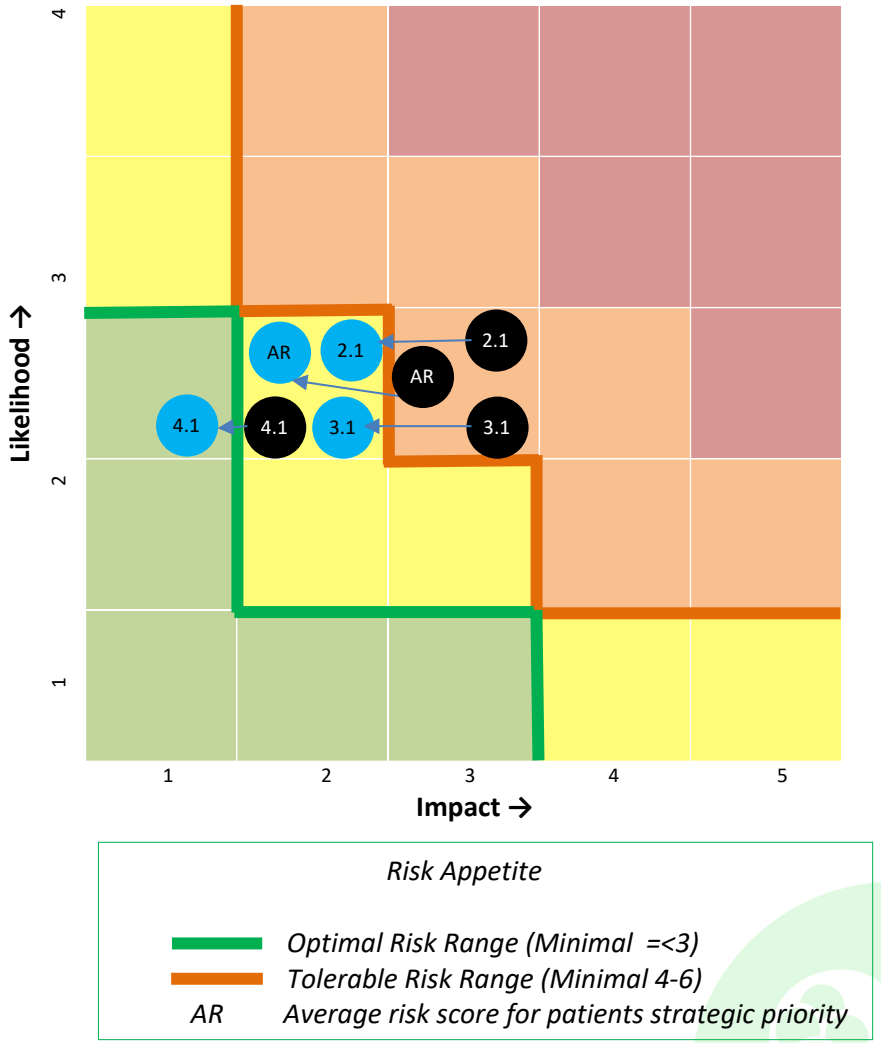
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

Monitoring: Quality and Safety Committee

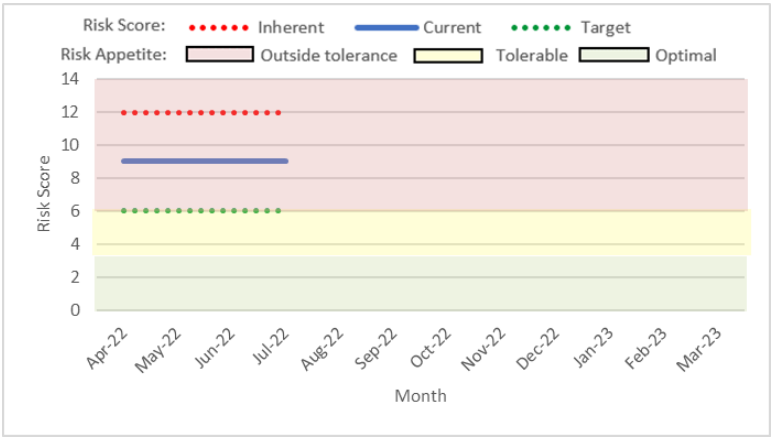
The following corporate objectives are aligned to the **patients** strategic priority:

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

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

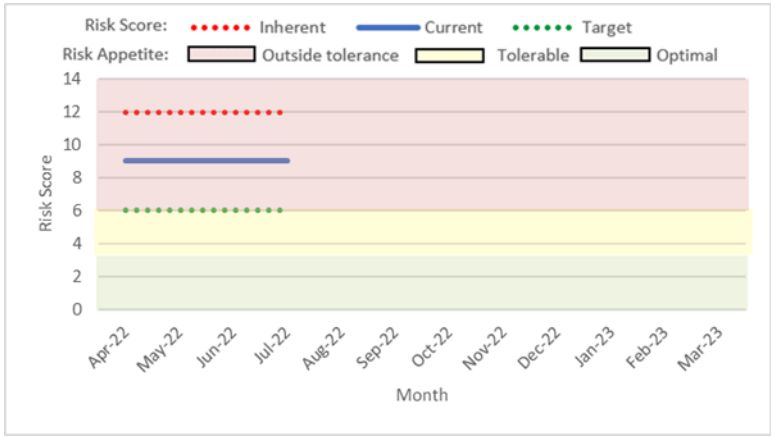


Corporate Objective: **CO1** Improve the safety and quality of clinical services							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 1: Clinical Services - Recognition, screening and treatment of the deteriorating patient**						
	Risk Statement:	There is a risk that patients who are deteriorating are not appropriately clinically escalated due to non-identification of sepsis, AKI or baseline observations resulting in mortality related to sepsis and AKI.						
Lead Committee	**Quality and Safety**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal	
Lead Director	**MD**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Safety, quality of services & patient exp.	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	3270	
Date of last review	**12.07.22**	**Risk Rating**	12. High	9. High	6. Moderate	**Risk treatment**	Treat	



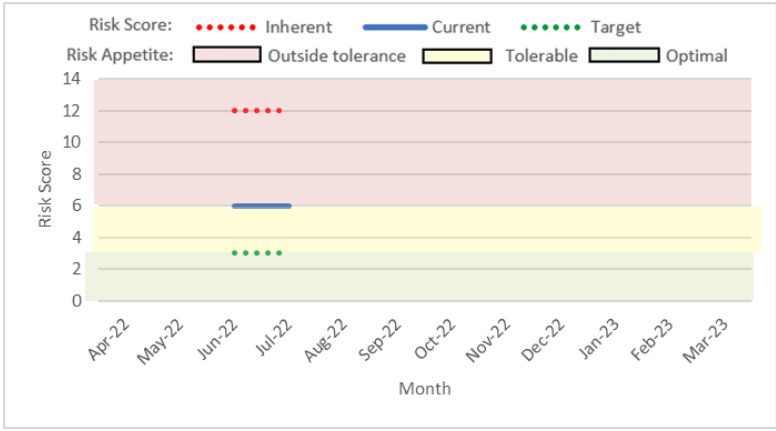
Strategic Opportunity / Threat Linked Risk	Existing controls	Gaps in existing controls	Assurances (and date last seen)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **2.1 (ID 3268)** 3270 – Consultant cross cover from SRFT for AKI service	• This is a dedicated corporate objective for FY2022/23. • Rapid Improvement Group. • Sepsis QI group. • Sepsis Improvement Plan. • Sepsis live in HIS. • Visibility of AKI and Sepsis Nurse in clinical areas • AKI and sepsis audits undertaken. • Themed SIRI panel on sepsis in Sept 2021 focused on improvement work and highlighted achievements to date.	• Workload demands for AKI and Sepsis nurses. • AKI Improvement Plan needs to be developed.	**2nd Line:** • Quality & Safety Committee May 22.	• No gaps currently identified.	1. Deteriorating Patient Improvement Group continues to meet monthly.	Monthly

Corporate Objective: **CO3** Improve the delivery of harm free care								**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 2: Harm Free Care - Avoidable Pressure ulcers**							
	Risk Statement:	There is a risk that our systems and processes, coupled with challenged staffing, may not facilitate the swift identification of potentially avoidable pressure ulcers resulting in harm to our patients.							
Lead Committee	**Quality and Safety**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal		
Lead Director	**CN**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Safety, quality of services & patient exp.		
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	3323		
Date of last review	**12.07.22**	**Risk Rating**	12. High	9. High	6. Moderate	**Risk treatment**	Treat		



Strategic Opportunity / Threat Linked risk	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **3.1 (ID 3322)** 3323 – Tissue viability team capacity	• Pressure ulcer link nurses trained within areas. • Training package. • Grade 2/DTI Pressure ulcer Panels in place. • Grade 3/4 & Unstageable Pressure ulcer panels in place. • New pressure ulcer rapid Review template launched for pressure ulcers. • New Pressure ulcer policy and procedure now approved. • Datix improvements started to better capture pressure ulcer management.	• Staff being able to be released to undergo training. • Package not yet live. • Junior workforce. • Investigation of developed ulcers are not investigated to a level to allow for full identification of learning. • Equipment issues. • Beds owned by individual Divisions. • under resourcing of Tissue Viability Team.	**2nd Line:** • Quality & Safety Committee May 22	• No gaps currently identified.	1. Harm Free Care Business Case to be drafted. 2. Continue to accurately record NEWS, PEWS and MEWS. 3. Continue the roll out of human factor training.	31.08.22 CN 31.03.23 CN 31.03.23 CN

Corporate Objective: **CO4** Improve the quality of care for our patients								**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 3: Ward accreditation programme**							
	Risk Statement:	There is a risk that future waves of covid may affect the supernumerary status of ward leaders, due to the impact of covid on staffing levels in clinical areas, challenging the achievement of silver accreditation level. This is a single person service with paper based scoring and reporting which may also influence the speed of the roll out.							
Lead Committee	**Quality and Safety**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal		
Lead Director	**CN**	**Likelihood**	4. Likely	2. Unlikely	1. Rare	**Risk category**	Safety, quality of services & patient exp.		
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	-		
Date of last review	**12.07.22**	**Risk Rating**	12. High	6. Moderate	3. Low	**Risk treatment**	Treat		



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **4.1 (ID 3507)**	• The Accreditation assessments are currently underway and to date wards assessed have achieved a bronze rating.	• Accreditation project plan to be developed.	**2nd Line:** • Quality & Safety Committee May 22	**2nd Line:** • Project plan to go to NMAHP, NMALT and new Quality Assurance Group.	1. Accreditation project plan to be developed by Clinical Quality Lead and service transformation lead.	30.09.22 CN

People

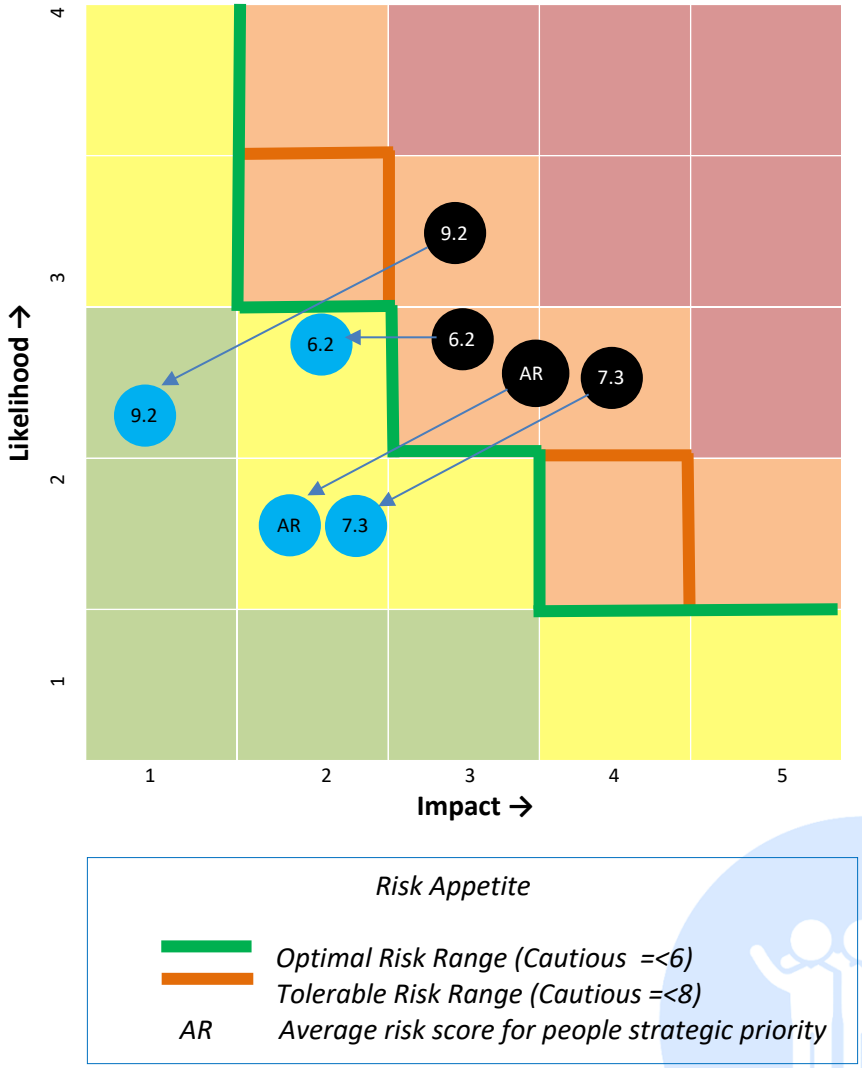
To create an inclusive and people-centred experience at work that enables our WWL family to flourish

Monitoring: People Committee

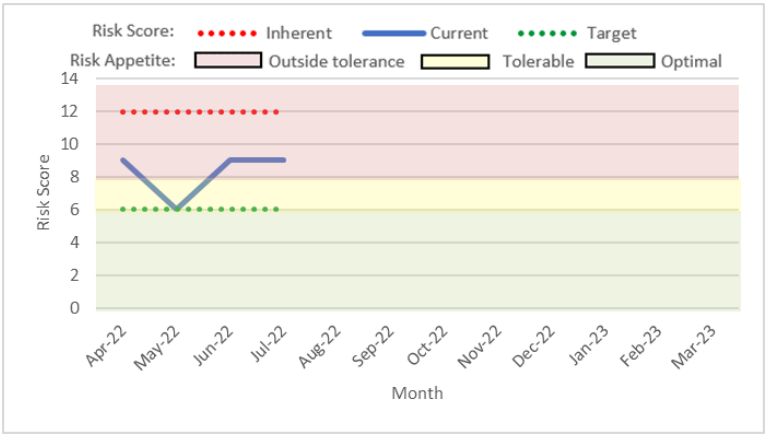
The following corporate objectives are aligned to the **people** strategic priority:

Ref.	Detailed objectives
CO6	We will advance and embed the implementation of our just and learning culture programme through leadership development, civility and team development / culture programmes that improve experience of work in a sustainable way and encourage our people to speak up. *No risks currently identified*.
CO7	We will support the physical health and mental wellbeing of our WWL family by ensuring we have a range of wellbeing activities and services that are accessible to our colleagues, supported by real time and accurate absence data.
CO8	We will improve the equality, diversity and inclusion of our Trust by increasing diversity and accessibility, reducing inequality and improving the experience of protected groups.
CO9	We will prioritise personal and professional development to enable our people to flourish, making full use of all available funding sources by aligning our programmes to the learning needs analysis and strategic aspirations such as university teaching hospital status.

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

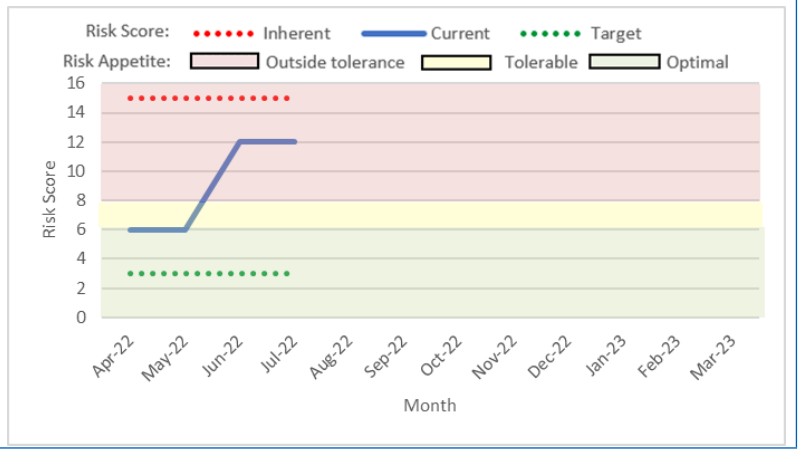


Corporate Objective: CO7 Support the health and wellbeing of our colleagues							**Overall Assurance Level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 4: Participation in preventative and restorative wellbeing activities**						
	Risk Statement:	There is a risk that sufficient time may not be available for staff to participate in preventative and restorative wellbeing activities within working hours, due to workload pressures and vacancies, resulting in lower engagement levels and evidence suggests this will reduce the success of the programme.						
Lead Committee	**People**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**CPO**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Staff Wellbeing	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	3227	
Date of last review	**10.06.22**	**Risk Rating**	12. High	9. High	6. Moderate	**Risk treatment**	Treat	



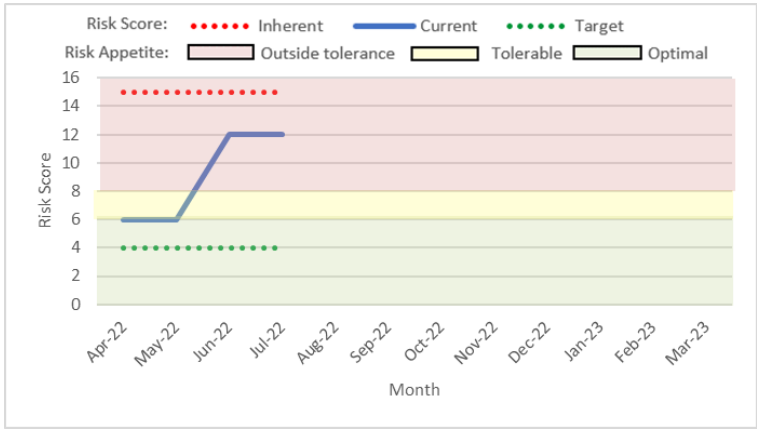
Strategic Opportunity / Threat Linked risk	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **6.2 (ID 3279)** 3227 - Maintaining safe staffing levels.	• Your Voice Survey – well-being score. • Steps 4 Wellness Service enhancements. • Targeted in-reach activities in high-risk areas. • Wellbeing walkabouts. • Re-prioritisation and amendment of offers.	• Commitment to roster time for people to be released as needed.	**2nd Line:** • Information shared at Trust Board Away Day. • People Committee and Trust Board considered National Survey results Mar/Apr 22. • Recruitment & retention report – People Committee (June 2022). • Your Voice Survey report – People Committee (June 2022).	None identified.	1. Strategic needs assessment to be completed working with divisional teams. 2. Divisional well-being plans that are prioritised and implementation monitored through divisional assurance reviews. 3. Recruitment to vacancies (including international recruitment) – performance against trajectory.	September 2022 - Consultant clinical Psychologist November 2022 – Divisional Triumvirate & S4W team March 2023 – DCN & DCPO (+ recruiting managers)

Corporate Objective: **CO8** Ensure inclusion and belonging for all –ED&I							**Overall Assurance Level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 5: Fairness and compassion - workforce EDI expertise and supporting infrastructure**						
	Risk Statement:	There is a risk that EDI may not be embedded in everything we do, due to a lack of sufficient workforce awareness about EDI and we do not have substantive Workforce EDI resource, resulting in failure to deliver the EDI objectives, strategy and our statutory duties under the Equality Act.						
Lead Committee	**People**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**DW**	**Likelihood**	5. Almost certain	4. Likely	1. Rare	**Risk category**	Staff Capacity and Capability	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	3231	
Date of last review	**10.06.22**	**Risk Rating**	15. Significant	12. High	3. Low	**Risk treatment**	Treat	



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **9.2 (ID 3287)** 3231- Culture of psychological safety, civility and compassionate leadership	• Workforce EDI specialist recruited (fixed term contract until January 2023). • EDI strategy approved. • Expanded staff networks supported. Training in place for network sponsors and EDI Champions. • Three independently assessed schemes approved for implementation – Rainbow Badge, Disability Confident & Race Equality Standard.	• No ongoing funding commitment.	**2nd Line:** • EDI report to People Committee June 2022. • Workforce EDI objectives reviewed at People Committee for approval – June 2022. **3rd line** Messenger review – highlights the need to improve EDI awareness and to increase diversity (June 2022).	No substantive EDI workforce resource to support delivery against strategic aims set out in the strategy. Workforce and leadership awareness of EDI and associated responsibilities	1. Embed colleague diversity networks. 2. Gap analyses and action plans from the three assessments. 3. Review shadow running of EDS 3 (2022) process in 2022-23. 4. Awareness and engagement programme for all (with specific focus on leadership EDI responsibilities). 5. EDI workforce objectives delivery. 6. Business case / business planning process regarding Workforce EDI specialist role. 7. EDI corporate objective cascade to all senior leaders.	Workforce EDI lead – Sept 2022 Workforce EDI lead – Nov 2022 Workforce EDI lead – March 2023 Workforce EDI Lead - Sept 2022 Workforce EDI lead - March 2023 CPO – Aug 2022 Divisional triumvirates & Corporate heads of service – Sep 2022

Corporate Objective: CO9 Create an environment where we are always learning, and everyone flourishes								**Overall Assurance Level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 6: Personal Development**							
	Risk Statement:	There is a risk that the prioritised learning needs analysis cannot be delivered due to funding constraints and / or inability to release staff for training, resulting in increased turnover and / or a lack of continued professional development for colleagues.							
Lead Committee	**People**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious		
Lead Director	**CPO**	**Likelihood**	5. Almost Certain	4. Likely	2. Unlikely	**Risk category**	Staff Capacity & Capability		
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	2. Minor	**Linked risks**	3230		
Date of last review	**10.06.22**	**Risk Rating**	15. Significant	12. High	4. Moderate	**Risk treatment**	Treat		



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **7.3 (ID 3283)** 3230 - Funding uncertainty around education, training and learning	• Full LNA completed and prioritised. • Mandatory and job specific training requirements reviewed and updated. • Agreed principles of apprenticeship and HEE funding allocations first.	• Ability to roll forward HEE funding allocations. • Ability to release staff due to vacancies / workload pressures. • Recurrent budget for training & development aligned to LNA.	**2nd Line:** • ETM review and in principle (LNA and apprenticeship plan) – May 2022 • People Committee report – June 2022	None identified.	1. Business case to deliver 2022-23 LNA. 2. Benchmarking review of nurse staffing establishment uplift to cover time for training. 3. Recurrent budget setting principles to be agreed.	July 2022 – CPO TBC – CNO December 2022 - ETM

Performance

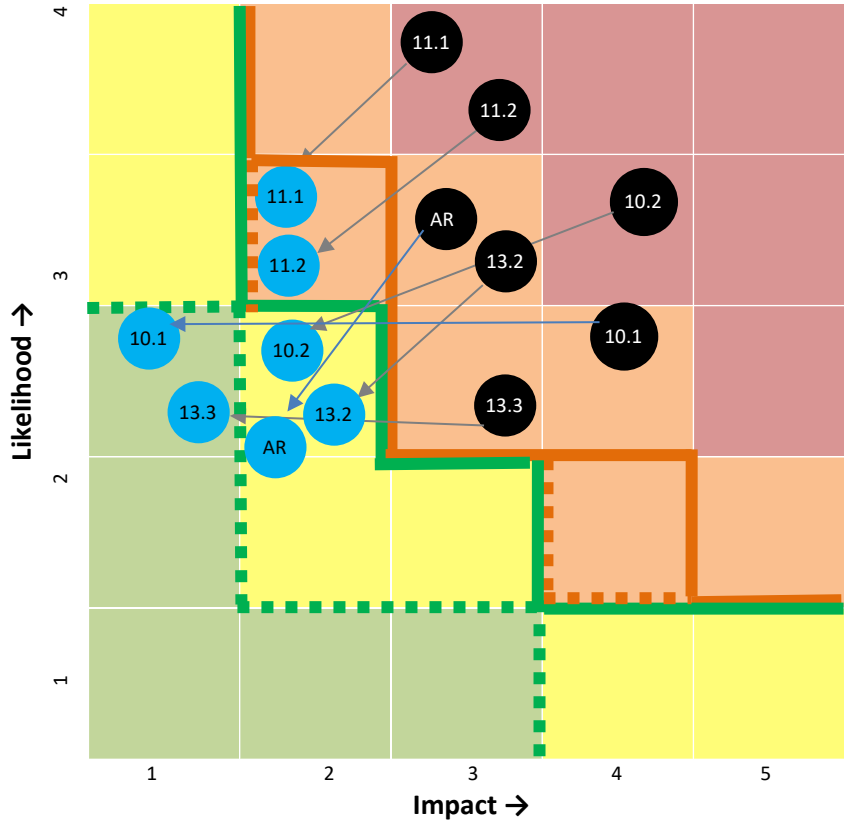
Our ambition is to consistently deliver efficient, effective and equitable patient care

Monitoring: Finance and Performance Committee

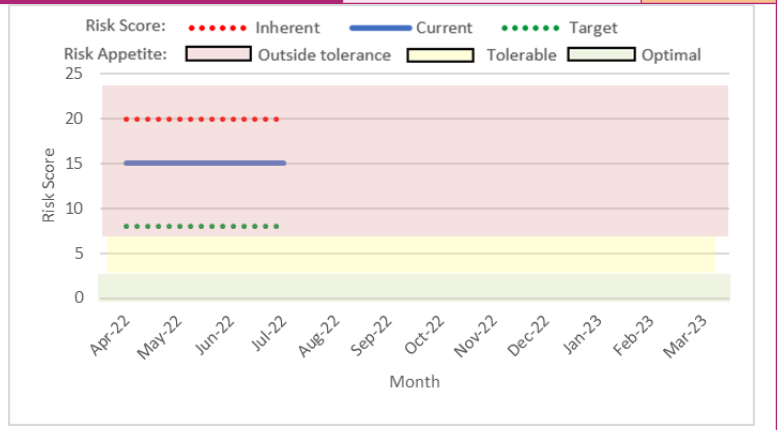
The following objectives are aligned to the **performance** strategic priority:

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

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

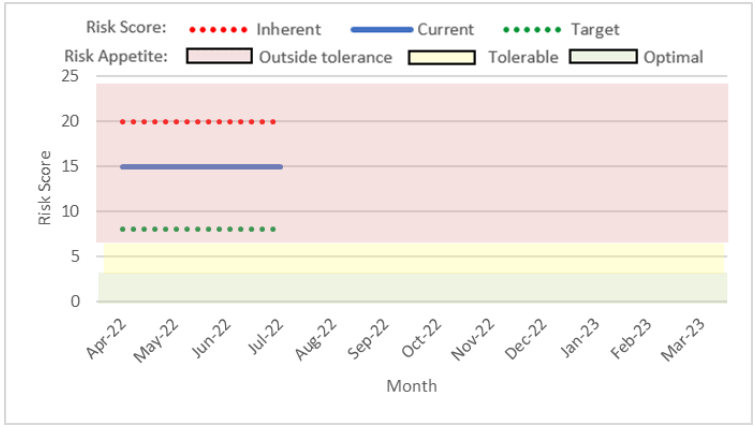


Corporate Objective: **C10** Deliver our financial plan, providing value for money services								**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 7: Financial Performance: Failure to meet the agreed I&E position**							
	Risk Statement:	There is a risk that the Trust may fail to fully mitigate in year pressures to deliver key finance statutory duties resulting in the Trust receiving significantly less income than the previous financial year.							
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current**	**Target Risk**	**Risk Tolerance**	Minimal		
Lead Director	**CFO**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Financial Duties		
Date risk opened	**19.10.21**	**Impact**	5. Critical	5. Critical	4. Major	**Linked risks**	-		
Date of last review	**20.07.22**	**Risk Rating**	20. Significant	15. High	8. High	**Risk treatment**	Treat		



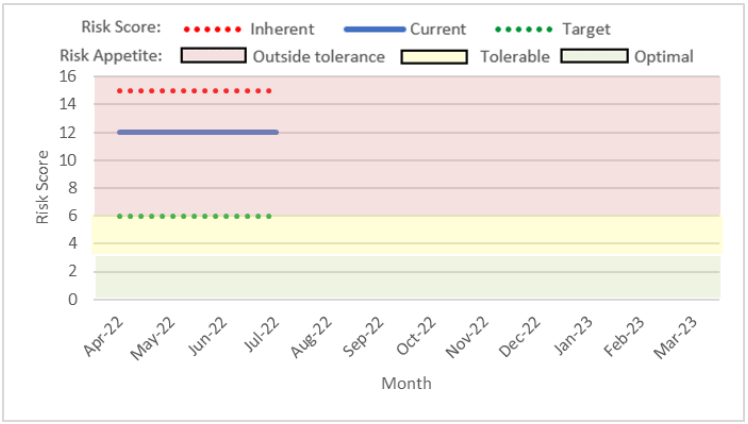
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **11.2 (ID 3292)**	• Final plan signed off by Board and submitted to NHSEI - 20th June 2022. • CIP in place with actions as described in PR10. • Continued lobbying via Greater Manchester in respect of additional funding which is appropriate for current clinical capacity (Ext.)	• No gaps currently identified.	**2nd Line:** • Finance & Performance Committee July 22	• No gaps currently identified.	1. No further actions currently identified.	

Corporate Objective: **C10** Deliver our financial plan, providing value for money services							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 8: Financial Sustainability: Efficiency targets & Balance Sheet**						
	Risk Statement:	There is a risk that efficiency targets will not be achieved, resulting in a significant overspend and that there is insufficient balance sheet flexibility, including cash balances, to mitigate financial problems.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current**	**Target Risk**	**Risk Tolerance**	Minimal	
Lead Director	**CFO**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Financial Duties	
Date risk opened	**19.10.21**	**Impact**	5. Critical	5. Critical	4. Major	**Linked risks**	-	
Date of last review	**20.07.22**	**Risk Rating**	20. Significant	15. High	8. High	**Risk treatment**	Treat	



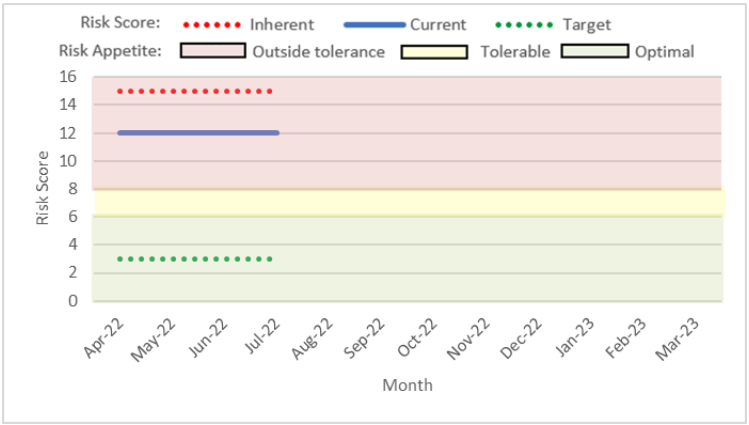
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **11.1** **(ID 3291)**	• Revised CIP delivery approach following review by Mersey Internal Audit Agency. • Monitored via Divisional Assurance Meetings, with additional escalation if Divisional delivery is off plan. • Further oversight at Executive Team, Finance and Performance Committee and Board of Directors. • Work is ongoing across the GM system on developing a joint approach to productivity and cross cutting efficiency (Ext). • Transformation Board input & oversight. • Effective credit control including monitoring debtor and creditor days and liquidity with oversight through SFT.	• No gaps currently identified.	**2nd Line:** • Finance & Performance Committee July 22	• CIP currently behind plan as at Month 3.	1. RAPID recovery meetings held with Surgery & Medicine. 2. Bi weekly updates on CIP presented to Executive Team, with regular updates at Trust Management Committee.	31/03/23 CFO, Deputy CEO.

Corporate Objective: C10 Deliver our financial plan, providing value for money services								**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 9: Estates Strategy - Capital Funding**							
	Risk Statement:	There is a risk that there is inadequate capital funding to enable priority schemes to progress. Due to uncertainties around capital funding arrangements the strategy may assume that more investment can be made than is available.							
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal		
Lead Director	**CFO**	**Likelihood**	3. Possible	3. Possible	2. Rare	**Risk category**	Financial Duties		
Date risk opened	**19.10.21**	**Impact**	5. Critical	4. Major	3. Moderate	**Linked risks**	-		
Date of last review	**20.07.22**	**Risk Rating**	15. Significant	12. High	6. Moderate	**Risk treatment**	Treat		



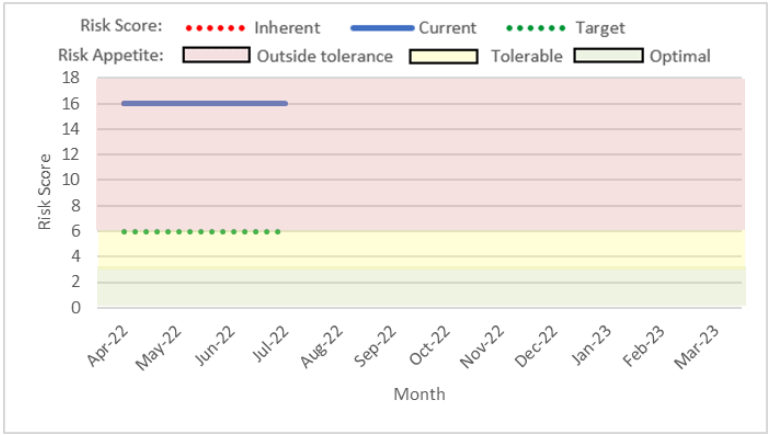
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **13.2** **(ID 3295)**	• Lobbying via Greater Manchester (Ext). • Capital Priorities agreed by Executive Team & Trust Board. • Cash for Capital investments identified. • Bids submitted in line with national timetables for centrally funded Community Diagnostic Centre and TIF Additional theatre at Leigh Hospital.	• No gaps currently identified.	**2nd Line:** • Capital plan on budget at Month 3 • Finance & Performance Committee • July 22	• Uncertainty in respect of envelopes for CDC and TIF theatre bids.	1. Ensure Capital spend in line with trajectory.	CFO, March 2023

Corporate Objective: **CO11** To minimise harm to patients through delivery of our elective recovery plan							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 10: Elective services - Waiting List**						
	Risk Statement:	There is a risk that demand for elective care may increase beyond the Trust's capacity to treat patients in a timely manner, due to challenges of restoring services presented by covid, workforce and IPC measures, new care demands, care backlog and late repatriations from the independent sector, resulting in potentially poor patient experience, deteriorating health, more severe illness and late cancer diagnosis.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**DCE**	**Likelihood**	5.Almost Certain	4. Likely	1. Rare	**Risk category**	Performance Targets	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks IDs**	3136, 3432,3020,3360	
Date of last review	**22.07.22**	**Risk Rating**	15. Significant	12. High	3. Low	**Risk treatment**	Treat	



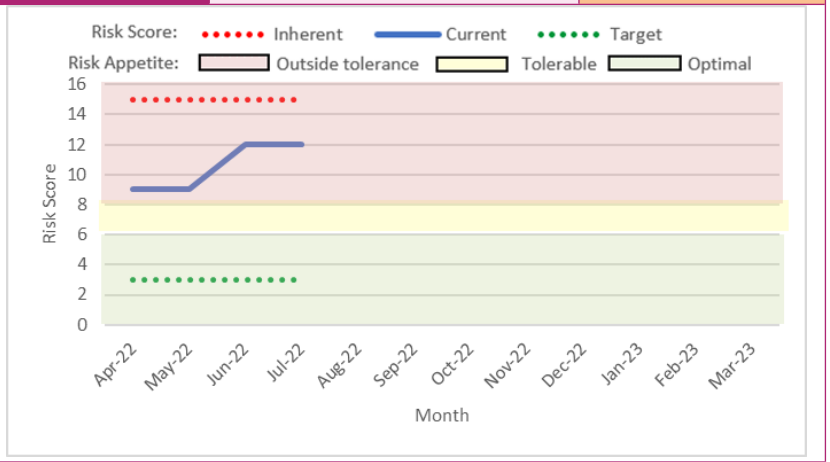
Opportunity / Threat Linked Risks	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **10.1** **(ID 3289)** **3020** Waiting list Dermatology **3136** Symptomatic breast imaging waiting times **3360** children with hearing loss waiting list **3432**Counselling waiting times	• Regular reviews of risk stratification are undertaken according to clinical priority in accordance with Royal College recommendations. • Additional clinical check has been introduced in Div. of Surgery. • Patient lists managed by risk stratification. • National communications being issued around how patients will be contacted for review (Ext). • Patients to be given mechanism for getting in contact with GP or WWL if deteriorating.	• Lack of capacity to undertake reviews of allocated risk stratification across all specialties. • Meeting new care demands such as increasing cancer referral rates and reduced bed capacity due to covid admissions and No Right to Reside. • Addressing care backlogs as a direct consequence of the pandemic, specifically the increase in the backlog of patients on follow up waiting lists. • Late repatriations from the independent sector.	**2nd Line:** • Finance & Performance Committee July 22.	• No gaps currently identified.	1. No further action currently identified.	

Corporate Objective: CO12 Improve the responsiveness of urgent and emergency care							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 11: Activity not in line with the funding available**						
	Risk Statement:	There is a risk that the cost of delivering activity exceeds the funding available because we have to use additional bank/agency or independent sector provision, or we are unable to access ERF funding if we exceed our trajectory. If the activity plan is not achieved it could result in clawback of ERF monies already received.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current**	**Target Risk**	**Risk Tolerance**	Minimal	
Lead Director	**CFO**	**Likelihood**	4. Likely	4. Likely	2. Unlikely	**Risk category**	Financial Duties	
Date risk opened	**19.10.21**	**Impact**	4. Major	4. Major	3. Moderate	3. Moderate	-	
Date of last review	**20.07.22**	**Risk Rating**	16. Significant	16. Significant	6. Moderate	**Risk treatment**	Treat	



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **10.2 (ID 3290)**	• 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.	• 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.	**2nd Line:** • Finance & Performance Committee July 22	• No gaps currently identified.	1. No further actions currently identified.	

Corporate Objective: C13 Progress towards becoming a Net Zero healthcare provider							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 12: Estate Strategy - net carbon zero requirements** **Risk Appetite**						
	Risk Statement:	There is a risk that Net Zero may not be delivered, due to investment not being available, resulting in failure to deliver the Green Plan and legislative requirements						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**CPO**	**Likelihood**	4. Likely	3. Possible	1. Rare	**Risk category**	Sustainability/Net Zero	
Date risk opened	**19.10.21**	**Impact**	4. Major	4. Major	3. Moderate	**Linked risks**	-	
Date of last review	**20.07.22**	**Risk Rating**	16. Significant	12. High	3. Low	**Risk treatment**	Treat	



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **13.3 (ID 3296)**	• Sustainability Manager in post. Recruited band 4 support (not yet in post). • Greener WWL comms commenced, supported by recruiting to the Ambassadors programme. • Third party commissioned to complete baseline assessment, develop prioritised investment plan, Net Zero Strategy and update the Trust's Green Plan. • Net Zero and sustainability e-learning programme. • Bidding strategy has been developed with a view to securing Public Sector Decarbonisation Scheme (PSDS) funding.	• Baseline emissions assessment • Prioritised action and investment plan • Climate Change Adaptation plan • Sustainable Travel Plan • Comms and Engagement strategy • Sustainability Impact Assessment • Capital funds should PSDS not be secured	**2nd Line:** • Finance & Performance Committee July 22. • Surgery Audit day based around sustainability Bid submitted to Salix Low Carbon Skills Fund 14/06/22 to enable bid to PSDS.	No substantive sustainability workforce resource to support delivery against strategic aims set out in the Net Zero NHS guidance document.	1. Complete baseline assessment. 2. Supply chain Net Zero review (national, regional & local). 3. Green prescribing plan. 4. Sustainability and Net zero to be included in business planning process for 2023-24.	1 Ricardo – Dec 2022 2 Associate Director of Procurement – TBC awaiting national direction 3 Chief Pharmacist – TBC 4 Director of Strategy - TBC

Partnerships

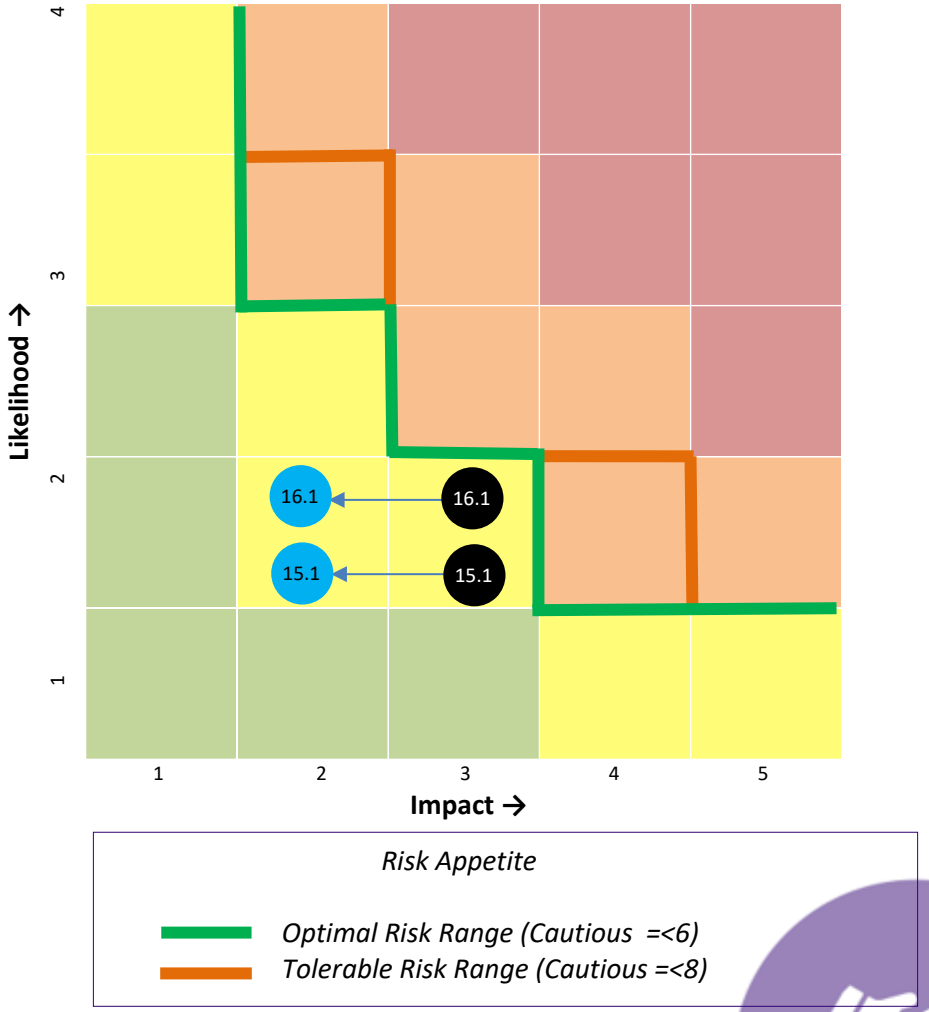
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

Monitoring: Board of Directors

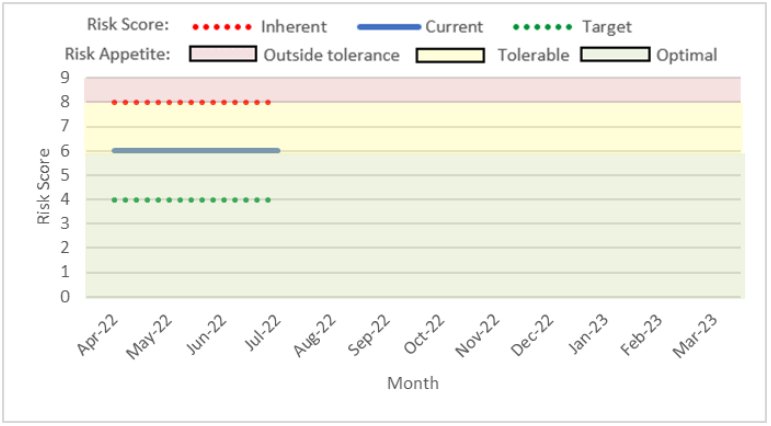
The following objectives are aligned to the **partnerships** strategic priority:

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

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

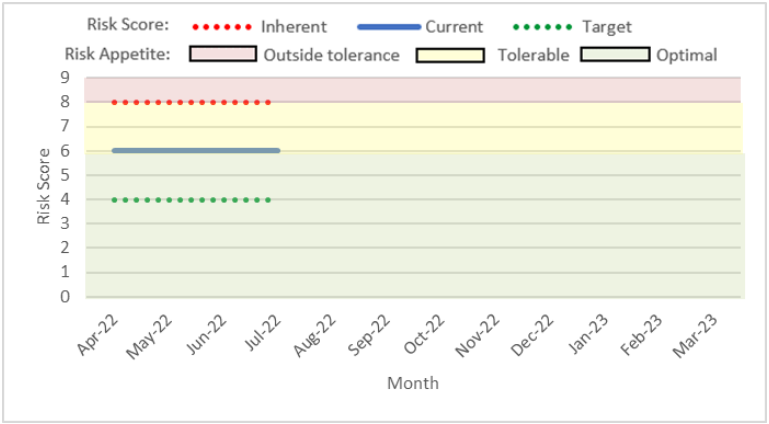


Corporate Objective: **CO15** Develop effective relationships within Wigan Borough and Greater Manchester for the benefit of our patients							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic	**Risk Title:**	**PR 13: Partnership working - CCG changes**						
	Risk Statement:	There is a risk that staff with local knowledge and understanding may be lost given the changes anticipated with CCGs.						
Lead Committee	**Board of Directors**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**DSP**	**Likelihood**	4. Possible	3. Likely	2. Unlikely	**Risk category**	Strategy	
Date risk opened	**19.10.21**	**Impact**	2. Minor	2. Minor	2. Minor	**Linked risks**	-	
Date of last review	**15.06.22**	**Risk Rating**	8. High	6. Moderate	4. Moderate	**Risk treatment**	Treat	



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **16.1** **(ID 3510)**	• Locality meeting structures in place to support lasting corporate knowledge.	• No gaps currently identified.	**2nd Line:** • Board of Directors June 22	• No gaps currently identified.	1. No further actions currently identified.	

Corporate Objective: **CO16** Make progress towards becoming a University Teaching Hospital							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 14: University Teaching Hospital - University Hospital Association criteria**						
	Risk Statement:	There is a risk that all the criteria that the University Hospital Association have specified may not be met, due to two key areas which we may find difficult to achieve, resulting in a potential obstacle towards our ambition to be a University Teaching Hospital.						
Lead Committee	**Board of Directors**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**MD**	**Likelihood**	4. Possible	3. Likely	2. Unlikely	**Risk category**	Strategy	
Date risk opened	**19.10.21**	**Impact**	2. Minor	2. Minor	2. Minor	**Linked risks**	-	
Date of last review	**26.07.22**	**Risk Rating**	8. High	6. Moderate	4. Moderate	**Risk treatment**	Treat	



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **15.1** **(ID 3299)**	• Project documentation including action log in place.	•A core number of university principal investigators. There must be a minimum of twenty consultant staff with substantive contracts of employment with the university with a medical or dental school which provides a non-executive director to the Trust Board. These individuals must have an honorary contract with the Trust in question. •For Trusts in England, an average Research Capability Funding allocation of at least £200k average p.a. over the previous two years.	**2nd Line:** • Board of Directors • University Hospital Group	• No gaps currently identified.	1. Risk to be quantified at the next University Hospital Group meeting.	MD Oct 22

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	WWL M3 Balanced Scorecard
Presented to:	Board of Directors
On:	03 August 22
Presented by:	Medical Director, Chief People Officer, Deputy Chief Executive and Chief Nurse.
Prepared by:	Data, Analytics and Assurance
Contact details:	BI.Performance.Report@wwl.nhs.uk

Executive summary

This paper is an interim report as the Data, Analytics and Assurance team work with stakeholders on a project to automate the production of a Balanced Scorecard with supporting commentary. The project is in progress, with the Scorecard Development Project Board meeting monthly.

Link to strategy
Patient
Partnership
Workforce
Site and Service

Risks associated with this report and proposed mitigations

The WWL Way

Financial implications
None currently highlighted.

Legal implications
None identified.

People implications
None identified.

Wider implications

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

Report: M3 WWL Balanced Scorecard: June 2022

QUALITY & SAFETY

	Month	ON/OFF Track	Why?
Patient Safety (Safe)			
Never Events	*M01*	*Off Track*	*1 in month, 1 YTD Target 0*
Number of Serious Incidents	*M11*	*Off Track*	*8 in month, 78 YTD*
Sepsis - Screening and Antibiotic Treatment (Grouped)	*M01*	*Off Track*	***Red Flag:*** *April 2022 Audits not Undertaken* ***Elevated Score:*** *Collection Suspended*
Serious Pressure Ulcers (Lapses in Care)	*M01*	*Off Track*	*1 Incident in month, 1 YTD (Community & Hospital Acquired)*
Serious Falls	*M01*	*On Track*	*0 in month, 0 YTD*
Infection Prevention and Control (Grouped)	*M01*	*Off Track*	*4 / 6 in month, 4 / 6 YTD; Metrics Off Track*
Patient Experience (Caring)			
Complaints Responses	*M01*	*Off Track*	*35.48% M01, 35.48% YTD; Target 90%*
Improved Discharge (Grouped)		*Under Development Not Currently Collected*	
Patient Experience			

ACTIVITY & EFFECTIVENESS

	Month	ON/OFF Track	Why?
Reduce 12-hour waits in EDs towards zero and no more than 2%	*M3*	*Off Track*	*9% M03, Target 2%*
Ambulance Handovers (Grouped)	*M3*	*Off Track*	*3 / 3 in month Metrics Off Track*
Cancer Referral Rates	*M3*	*Off Track*	*1551 M03, Target 1310*
Cancer - Waits Longer Than 62 Days	*M3*	*On Track*	*121 M03, Target 130*
Virtual Outpatient Consultations	*M3*	*On Track*	*28% M03, Target 25%*
Outpatient DNA Rates	*M3*	*Off Track*	*9.96% M03, Target 6%*
Outpatient Utilisation		*Under Development*	
Total Patients Waiting Over 104+ weeks	*M3*	*On Track*	
RTT Clock Stops	*M3*	*Off Track*	*7861 M01, Target 9069*
Elective Theatre Utilisation	*M3*	*On Track*	*83%, Peer Median 79%, National 81%*
G&A Bed Occupancy - Adults	*M3*	*Off Track*	*98% M03, Target 96%*
Elective Recovery Plan	*M3*	*Off Track*	*94% M03, Target 103%*

PEOPLE

	Month	ON/OFF Track	Why?
Output			
YVS - engagement score	*Q1*	*Off Track*	*3.94 Q1, 3.91 Q3, 3.90 Q2 Target 4*
% turnover rate	M03	*On Track*	10.32% M3, 10.45% M2, 10.08% M1 Target 10%
Sickness - % time lost	M02	*Off Track*	6.15% M2, 7.12% M1, 6.96% M12 Target 4%
Culture			
FTSU contacts	M03	TBC	5 M3, 8 M2,3 M1, 5 M12, 4 M11
YVS - psychological safety	Q1	*Off Track*	*3.71 Q1, 3.61 Q3 Target 4*
Comms & Visibility			
Leaders Forum reach (number of Leaders attending the Forum)	M03	*On Track*	147 M3, 133 M2, 162 M1, Target 110
Usefulness of Trust wide comms - % of participants stating they found the ASTB session useful	M01	*On Track*	82% M1 (Quarterly), Target 70%
Number of outputs per month (LF, ASTB, Executive Vlogs, CEO Vlog/Blog)	M03	*On Track*	6, M3, 6 M2, 7 M1, Target 6
Well-being			
Empactis coverage (% of staff)	M03	TBC	*17.9% M3,12.1% M2, 11.4% M1*
YVS - well-being score	*Q1*	*Off Track*	*3.35 Q1, 3.22 Q3, Target 4*
Leadership & Teams			
Vacancy rate	M03	*Off Track*	*10.21% M3, 10.64% M2, 10.83% M1 Target 5.0%*
Roster timeliness	M03	*Off Track*	*51% M3, 48% M2, 39% M1 Target 90%*
Rate card adherence (medical)	M03	*Off Track*	*53% M3, 55% M2, 50% M1, 62% M12 - Target 85%*
Personal development			
Mandatory training compliance	M03	*Off Track*	*89.3% M3, 88.6% M2, 88.2% M1 Target 95%*
Appraisal	M03	*Off Track*	*76.6% M3, 75.5% M2, 75.1% M1 Target 90% NB. Excludes M & D Staff*

FINANCE

Financial Position (£000s)	**In Month**	**Year To Date**
Surplus / Deficit (variance to plan for adjusted financial performance)	(1,483)	(3,823)
Capital Spend (variance to plan)	464	527
Cash (YTD variance to plan)	1,508	1,508
CIP (variance to plan)	(886)	(3,958)
Agency spend (variance to NHSE agency ceiling)	(654)	(1,541)
Beter Payment Practice Code (target 95%)	86.7%	90.2%

Note: Showing June 2022 data where available. *Details in italics where latest month details have not been signed off or been presented to the relevant committee.*

M3 WWL Balanced Scorecard Commentary: June 22

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)
During the month of April 2022, the Trust reported a new Never Event incident relating to a Platelet Rich Plasma (PRP) injection being given into the wrong side of an elderly patient who suffers from hearing loss, poor mobility, and confusion. This meets the National Never Events Framework definition of wrong site surgery due to the way the procedure is carried out. Investigation into this incident identified a number of learning points and changes have been made including, amendments to the local safety procedures, as well as taking into account human factors such as ensuring time outs.

Patient Experience (Caring)
During the month of April 2022 – Clinical Treatment remains the highest subject in the formal complaints followed by communications (x5), Admissions and Discharges (5) – 4 x discharged too early, 1 x cancelled / rescheduled surgery/procedure, Appointments (4) – delay x2, cancellation, availability.

Clinical Effectiveness (Effective)
The figures show the Trust's best score in the last 3 years and is now listed as within the 'expected' range. Work continues across the Borough to improve this indicator. The Mortality Board meets regularly to scrutinise performance and investigates areas of particularly high rates.

ACTIVITY & EFFECTIVENESS

Scheduled Care
WWL successfully achieved the milestone of eradicating the backlog of 104 weeks waits by the end of June, excluding patient choice. The Trust is ahead of plan to deliver the next key milestones of eliminating 78 weeks, and improve 52 weeks, by March 2023. This includes mutual aid offered through the surgical hub to support systems with longer waiting times.
The Number of Two-Week referrals continue to rise above pre-covid levels. Wigan is an outlier In comparison with neighbouring Trusts within some tumour sites, this has been escalated to Manchester Cancer to review referral patterns. 62-day cancer recovery plan remains ahead of plan. There has also been a reduction in the number of patients waiting with a clinically urgent flag as the Trust continues to prioritise both cancer and urgent patients.
The Trust continues with its success during the pandemic at increasing the share of virtual appointments, we are currently 27.9%, 2.1% above the target of 25% for June.
Theatre Utilisation in June is 83% against a peer median of 79% and national 81%, this prompted, along with an increase in activity, a review of phasing in the elective recovery plan over the fiscal year. Following review, the plan has now been realigned to working days and rebased to recover the position throughput the remainder of the year. The under delivery is not all due to activity profiling, covid admissions alongside sickness absence and patient availability continue to impact recovery.
The waiting list reduced by 0.3% in June, although a minimal change, this is the first month there has been no continual growth in nearly 2 years. A more accurate indication is the increasingly bigger reduction in the 3-month growth rate since the operational plan was initiated in April.
Unscheduled Care
The Trust continues to perform well both locally and nationally. This is despite A&E consistently running above capacity levels since the beginning of the year, ambulance handover times are challenged and 9% of people in June, on average, waited 12 hours against a national target of 2%. We continue to build on the progress streamlining hospital processes thorough participation in the National discharge programme and work with system partners, and Greater Manchester Gold Command, on reducing the number of people no longer requiring acute care.
The planning assumptions to support urgent and elective care has not been met for the third consecutive month with the Trust still experiencing high bed occupancy rates, non-elective demand has not returned to pre-pandemic levels, covid admission rates are higher than planned and cancer referral rates are outside of pre covid levels

PEOPLE

Culture
2 exit interviews completed and 9 scheduled between 1st July to 14th July.
Developing a range of financial support measures to ease the cost of living burden felt by our people and are influencing across our partner organisations to follow suit.
Race Equality Code actions plans available from July. FAME network, Disability and LGBTQIA+ networks all now have a Chair, executive sponsors, budget and protected time

Comms & Visibility
Attendance at Leaders' Forum remains c. 150 and positive engagement/ reaction to new interaction tools – IdeaBoardz
Positive feedback for All Staff Team Brief featured items and guest speakers and proactive engagement to be involved in future sessions
Continue to match balance between Operational Priorities and Supporting Staff within All Staff Team Brief and Leaders' Forum
New Intranet preparation – 206 webmasters - signalling strong engagement

Wellbeing
Wellness at Work Lounge - June launch
IAPTUS system launching soon for managing Psych Support referrals.

Leadership & Teams
Vacancy trajectory under development to measure the gap once recruitments and turnover factored in.
Ongoing recruitment events - Surgical theatres on 16th July
Reducing the number of recruits - introduction of talent pools underway, expansion of the transfer protocol linked to the TRAC system and plans to introduce remote ID checking
Strategic retention group established and divisional task forces being set up
Medical workforce plan under development. Locum reduction plans underway.

FINANCE

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

The Trust has reported an actual deficit of £0.3m for June 2022 (month 3), which is £1.5m adverse to the planned surplus of £1.1m.

The plan has been updated in month 3 to reflect the final plan submission to NHSE made on 20th June 2022. The final submission reduced the planned deficit from £19.8m to £8.4m for the 2022/23 financial year.

The plan has been adjusted year to date in month 3, which resulted in a planned surplus in month 3. Year to date, the Trust is reporting an actual deficit of £6.0m against the planned deficit of £2.2m, creating an adverse variance of £3.8m.

In month 3, CIP of £1.1m was transacted against the target of £2.0m, creating an adverse variance of £0.9m. Year to date, there is an adverse variance of £4.0m to the CIP target and this is the key driver behind the Trust financial position and variance to plan.

Cash is £37.3.m at the end of month 3 which is £1.5m above the plan.

Total capital expenditure is £0.5m below plan in month and year to date.

Please see the monthly finance report for further commentary.

Note: Relating to June 2022 where available. *Details in italics where latest month details have not been signed off or been presented to the relevant committee.*

Title of report:	Well-led action plan
Presented to:	Board of Directors
On:	03 August 2022
Presented by:	Director of Corporate Affairs
Prepared by:	Paul Howard, Director of Corporate Affairs
Contact details:	E: paul.howard@wwl.nhs.uk

Executive summary

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

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

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

- Approve the revised deadlines in respect of recommendations 1 and 4
- Approve closure of recommendation 7
- Note the progress made against the remaining open recommendations

Link to strategy

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

Risks associated with this report and proposed mitigations

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

Financial implications

There are no financial implications associated with this report.

Legal implications

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

People implications

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

Wider implications

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

Recommendation(s)

The Board of Directors is recommended to review the updates provided.

Well-led review of leadership and governance
Action plan as at 27 July 2022

Open actions

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
1 High	The CEO should ensure that the pending executive team development programme explicitly captures good practice in providing focused executive presentations to board and committees and addresses the need to embed collective ways of working across the executive team.	Seven executive development sessions will be held between April and December 2022. Each session will last around 3 hours and will focus on team and personal development. An additional executive development session on presenting to board and committee meetings will be delivered by 30 June 2022. Team members have agreed that attendance at all these sessions will be prioritised above all other items, including annual leave.	Chief Executive	The executive programme has been commissioned and the first session took place on 8 Apr 2022. Part of the first session involved a diagnostic to allow team members to identify areas of focus for the remainder of the programme. The session on presenting to board and committee meetings took place on 9 Jun 2022. Due to diary and other commitments, it has not been possible to profile seven sessions before December 2022 but this is planned to be completed before 31 March 2023. **The board is asked to agree this revised deadline.**	

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

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
4 High	The CEO should consider including senior divisional leaders in some executive team development activities to help further build cohesion between the executive and divisional leadership levels, as well as exploring ways in which leaders can further demonstrate the values and behaviours expected within the organisation.	As part of the executive development programme referenced at recommendation 1 above, divisional leaders will be invited to participate in at least 1 session in H1 2022/23 and at least one further session in H2 2022/23.	Chief Executive	This has been shared with the programme facilitator and is being built into session plans. Due to the slippage in action 1, it will not be possible to deliver a joint session in H1 2022/23. This will now be profiled to take place during H2 2022/23. **The board is asked to agree this revised deadline.**	
5 High	The Trust should consider the development of a refreshed accountability and performance framework, in collaboration with divisional leaders, to formalise responsibilities and accountabilities for divisional and directorate leaders at different levels of the organisation.	By the end of Q2 2022/23, we will have developed an 'Accountability Framework' incorporating the existing trust behaviours and we will have implemented this by the end of Q3 2022/23.	Deputy Chief Executive	A task and finish group has been established to consider the development of an Accountability Framework.	
7 High	The CEO should prioritise a range of activities aimed at developing senior leaders at the divisional and directorate levels, including clarifying individual and collective roles and accountabilities, raising the status of Divisional Assurance Meetings and providing greater focus to support leadership development and succession planning.	By the end of Q4 2021/22, we will have advertised a Shadow Board programme and sought expressions of interest. By the end of Q1 2022/23, the Shadow Board will have held at least one training module and one meeting. By the end of Q1 2022/23, we will have reviewed the status of Divisional Assurance Meetings and agreed how best this may be raised; with any actions being implemented by the end of Q2 2022/23.	Chief Executive	The Shadow Board programme was advertised during Q4 2021/22. 15 senior managers are participating in the programme. The first training module for the Shadow Board took place on 24 May 2022 and its first meeting took place on 7 June 2022. The review of Divisional Assurance Meetings has been completed.	

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

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

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

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

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

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
12 Medium	The Chair should introduce a range of virtual forums aimed at providing additional organisational oversight for Non-Executive Directors (NEDs), whilst also raising NED visibility with staff. Initiatives could include NED divisional alignment, NED-led staff focus groups, 1:1 staff meetings and Chair webinars.	By the end of Q1 2022/23, NED walkabouts will have recommenced. By the end of Q2 2022/23, we will have introduced appropriate publicity materials on all main trust sites.	Chair	NED walkabouts have commenced and these will cover all parts of the Trust to ensure visibility amongst clinical and non-clinical teams. NEDs will be invited to undertake a walkabout at least once per quarter, accompanied by an Executive Director who they do not usually work with, to facilitate an additional networking opportunity. Non-Executive Directors will also be providing mentorship support to the Shadow Board programme which will help in increasing visibility with senior leaders.	
13 High	There is a need to revisit the role of the governor, both in relation to expectations regarding the participation of governors in trust forums, alongside how current activities could adapt and evolve in response to the emerging Integrated Care System. This should include the provision of bespoke training and development in order to further support governors with potential changes to their role in the coming months.	By the end of Q2 2022/23, we will have facilitated a workshop with governors to outline the trust's expectations around participation and to outline new ways of working. Bespoke training and development to support governors with potential changes to their role will take place during Q2 to Q4 2022/23.	Chair	Engagement with the Council of Governors will take place during Q1 and Q2 2022/23 and will commence at a workshop which is scheduled for 14 Sep 2022. This will be supported by draft guidance from NHS England on the role of foundation trust councils of governors in system working and collaboration which was released for consultation on 27 May 2022.	

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

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

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

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
15 High	At the time of fieldwork, a number of changes were underway to strengthen leadership development, including identifying and supporting future talent. This should take into account opportunities for a multidisciplinary approach (both within the trust and across system partners where appropriate) and should also consider the skills required both as a leader within the trust as well as those which will be needed as a result of greater levels of integrated system working.	By the end of April 2022, we will have relaunched the Leadership Development Framework within the organisation. The talent programme will be prioritised for development from April 2022, which will include identification of talent, assessment of potential, talent pathways and development programmes. The design element of the programme will be completed by the end of Q1 2022/23 and phased implementation for organisational tiers will commence from Q2 2022/23.	Director of Workforce	The Leadership Development Framework has been agreed and relaunch took place during March and April 2022. Work is underway to scope and develop the talent programme. Feedback has been obtained from key stakeholders and a survey has been distributed to leaders to gain insight on talent identification and talent management, coupled with the skills required for future leaders. The initial draft of the programme is being shared in August for consultation, input and feedback. The design element of the programme was not completed by the end of Q1 2022/23 and is therefore behind plan, but we are confident that this will not impact on the overall intention to commence phased implementation for organisational tiers during Q2 2022/23.	

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

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

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

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

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

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

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

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

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Mortality Review: Learning from Deaths Report (Q1 2022/2023)
Presented to:	Board of Directors
On:	03 August 2022
Presented by:	Dr S Arya, Medical Director
Prepared by:	Alison Unsworth, Clinical Audit and Effectiveness Manager **Contributors:** Dr M Farrier, Associate Medical Director Sam Barnsley, 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 Report produced 22nd July 2022
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 Q1 2022/2023

- Total number of deaths: 351
- Total number of deaths reviewed: 191 (63%)
- Total number of potentially preventable deaths: 1
- Total number of patients with Learning disabilities submitted to LeDeR: 8 (6 within the acute Trust)
- Total number of Maternal Deaths, Still Births and Child Deaths (reported to MBRACE-UK): 1
- Total number of deaths in community recorded via Datix: 3
- Total number of Prevention of Future Deaths Notices: 1
- Current SHMI: 112.9 (Within expected level)
- Current HSMR: 92.5 (Within expected level)

Risks associated with this report and proposed mitigations

None known

The WWL Way

Financial implications

None known

Legal implications

None known

People implications

None known

Wider implications

None known

Recommendation(s)

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

Mortality Review: Learning from Deaths Report: Quarter 1: 2022 - 2023

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)

2.0 Quarter	**2022/23**	**2022/23**	**2021/22**		**2020/21**		**2019/20**	**2018/19**
Chart 1	Inpatient	A&E Deaths	Inpatient	A&E Deaths	Inpatient	A&E Deaths	Total (A&E deaths not included)	Total (A&E deaths not included)
Quarter 1	302	49	256	35	443	41	312	293
Quarter 2			297	38	261	23	270	271
Quarter 3			348	45	549	47	330	286
Quarter 4			356	51	387	39	310	343

2.1 Length of Stay

Out of the 302 inpatients who died, 41 died within 0 to 1 days of admission (13%).

2.2 COVID Cases

In Q1 2022/2023, there were 50 patients with COVID 19 on the Medical Certificate Cause of Death. Chart 2.2 shows the number of COVID-19 deaths per month since march 2020 (start of the pandemic).

3.0 Deaths Subjected to Review

The Corporate Mortality Review Team, led by Dr Martin Farrier, Associate Medical Director, review the deaths of patients who have died at WWL. Patients who are not on the individualised plan of care receive an in-depth review. Review of any patients identified for further analysis by others is also carried out. An in-depth review does not take place if there are no clinicians present.

Deaths are grouped using the "NHS Learning From Deaths" guidance into the categories in the table below.

In Q1 2022/2023, 63% (191) of all deaths were reviewed and the following were concluded based on the NHS learning from deaths guidance:

	Deaths - Not learning disability			Review and Score						Learning Disability		
Quarter	Total	Reviewed	Avoidability >50%	Score 6 - Definetly not avoidable	Score 5 - Slight evidence Avoidability	Score 4- Possibly avoidable but not very likely	Score 3- Possibly avoidable	Score 2 - strong evidence of avoidablity	Score 1 - Definetly avoidable	Total	Reviewed	Avoidability
Q2	302	191	1	183	3	4	1	0	0	6	6	0

3.1 Potentially Preventable Deaths

There was 1 potentially preventable death noted (Score 3, Possibly Avoidable):

- Patient discharged whilst awaiting CABG, returns and dies from MI. An earlier CABG could have potentially prevented the patient from dying. This patient is included in the StEIS figures in section 4.

3.2 Themes/Learning

Following review, the following patients were identified with a score of less than 6 based on the categories in the table above.

Score 4: **Possibly avoidable but not very likely**

- Patient on telemetry with DNACPR in place. The DNACPR has a caveat of giving a shock if in VT/VF. The telemetry isn't continuously monitored. When the patient arrests we are late to respond and don't notice the caveat. There are systematic problems in the use of telemetry and DNACPR, which is being looked into.

- Patient on thickened feeds given normal feeds then aspirates before dying.
- Potential harm caused by use of inappropriate IV fluids.
- Patient with significant renal problems who dies with haematemesis (vomiting blood). Issues raised with complexity of care in a young patient with the involvement of multiple teams and the possibility of missed opportunities to treat bleeding.

Score 5: Slight evidence Avoidability

- In-hospital fall with death 12 hours later
- There were two patients where there was a failure to provide good sepsis care.

Other learning:

- Use of naloxone to reduce opiates in a patient receiving palliative care causes pain and distress
- Potential harm caused by long waits in A&E
- Patients brought to hospital to die because of the problems with managing death outside hospital

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

4.0 External Reporting

4.1 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 Q1, the Trust reported 8 deaths to LeDeR. 6 of these died in the acute Trust at WWL, with no concerns/avoidability.

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.

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

The Trust had 0 Maternal Deaths, 1 stillbirth and 0 Neonatal death in Q1 2022/23.
The stillbirth was a case of 25 weeks and 3 days gestation, this was a termination of pregnancy for abnormalities. The case was reported to MBRRACE.

4.3 StEIS Reporting

There were 3 deaths of patients who were reported to StEIS

- Patient presented to A&E with mental health issues, streamed to UTC discharged and passed away the following day
- Lack of escalation of a deteriorating patient - Cardiac Patient Death
- Mismanagement of T2DM Patient (Community patient)

5.0 Community Deaths

There have been 3 community deaths reported via Datix in Quarter 1 2022/2023:

- Child under care of community services who died in hospital.
- Patient who was transferred from care home to WWL ED who died in ED. This patient is included in the acute Trust figures.
- Death of a child known to community services who suffered respiratory arrest (the patient died in the ambulance).

6.0 Prevention of Future Deaths Notices

There has been 1 Prevention of Future Deaths Notices (Regulation 28) issued by HM Coroner.

This was following a concern raised at inquest that a Mental Health Trust and WWL had separate IT record systems with the inability to share information electronically between Trusts. The Trust is currently exploring methods to facilitate record sharing between Trusts.

7.0 SHMI (Summary Hospital Level Mortality Indicator) includes Deaths in hospital and deaths 30 days post discharge and HSMR (Hospital Standardised Mortality Rate) includes 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 using NHS digital SHMI / HED data rolling 12 months data is 112.9 for the time period April 2021 to March 2022. This is an increase from the previously reported data for the time period January 2021 to December 2021 of 107.47. WWL is currently ranked 113 out of 123 in terms of SHMI value. The chart below shows the SHMI value relative risk per rolling twelve months to the latest data period.

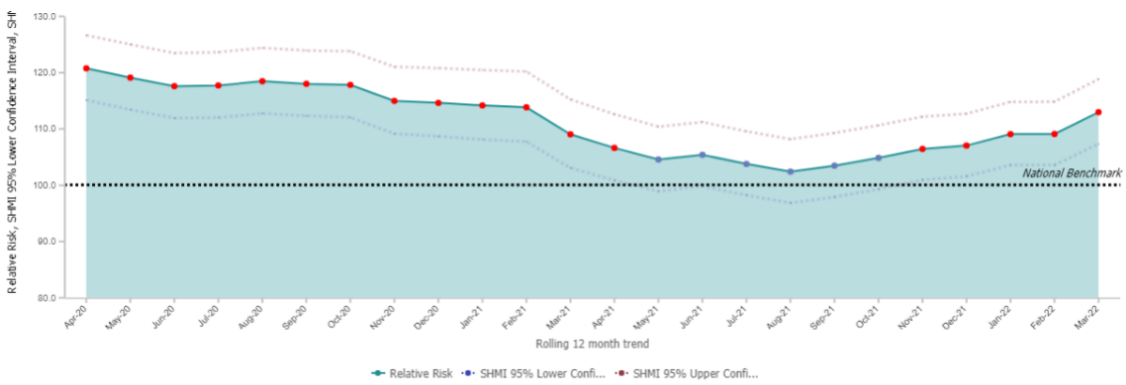
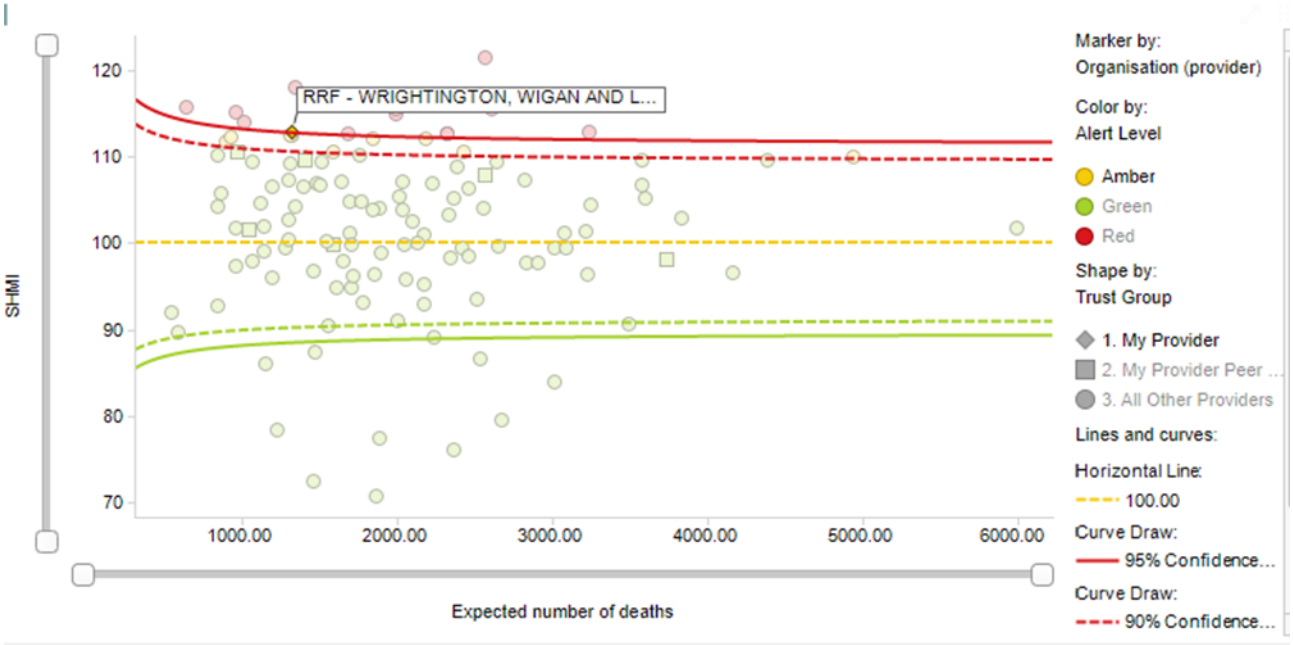


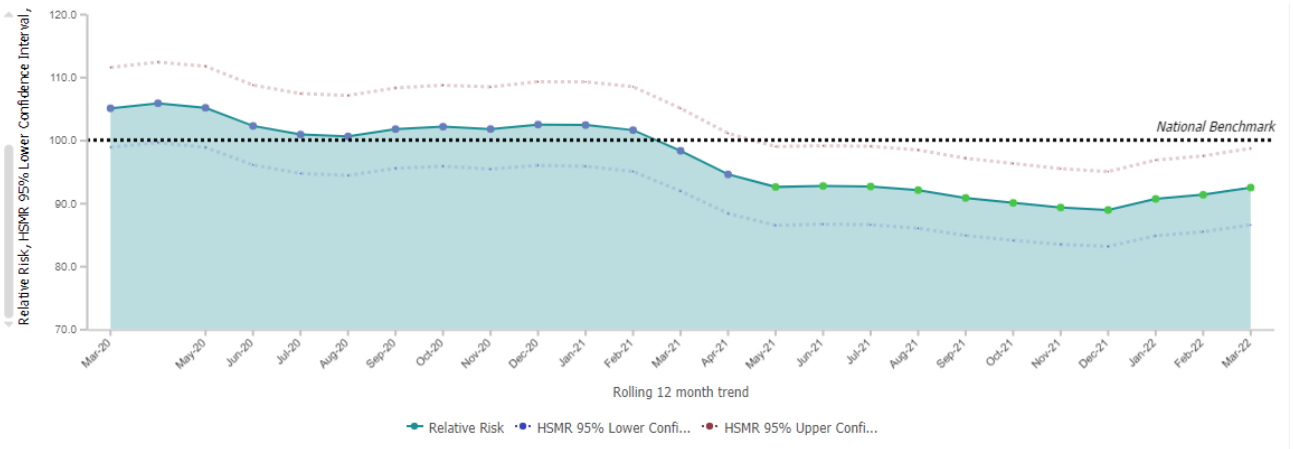
Chart 5 shows the national position of WWL when compared nationally.



7.2 HSMR

The current HSMR is for the rolling 12 month period of April 2021 to March 2022 using HED is 92.5 which is below the national benchmark of 100. This is slightly higher than the previous reported figure for Jan 2021 to December 2021 using HED of 91.0.

It should be noted that patients with COVID-19 are not included in the figures.



8. Quarterly Trust Mortality Meeting

The Quartlery Mortliaty meeting held in April 2022 inlcuded two clinical audits which were commissioned following alerts on mortality metrics.

An audit was completed on Cancer of the Ovary (5 deaths over a 12 month period). The audit concluded that all cases were advanced disease at diagnosis.

A further audit was completed on cardiac arrhythmia. (16 deaths over a 12 month period). The audit concluded there was no issue with care in any of the cases reviewed. The mortality metric uses the

first coded episode to calculate the risk of death for each patients, which may not be the cause of death. Coding was reviewed and provided assurance that the coding was in line with national standards.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Monthly Trust Financial Report – Month 3 (June 2022)
Presented to:	Board of Directors
On:	03 August 2022
Presented by:	Ian Boyle [Chief Finance Officer]
Prepared by:	Senior Finance Team
Contact details:	E: Kelly.Knowles@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	39,789	39,969	(179)	115,055	114,220	835
Expenditure	(38,406)	(37,094)	(1,312)	(115,914)	(111,206)	(4,708)
Financial Performance	(344)	1,139	(1,483)	(6,016)	(2,192)	(3,823)
Cash Balance	37,318	35,810	1,508	37,318	35,810	1,508
Capital Spend	736	1,200	464	1,510	2,037	527

Key Messages:

- The Trust has reported an actual deficit of £0.3m for June 2022 (month 3), which is £1.5m adverse to the planned surplus of £1.1m.
- Year to date, the Trust is reporting a deficit of £6.0m which is £3.8m adverse to the planned deficit of £2.2m.
- The plan reflects the revised submission to NHSEI made on 20th June 2022 which has a full year planned deficit of £8.6m.

The WWL Way

- The Trust has a Cost Improvement Programme (CIP) target of £23.9m, which equates to 5% of expenditure. This was mandated across providers within the Greater Manchester Integrated Care System (ICS).

- Year to date, £2.0m was transacted against the target of £6.0m. A full programme of support has been put in place by the Transformation Team and Finance. A trust wide communications campaign is underway, and a series of ideas generation workshops are being facilitated.

- Cash is £37.3m at the end of Month 3.

- Capital spend is £0.7m in month.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Cover report - Guardian of Safe Working
Presented to:	Board of Directors
On:	3rd August 2022
Presented by:	N/A Consent Agenda
Prepared by:	Deputy Chief People Officer
Contact details:	T: [07795 021694] E: [james.baker@wwl.nhs.uk]

Executive summary

Dr Shams Khan presented the guardian of safe working hours report to the People Committee on 22nd June.

In response to the concerns raised in the report, namely the instances of surgical consultants telling trainees not to exception report, the committee heard that ensuring compliance with exception reporting is a contractual requirement under medical employment terms and conditions and that junior doctors have a contractual right to exception report.

The committee agreed that the instances of consultants either failing to encourage exception reporting or instructing juniors not to exception report will be picked up as an action by the Medical Director and the Guardian of Safe Working.

This has been noted in the People Committee AAA report:

“The Guardian of Safe Working noted that exception reporting is being discouraged in the Surgical Division. Actions have been put in place to address this.”

Recommendation(s)

Board is asked to note the context of the discussion at People Committee and follow up action agreed.

The WWL Way

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Guardian of Safe Working Hours Quarterly Report, Qtr 4 2021-2022
Presented to:	Board of Directors
On:	03 August 2022
Presented by:	Consent Agenda
Prepared by:	Guardian of Safe Working Hours 10 June 2022
Contact details:	T: 8667 E: [shams.khan@wwl.nhs.uk]

Executive summary

This quarter there were a total of 45 Hours and Rest Exception Reports, with 6 being surgical and 37 being medical. The last 2 were from Trauma and Orthopaedics. The huge drop is surgical exception reports is not matched by satisfaction expressed by, in particular, Foundation Trainees, at Junior Doctor Forum. Very disappointingly, there are very serious reports in this forum (minuted at the last JDF) of surgical consultants telling trainees not Exception Report. This has in many ways undone some of the excellent work by two surgical consultants in tackling exception reporting in the way it should be done. This work has been commended at a regional level. Sadly, the low number of surgical exceptions is a very unreliable number. I must stress that in taking action on exception reports, it is important to understand that it is not the number that is important but how trainers and departments respond to exceptions. In the first instance, the educational supervisor should make contact with the trainee and should try to understand the circumstances. In most cases, the Exception will be unavoidable. In some cases, particularly if the circumstances are recurrent, the supervisor may consider the trainee to need changes to the work schedule (or more simply, their rota). This could be individual or it may affect other trainees on the rota. This is why the Educational Supervisor – Trainee relationship is so unique and crucial to trainee and supervisor.

Sanjay and I are writing to all Educational Supervisors to outline this and I will be speaking again at the Trusts Educational Supervisors Event to ensure this is understood

I will also speak directly to the Clinical Director of Surgery about trainees being asked not to exception report. This is very serious as it is a trainees' contractual right to exception report and no individual has any right to ask a trainee to do this.

In the medical exceptions, staff shortages dominate again and significant issues that cam up in the last quarter in exception reporting (holding of multiple bleeps by junior doctors) is being reported in different ways. I note that many juniors have taken to writing "short-staffed" in their report.

Whilst I do not wish an extensive report to be a barrier to exception reporting, this is clearly not acceptable and this has been addressed in Junior Doctor Forum with a request for some more detail from Juniors.

In those with more detail, lack of cover in Care of the Elderly and also CCU / Ince led to recurrent Exceptions whilst medical complexity led to the bulk of hours and rest reports.

In surgery, a combination of complex cases and short staffing led to the Exceptions. I believe the numbers are underrepresented.

The vacancy report shows that surgical and medical rotas are short staffed even before annual, study or sick leave is factored in.

Link to strategy

Surgical consultants asking juniors not to exception report has been raised at Junior Doctors Forum and also LNC and will be raised and minuted at People's Committee and also at next available TMEC. The Director of Medical Education (DME) has been made aware and I propose to meet directly with the Clinical Director of Surgery and formally ask that all consultants are told not to do this. Surgical Educational Supervisors answer directly to the Director of Medical Education and this is why I have asked the DME to support this and directly challenge surgical supervisors.

Short staffing is an ongoing risk despite a significant lightening of covid measures. In LNC, Sanjay Arya (medical director) has asked Elaine Middleton (Allocate) to work with General Medicine in particular to ensure that a more junior member of the rota is not holding the bleep of a more senior doctor. The vacancy report shows that medical and surgical are short of trainees either due to less than full time working or due to a vacant slot. This is described in detail, later, under Vacancies.

Whilst a breakdown of exception reports per ward has been requested and can be made available, I call upon all executives and medical director to understand the complex nature of exception reporting and not to try and manage this by numbers or in a manner that would appear to apportion blame to individual departments. The nature of exceptions are nuanced and close working of educational supervisors with consultants of affected specialities is preferable. Elaine Middleton is a unique position to facilitate this with a "no blame approach" and this is worth considering.

People's Committee have led to the issue of dual bleep holding being tackled directly in a constructive manner.

Risks associated with this report and proposed mitigations

The most serious risk is trainees being asked not to exception report. This is denying trainees their contractual right and poses significant to the organisation particularly from Health Education England and Training Programme Directors. This is being tackled directly by myself and the DME with the full support of the medical director with the results being fed back to LNC, People's Committee and Junior Doctor's Committee.

Vacancies – as can be seen from the table below, both surgery and medicine are short staffed even before sickness, annual leave and study leave take effect.

Financial implications

Payment from extra hours worked through exception reporting from understaffing, risk of clinical error and litigation will rise whilst understaffed. The Trust is exposed to significant criticism from Health Education England and the British Medical Association over trainees being asked not to Exception Report.

Vacancies – these are often covered by locums which are sometimes picked up last minute at significant cost to the Trust

Legal implications

Asking trainees not to Exception Report is denying them their contractual right to do so. This has potential legal implications.

Vacancies are leading to frequent exceptions that are directly related to short staffing.

People implications

Junior doctors having to both step up and step down leading to increased workload, consultants also stepping into resident roles will lead to burnout in doctors and a rise in the incidence of sickness. I have noticed a rise in complaints and DATIXES coming from overcrowded and understaffed areas. Overcrowding in itself is recognised as an independent risk to increased patient mortality, morbidity and clinical error.

Wider implications

I recall a child serious case review from several years ago that is associated with a consultant having to step down and cover multiple roles. There are significant potential risks from this happening again. There are potential legal implications if there is a perception that trainees being asked not exception report has become cultural normality in General Surgery. This will be the second time that the Guardian of Safe Working Hours has had to have a formal conversation with General Surgeons over this matter

Recommendation(s)

Consider language and rhetoric when dealing with specialities over exception reports – these occurrences are often unpreventable but there are opportunities when looking at patterns to try and see if there are areas and times of staffing shortages or lack of support for trainees. Individual episodes should be entrusted to Educational Supervisors in the first instance.

Report Quarter 4

Row Labels	Hours	Pattern	(blank)
Cardiology	**2**		
FY1	2		
General medicine	**37**		
CT1	4		
FY1	14		
FY2	10		
ST1 *	9		
General surgery	**6**		
FY1	4		
FY2	2		
Trauma & Orthopaedic Surgery		**1**	
FY2		1	
(blank)			
(blank)			
Grand Total	**45**	**1**	

The above table summarises Hours and Rest Exceptions (Education exceptions are reported on by DME)

Numbers remain consistent and within expectations of Exception Reporting in medicine with the main concern being level of cover in both care of the elderly and cardiology. In surgery, the numbers are unreliable for the reasons described above

Vacancies

Speciality	Rota	Tracks	Vacancies	LTFT	
General Medicine	FY1	18	1	0	
General Medicine	SHO	27	1	2	1 x 50% 1 x60%
General Medicine	ST3+	12	1		1 x 80%
General Surgery	FY1	10	3	0	
General Surgery	SHO	10	1	0	
General Surgery	ST3+	12	3		
Paeds	SHO	13	2	2	1x 60% 1x 80% Psych
Paeds	ST3+	8	1		
A&E	FY1	3	0		
A&E	SHO	18	5	2	1x60%, 1x 80% Psych
A&E	ST3+	3	0	3	1x60%, 2x 80%

Many thanks to Leanne Preston for the increasingly detailed Vacancy Reports. In discussion with Leanne, it is clear that the above table represents a snapshot in time and that vacancies are fluid

and changing. However, we feel that this gives us an idea of vacancies over Quarter 4. It is important to note the LTFT (Less Than Full Time) column. Our LTFT trainees are highly valued and skilled trainees providing equally skilled service to a full time trainee but as is clear from the title, will provide less service hours. This equates effectively to a vacancy if not the same as a vacancy from an absent track. So, for example, in General Medicine SHO, of the 27 tracks, 2 are LTFT and one is vacant. There are therefore 24 full time doctors training to provide the cover of 27 with 2 making up some hours but not to the equivalent of 2 full time doctors. One can therefore get an idea of the difficulties Cardiology and Care of the Elderly are experiencing. I note the surgical trainee rota has a total of 7 vacancies. This means both specialities, who experience the bulk of exception reporting, are starting off short staffed before sickness, annual leave and study leave are factored in. This should highlight the real challenges rota co-ordinators are having.

Summary

In short, we should be encouraging Exception Reporting and empowering Educational Supervisors to manage short term matters with longer term issues addressed by divisions through quarterly and annual reporting. Vacancies continue to contribute to staffing issues.

Medicine Exception Reasons

Gastro consultant called the handover phone during handover, discussed a patient with me and then requested that I request an OGD for my patient, and another patient I did not know. As the proforma request took a long time for each I ended up staying half an hour late.
After handing over my jobs, I had some documentation to do for my patients, and some jobs to do. Among the jobs were vetting scans that I had ordered but not had a chance to vet before handover, discussion with family, and determining clinical frailty scores for the surgical team
short staffing
short staffing, not much help for jobs
short staffing
short staffing
short staffing
could not avail SDT as was sick
short staffing
overtime due to short staffing,
overtime due to short staffing
Overtime due to short staffing
Overtime
Unable to attend Mandatory FY1 Teaching due to ward staff levels.
Worked late past finishing time.
Overtime past finishing time.
Reviewed a patient who had chest pain on CCU before leaving, was just myself as two other SHOs were sick, and we needed a locum from respiratory medicine to cover Ince ward as well.
Stayed late as had to review two patients who needed reviewing, both with chest pain, one of whom became unwell with runs of VT and discussed with the cardiology consultant on-call. Also supervised another FY1 who used the opportunities to attempt venepuncture and cannulation.
Was supposed to have SDT, but had a long ward round and a patient with a lot of jobs, because they needed a neurology referral and during their neurology examination they became acutely unwell
Patient became acutely unwell on Ince ward just as I needed to go to Grand Round, dropping their Oxygen saturation to 80%. I was therefore unable to attend grand round.
Please excuse clock time above as this is incorrect. However, I am claiming 1.5 hours of extra time worked. Currently, the Respiratory Team ask 1 juniour to attend the ward 30 minutes earlier (8.30am) to be a part of the

allied professional 'board round' and attain social, nursing, PT/OT problems and discharge care planning of patients in the last 24 hours. In return we can leave 30 minutes 'early'. Today was my turn. However, I left the ward at 5.30pm (1 hour late) after not having any lunch or breaks throughout the day due to staffing pressures and unwell patients. Three of the patients on the ward became extremely unwell, one resulting in IPOC and multiple conversations with the family in order for them to understand how unwell she was, one very unexpected death for which the husband required a prolonged time explaining what had happened and why, in addition to general comforting and one deteriorating patient on CPAP. Additionally, a chest drain fell out unexpectedly, which needed suturing. There was no respiratory registrar today and the consultant was off site in TLC clinic. During these events there was myself and 1 SHO. - The SHO had not received training on using lidocaine for an ABG (for which the patient on CPAP refused to have one without it) and therefore the SHO was uncomfortable to perform the task. - He also was not comfortable suturing the chest drain wound closed as he had no training on this. There was no registrar and the site was profusely loosing chylothorax fluid , plus leaving it open risked a pneumothorax - so I therefore did it. - Additionally, the SHO was not on WR when the potential IPOC patient was discussed and therefore unable to have the family discussion to aid family understanding and was leaving half day so this would not present continuity of care to the family who were highly distressed. - The SHO left for teaching at 12.30pm. This left a gap in the day awaiting a locum doctor to come to the ward and then I had to re-explain the WR and jobs needed to be performed and placed further pressures on my task/job management in order to keep patients safe. In order to see the patients promptly in the am and early pm I did not get chance to document and therefore stayed late to document on HIS - something I could not hand over to the on-call team.
Stayed late due to busy ward with lots of jobs that needed to be done before the weekend. Lots of new patients to the ward.
Due to sickness, only 3 doctors on cardiology in the morning. The FY1 was on call and left at 12 to start clerking, and the PFD was presenting at teaching in the afternoon. I covered cardiology and COE on Ince and CCU alone in the afternoon after 1:30. Was asked to do a secondary ward round at 3 by the CCU consultant. Had all the jobs to do for Ince and CCU so left late.
A patient came into the ward acutely unwell (at around 16:30) after being unstable on angiography table post-MI. I was the only ward junior doctor on in the afternoon and stayed to support the consultants, running gases and prescribing medications, as well as speaking briefly to a relative who called, until the patient had stabilised.
The ward round finished slightly later than usual - at 12:30 which unfortunately meant I was not able to join grand round that week. Due to needing to help Cardiology jobs on CCU and Ince, and there being an unwell patient on CCU my SHO and I both left at 18:00.
I had scheduled SDT on this day, due to start at 1pm, but was unable to take it as the ward round itself finished at 2pm, and there were too many jobs to safely handover to the only other FY1 covering both cardiology and CoE on Ince ward, so stayed until 5PM.
Please ignore 2 previous report. This is the correct one. SDEC shift overtime due to poor staffing.
SDEC shift. No support sent to help despite workload.
SDEC shift. At 6pm still 10 new patients to review. (Backlog from previous day with no doctor). Only 2 juniors and one consultant available. No extra help sent.
I was the only junior doctor on the ward, covering both care of the elderly and cardiology. This meant I was unable to attend both ward round. I had no junior support on the ward all day and had to manage the patients and the jobs on my own. I also had to attend grand round on this day
I was the only junior doctor on the ward covering both care of the elderly and cardiology in the afternoon due to teaching, as the ward round went on for the entirety of the morning very few jobs were completed prior to the other junior left. I therefore had a large number of jobs to complete in the afternoon as a result of this I ended up leaving an hour late.
I was the only junior doctor on the ward covering both care of the elderly and cardiology in the afternoon due to teaching, as the ward round went on for the entirety of the morning very few jobs were completed prior to the other junior left. I therefore had a large number of jobs to complete in the afternoon as a result of this I ended up leaving an hour late.
I was the only member of the team on the ward to cover 2 ward rounds. I was supposed to have teaching in the afternoon, I was late to teaching due to having to find and hand over to another doctor who would cover the

ward while I attended my mandatory teaching session. I returned to the ward after teaching and stayed an hour late due to having to finish jobs left from the ward round.
Due to rota gaps, as per previous exception reports, I was the only junior covering CCU while another junior covered INCE Cardiology and COE patients. After finishing my work on CC, I went to help on INCE to get some jobs done, and so that the junior that was there alone all day could go home at a reasonable time also.
Worked late as I was the only junior covering COE and Cardiology patients (including ward rounds) on Ince, keeping in mind I am a Cardiology junior. It was a very busy and stressful day with minimal senior support after the ward round. After trying and failing to get in touch with the COE consultant, had to call the on call registrar when I needed senior advice.
Ward round lasted until around 12:45, and we had 19 patients to take care of with many jobs. I needed to go to the mess to rest before finishing jobs, and rested for something between an hour and an hour and a half, therefore willing to claim just one hour and a half for compensation. However, would like to flag that the fatigue from overworking, and needing to stay late the day before slows down the work as well - required rest before finishing. I moved my SDT to a different date so as not to abandon my SHO.
I was the only doctor on the ward covering both Care of the Elderly and Cardiology, the ward round extended beyond midday and two patients became acutely unwell afterwards, taking much time and leaving jobs to the end of the shift.
Again, limited staffing. I was covering cardiology and COE patients on Ince after 1 as FY1 had to go to teaching. Stayed hour late.
Finished late as was on CCU and had to clerk a new patient coming directly to CCU (although I wasn't on call) that was unwell and had critical meds including Parkinson's meds.
Only 2 doctors on cardiology covering CCU, Ince cardiology patients and Ince COE patients (COE consultant does the ward round for these patients but cardiology juniors cover - previously there was a medical outliers Locum). Had to stay to complete urgent jobs.
Stayed an hour late as a lot of jobs on CCU and only me to cover.

Surgery Exception Reasons

I stayed additional 2 hours as I was the only junior on urology on Monday after a Wigan weekend, with over 20 patients to myself. I also did not get to have a break during the day.
Due to finish work at 17:00, however due to workload and limited staffing I was unable to. This was due to annual/compassionate leave and sickness, unfortunately leaving myself as the F1, one SHO and the CEPOD F1 who helped (fortunately there was only one emergency theatre case) to cover the ward rounds and tend to all ward round jobs. This was particularly difficult as it was Friday so the on call list had been merged with the ward lis, doubling the work load.
On my surgical EPR shift the urology consultant on call (Mr Gkentzis) had two emergency urological cases to attend in Bolton. This meant he was in theatres in Bolton and was not able to attend Wigan for the urology ward round until 15:15. My shift was supposed to finish at 15:30 however the on-call F1 was very busy and did not have time to assist with the urology WR therefore I was required to stay. Due to the delayed start and the need to chase jobs following the ward round I was at work until 17:30.
Delayed handover at end of Standard Day On Call shift
No SDT throughout placement. Email from rota coordinator confirms this was in error.
I was working the second on-call shift scheduled to work from 8-19:30. Due to service provision I had to stay an hour late until 20:30. I received several bleeps after 5:30pm in relation to discharge letters required for daycase urology and Gen Surg patients in SAL that had not been completed and patients could not leave without them as they required meds to go home with.
Referred a patient with ?cauda equina syndrome from bolton with no verbal handover after 19.00. Attended despite being close to end of shift as possible medical emergency. While clerking patient discovered he had already had scans at Bolton, although no documentation of these was provided. Once I had made sure no medical emergency was taking place, I returned to prep for handover which was delayed as a result. After handover, I had to stay to copy over documentation sent by Bolton onto our trust systems to ensure that the patient could be looked after by local teams. Eventually finished at 9.30, one hour after I was due to.

Title of report:	The Guardian Service - Freedom to Speak up 6 month Report
Presented to:	Board of Directors
On:	03 August 2022
Presented by:	Consent Agenda
Prepared by:	Natalie Morgan, Guardian
Contact details:	Tel: 07732496588 // natalie.m@theguardianservice.co.uk

Executive summary

This report covers the provision of service from 1st October 2021 to 31st March 2022. Covering Q3 and Q4 data and marking 6 months since service commencement. 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 from staff. 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 Board 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 March 2022 – Q3 & Q4. 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	**35**
Themes	
Patient Safety / Quality	2
Management Issues	12
Systems and Processes	4
Bullying and Harassment	12
Discrimination / Inequality	0
Behavioural / Relationship	4
Other	1
Why use the Guardian Service	
Fear of damage to career	2
Fear of losing job	2
Fear of Reprisal	11
Believe they would not be listened to	11
Believe the organisation would not take action	7
Have Raised Concern but have not been listened to/nothing done	2
Confidentiality	
Keep it confidential within the Guardian Service Remit	12
Permission to escalate with names	10
Permission to escalate anonymously	13

Reasons for contacting the Guardian are captured upon the opening of a new case. Reasoning selection is set by NGO reporting requirements. GSL is aware that sometimes there can be more than one reason a staff member may choose to contact the Guardian and for reporting purposes will select the main reasoning in agreement with the staff member raising the concern. Following discussion with the Director of Workforce the Guardian has agreed to capture and report reasoning that falls outside of the required categories. In the last 3 months reasoning has also been captured as; An alternative listening ear, looking for a confidential space to talk openly, someone outside of the situation to talk to without judgement and in some instances directed by colleagues as an alternative support pathway.

No. of concerns raised

Detailed below are the number of concerns raised across the Trust for Quarter 3 & 4 (1st October 2021 to 31st March 2022) and a comparison to previous Quarter 3 & 4 (1st October 2020 to 31st March 2021) prior to the Guardian Service commencement showing a 85% increase in concerns raised.

Date	Number of concerns	
Q3 & Q4 2021	35	The Guardian Service
Q3 & Q4 2020	5	Internal Guardian

23 concerns were escalated to the Trust within this period, all of which were responded to within the agreed RAG Protocol timeframe.
From the 35 cases raised within this period moving into Q1 (2022) 17 cases remain open and 18 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 committee requested a review of the timescales involved from the point of escalation of concerns into the Trust to closure, this was an average of 21 days. Although important to have an oversight of timescales of this nature, it is also important to consider the varied factors that may affect timescales for closure. Factors to consider are, the staff members need for reflection time and the opportunity for them to access any impact both of which can vary due to the nature of concern and nature of the agreed resolution. Unfortunately, the information is not available to provide a comparison across previous FTSU data held within the Trust.

The number of emails, telephone calls and face to face visits engaged by the FTSUG in responding to concerns are as follows:
Email – 114 Telephone – 125 Face to face – 7

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, but can be contacted by telephone, email or virtually.

Themes

Bullying and Harassment

Concerns raised under the theme of bullying and harassment account for 34% of cases. The concerns that have been reported under this category were raised from both witnessed and experienced perspectives, in the context of adverse managerial styles and negative behaviors. Concerns relate to both worker to worker and manager to worker relationships. Several concerns have been escalated into the Trust to be managed with continued support to staff members provided by the Guardian.

Management Issues

Management Issues account for 34% of cases, which were associated with.

Communication:

- General quality of management communication with staff.
- Inconsistent messages relating to workload and performance expectations
- Feeling that managers only communicate to deliver negative information
- Managers not listening to staff concerns, or service improvement suggestions.
- Quality of line management support during sick leave
- Minimal feedback or understanding of next steps following meetings
- Opportunities to avoid formal process not acted upon in a time sensitive manner

Working Environment:

- Creating hostile working environments
- Management practice and decision making.
- Inconsistencies in return-to-work processes
- Autonomy

Interpersonal Issues:

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

Where concerns of this nature have been raised collaboration between HR, Learning and Development, management teams and the Guardian has identified areas of focus.

With HR involvement, managers have been provided with support and guidance relating to formal processes and procedures.

Following concerns highlighted to HR, managers have been provided with guidance and encouragement to increase communication and feedback to staff as well as the support that is provided during sick leave.

A Guardian facilitated meeting between a staff member and their manager resulted in positive outcomes for both, highlighting how both can improve their methods of communication and rebuild their professional relationship.

Behavioural/Relationship

Concerns in this area were in context of incivility and relationship breakdown with impact on relationships from communication styles and perceived negativity between colleagues.

Systems and Process
Concerns were associated with the clarity of processes and communication in the context of.

- Little to no understanding of timeframes of internal or external investigations
- Barriers to understanding of specific internal procedures
- Communications associated with the exit interview process
- Absence management procedure specifically the return-to-work process.
- Occupational health referrals

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. The Guardian has shared policy documentation for staff reference.

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.

Two concerns under this heading were reported in the period from 1st October 2021 to 31st March 2022.

In both instances concerns were acknowledged within the agreed escalation timeframes. Action was taken by the Trust to investigate and put in place any necessary measures to prevent concerns for patient safety. Both highlighted communication as a key factor in prevention of escalation.
In the first concern the staff member received an update regarding measures that had already been put in place because of the concern already being known in the organisation prior to the Guardians escalation. In this instance the staff member felt that an outcome had not been communicated effectively for them to feel that their concern had been heard prior to the Guardians contact. In the second instance the concern highlighted development opportunities for individuals concerned around their communication style.

3.Action taken to improve FTSU culture

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

- The FTSUG listens and supports staff in identifying how they want a current situation to progress, often become an empathetic listener when a staff wishes to download. Coaching staff in structuring their concerns and helping them to communicate them clearly in meetings and supervision, can help an individual bring about an informal resolution often mitigating the requirement for formal process.

- Staff are advised at the start of a call that should their concern have elements of patient, staff safety or safeguarding, that the Concern must be escalated immediately. Staff have the option to escalate their concerns anonymously thus providing a safe space for concerns to be raised. Providing this as an option gives the Trust the opportunity to hear what they may not have ordinarily heard without having this option in place.

- The FTSUG support staff to raise and forward their own concerns. The FTSUG also assists with verbal communication and preparation for staff attending facilitated or one to one meeting with their manager to discuss how they are being treated.

- The FTSUG has supported staff by encouraging the staff member to put forward suggestions in a positive way as opposed to complaining. This allows for a more positive partnership between staff and managers and helps improve the service. Sometimes helping the individual see the bigger picture or helping them see the issue from a manager's perspective can be helpful.

- 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. Confidentiality of staff members is protected in the conversation.

- The FTSUG attends regular 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 FTSUG has attended meetings with the Head of Organisation Development and Engagement and members of the staff engagement team to highlight areas of concern and discuss any common themes from staff engagement work being undertaken and planned across the Trust.

- 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. In instances where staff have reported that they feel they will not be listened to, they have fed back that the FTSUG has allowed their voice to be heard. Staff have been appreciative of the level of communication once concerns have been escalated into the Trust.

- 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.FTSUG Learning and Improvement

- The FTSUG routinely reflects on practice which informs continual learning. Peer support through other GSL Guardians is always available and used when dealing with complex concerns.

- The FTSUG attends the meetings and events organised by the NGO. This includes regular catch-up meetings with NGO Northwest 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 for consideration

- Acknowledgement of the personal courage required to call out poor practice. All staff should be assured of the confidentiality and safe environment that will be afforded to them while the appropriate action is taken to address the issues alleged. Greater focus on resolution rather than process would serve the Trust better. Some managers are inclined to deflect a concern towards the formal process of grievance, rather than try to resolve it themselves.

- Consideration be given to mandatory people management training for all who have supervisory, team or individual leadership roles or responsibilities. This may lead to management that is kinder in nature and ensure high continuity across the Trust with the implementation of policy and procedure. Often the concerns raised contain an element of harsh/abrasive management and communication style.

- Mentors and coaching relationships could be offered to help newly promoted managers get to grips with the full range of their people responsibilities. Also, appraisal of experienced managers to ensure their people management responsibilities are fulfilled in line with Trust policies and values. In some situations, it would be appropriate for a line manager to contact the Guardian when faced with a new, unusual, or challenging situation.

- 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 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 their issue is still of relevance can go a long way for staff moral and in enabling them to continue to work effectively and in instance where staff members are absent from work may assist in an earlier return.

- 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 provided.

6. Themes from FTSU and National Staff Survey Results

The information captured and themes highlighted from the concerns raised into FTSU over the last 6 month reinforce the opportunities for continued improvement that have been identified from the results of the national staff survey within the following areas.

- 'We are recognized and rewarded' People Promise 2 - results suggesting that approx. half the staff surveyed are not satisfied with the recognition they receive at the Trust and not feel valued.
- 'We each have a voice that counts' People Promise 3 - an area where WWL are scoring, albeit insignificantly lower compared to sector is 'feeling safe to speak up about concerns in the organisation scoring 60% compared to sector 61% and 'If I spoke up about something that concerned me, I am confident my organisation would address my concern' 51% to 48%. With the introduction of the Independent Guardian Service going forward it will be interesting to view if there is an increase in positive responses within future surveys.
- 'We are Safe and Healthy' – People Promise 4 – Staff engagement will continue with the culture work to support staff engagement and raise awareness with regards to psychological safety, civility, and compassionate leadership.
- 'We are always Learning' People promise 5 - Recognition has been given for the need for development of managers and leadership teams from results within this area.

** Information taken from National Staff Survey Report Prepared by Dr Angelique Hartwig senior Organisational Psychologist, Andy Hayward, OD Practitioner, Martin Ball OD facilitator

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	IPC Board Assurance Framework update
Presented to:	WWL Board of Directors
On:	03 August 2022
Presented by:	Rabina Tindale, Chief Nurse
Prepared by:	Julie O'Malley, Deputy Director IP
Contact details:	T: 01942 773115 E: Julie.omalley@wwl.nhs.uk

Executive summary

This report provides an update on progress with the IPC BAF following receipt of the last report, with the ongoing gaps in assurance listed below. The full IPC BAF is tabled at the Trust Quality and Safety Committee.

The IPC BAF will be reviewed at the next IPC Group. An updated NHSE IPC BAF is expected for quarter 2.

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

- **Microbiology provision within the Trust:** Limited Microbiology provision continues within the Trust. This is noted within the Organisational Risk register and reviewed by the Risk Management Group.
- **The demand on the IPC workforce** has increased on the background of depleted team capacity, the continuing COVID-19 Pandemic, and the On-call commitment required by the team. The Finance decision has confirmed, the IPC Business case will not proceed until an identified funding source is found. Support has been requested to secure funding for investment in the IPC Service. Risk assessments have been submitted for review.
- **The IPC Audit Programme** continues to be modified in response to COVID-19. The increase in positive COVID-19 cases within the Trust continues to impact on bed capacity and the response required by the IPC Team to deliver a full IPC audit programme.
- **The current impact and uncertainty of the path the COVID-19 Pandemic** requires services to manage the additional impact on capacity and demand of the rising COVID-19 cases. In response the Executive Team are asked to consider the following measures: In-patient asymptomatic COVID-19 testing protocol, the re-introduction of mask wearing in non-clinical areas, and a further pause to in-patient visiting, in addition to the current IPC measures, management guidance and SOPs, in place to support patient and staff safety.

- **Within the Trust there is limited side room capacity** to consistently enable isolation as required, for patients with confirmed or suspected infections, not limited to COVID-19. All identified COVID-19 positive in-patients are transferred to designated COVID-19 positive areas. The IPC Team attend daily bed meetings and support bed managers with decision making, including during IPC On-call provision. A Datix is completed if a patient cannot be isolated and mitigating IPC actions and measures are implemented to maintain safety whilst bed management colleagues continuing to secure isolation capacity.
- **Limited capacity to segregate patients within ED without adaption of the environment.** Rapid PCR and Point of care/ LFD testing are available within ED.
- **The Trust has a heavy reliance on natural ventilation**, particularly at the RAEI site. Some limited small areas may still have poor ventilation.
- **Lateral Flow Device (LFD) testing by staff** may be impacted with the Government decision regarding terms and condition in relation to staff COVID-19 sickness/ absence.
- **Mandatory IPC e-learning modules:** A small month on month increase demonstrated during quarter 1, however the Trust target of 95% has not been achieved during Q1 for the IPC modules. IPC seeking support from the Executive team to enable compliance.
- **Mask Face fit testing:** Quarterly data is not available at the time of the report, IPC seeking support from the Executive team to enable regular timely updates.
- **Currently the Trust are only cleaning prioritised areas within the non-clinical areas**. The 2nd wave of recruitment to undertake the cleaning and monitoring of non-clinical areas in 2022/23 has not been implemented due to the current financial position.
- **Mandatory IPC e-learning modules:** Quarterly data is not available at the time of the report.
- **Hand hygiene and PPE compliance** is below expected standard in some ward areas. The focus on IPC compliance will continue to support improved compliance and ownership, within the capacity of the IPC Team. The reintroduction of the full audit programme will focus on standard IPC.

Updated action

- Asymptomatic in-patient COVID-19 testing: A pilot of LFD testing has commenced in line with NHSE testing guidance. LFD test results can now be recorded onto the electronic hospital information system (HIS). The proposed adoption of LFD asymptomatic in-patient testing across the Trust on 1 August 2022.

Link to strategy

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

Risks associated with this report and proposed mitigations

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

Financial implications

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

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

People implications
Additional resource will be required in some areas e.g., to address the current challenges associated with COVID-19 on a background of a depleted team the increasing IPC workload that continues to create additional ongoing pressure on the IPC team.

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

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

Appendix 1: Infection Prevention and Control (IPC) Board Assurance Framework (BAF). (only including changes as of 22 July 2022):

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: A respiratory season/winter plan is in place: ▪ that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services • to enable appropriate segregation of cases depending on the pathogen. ▪ plan for and manage increasing case numbers where they occur. ▪ a multidisciplinary team approach is adopted with hospital leadership, estates and facilities, IPC Teams, and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan.	**At 22.7.2022:** ▪ Testing arrangements in line with NHSE Guidance: 1 June 2022 ▪ All patients requiring admission undergo a PCR, Rapid PCR or POCT/ Lateral Flow Device (LFD). ▪ POCT equipment updated and recording of LFD testing recorded within HIS ▪ In-patient COVID-19 contacts not required to isolate ▪ All COVID-19 positive in-patients transferred to designated COVID-19 positive areas ▪ Current In-patient visiting: Two visitors per patient with duration of one hour ▪ Current increased incidence of COVID-19 cases managed in collaboration with Operations Team, IPC Team, and Estates/ Facilities ▪ Dedicated COVID-19 Ward areas currently in operation ▪ Escalation planning in collaboration with Operations Team, IPC Team/ Microbiology	Limited Isolation capacity	Patient placement/ isolation priority managed in collaboration with Operations Team, IPC Team, and Estates/ Facilities. Escalation to Executive Team: Options appraisal paper for discussion/ approval of adopted approach and enhance IPC measures, including review of visiting
Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	**At: 22.7.2022:** IPC measures remain in place within the trust in line with National guidance/ NHSE/ UKHSA and National IPC Manual.	The current increase in positive COVID-19 cases within the Trust has further increased demand on bed capacity and impacts on the response required by the IPC Team. Finance decision: The IPC Business case will not proceed until an identified funding source is found. The Band 8a Acting-up role only has funding for a further 3 months and post	Resource and investment within the Trust IPC Service required. July 2022: Support with identifying a funding source for the IPC Staffing Business case has been requested Band 7 IPC Junior Matron scheduled to commence post in September 2022. Discussion with Finance/ Budget Lead to progress recruitment to Band 5 and

		holder will return to a Band 7 role. Band 4 IPC Nursing Associate left post and retirement application submitted by further Band 4 staff member.	Band 3 roles (within budget limits) to enable succession planning for the IPC Team.
If the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems.	▪ July 2022: Unable to actively manage outbreaks due to current demand on bed capacity requirements. ▪ Routine asymptomatic in-patient PCR swabbing in line with NHSE guidance at day 3 and day 5 continues. ▪ LFD Testing Pilot in progress on four wards: Medical: MAU and Bryn Ward North and Surgical: Swinley and Langtree for asymptomatic in-patient LFD testing on day 3 and day 5. ▪ No further asymptomatic in-patient testing post day 5, unless patients become symptomatic or for transfer to Care Home, Intermediate Care or Hospice (pre 48 hours PCR testing required or LFD if COVID-19 positive in previous 90 days). ▪ Reporting of LFD test results onto HIS now enabled. ▪ Proposed adoption of LFD testing across the Trust on 1.8.2022. ▪ System Meeting (WWLFT, CCG and LA): Care Homes/ IPC/ Pathways/ capacity	July 2022: Outbreaks meeting the case definition are reported but IPC Team are currently unable to actively manage outbreaks due to the increased incidence of COVID-19 and the current demand on bed capacity requirements	All COVID-19 positive patients are transferred to designated positive ward areas or side-room. Patient placement/ isolation priority managed in collaboration with Operations Team, IPC Team, and Estates/ Facilities.

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
No changes to any of this section as of July 22

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and process are in place to ensure: Arrangements for antimicrobial stewardship are maintained	At 22 July 2022: Microbiology provision: ▪ One part time Microbiologist (3 days) ▪ One full time Locum Microbiologist provides remote/ virtual support 5 days per week with a specific/ limited remit.	Limited Microbiology support available within the Trust. No Microbiologist/ Infection Control Doctor in post to support the IPC Nursing Service and lead on	One part time and one locum Microbiologist currently providing a specific/ limited remit, via virtual/ remote service arrangement in the interim period.

		specific IPC Doctor role, i.e., IPC Group (formerly Committee, Decontamination, Ventilation.	Recruitment of new/ Microbiologist discussed at Senior Meeting (Risk Management Group). Microbiology provision remains on Organisational Risk Register Assessment: reviewed by Risk Management Group Two IPC Risk Assessments currently subject to the review process: *Lack of Microbiology support to IPC Nursing Service* and *IPC Service unable to deliver service due to lack of specialist staff*. Both awaiting review at Risk Management Group
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
There is evidence of compliance with routine patient testing protocols in line with Trust approved hierarchies of control risk assessment and approved.	▪ All patients are tested for COVID-19 on admission (day 1) (PCR, Rapid PCR or LFD) followed by asymptomatic in-patient PCR testing on day 3 and day 5. ▪ LFD Testing Pilot currently in progress on four Wards: Medicine: ASU and Bryn Ward North and Surgical: Swinley and Langtree. Day 3 and day 5 testing by LFD. ▪ No further LFD or PCR patient testing unless symptoms present or planned discharge to Care Home, Intermediate care, or Hospice. ▪ LFD Test results can now be entered/ recorded onto the electronic system (HIS). ▪ Proposed adoption of LFD testing across the Trust on 1.8.2022.	Evidence of non-compliance with current asymptomatic testing protocol: Over and under testing	Audit of Testing Process by Ward Leaders and IPC Team Support to Ward area staff to improve compliance with testing protocol Resources provided to ward areas to remind/ support compliance Support to LFD Pilot Wards from IPC Team, HIS Team, Testing Lead and Facilities
5. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

To monitor compliance and reporting for asymptomatic staff testing	From 7 July 2022: Government change in relation to COVID-19 sickness absence arrangements. Global communication to staff. Twice weekly LFD testing with responsibility for ordering test kits and reporting results directly to .GOV portal by Clinical staff only All symptomatic staff can order LFD test kits and report results directly to .GOV portal	July 2022: Impact on COVID-19 related staff sickness absence arrangements and staff testing/ absence	To encourage staff to continue LFD testing: Clinical staff twice weekly and all staff if symptomatic to reduce risk of transmission to patients and staff

6. Provide or secure adequate isolation facilities

No changes to any of this section as of July 22

7. Secure adequate access to laboratory support as appropriate

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
That emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission	▪ All patients are tested for COVID-19 on admission (day 1) (PCR, Rapid PCR or LFD) followed by asymptomatic in-patient PCR testing on day 3 and day 5. ▪ LFD Testing Pilot currently in progress on four Wards: Medicine: ASU and Bryn Ward North and Surgical: Swinley and Langtree. Day 3 and day 5 testing by LFD. ▪ No further LFD or PCR patient testing unless symptoms present or planned discharge to Care Home, Intermediate care, or Hospice. ▪ LFD Test results can now be entered/ recorded onto the electronic system (HIS).	Evidence of non-compliance with current asymptomatic testing protocol: Over and under testing	Audit of Testing Process by Ward Leaders and IPC Team Support to Ward area staff to improve compliance with testing protocol Resources provided to ward areas to remind/ support compliance Support to LFD Pilot Wards from IPC Team, HIS Team, Testing Lead and Facilities
That sites with high nosocomial rates should consider testing COVID negative patients daily;	NHSE Testing guidance from 1.6.2022 in place as above.	None	N/A
That those being discharged to a care home are tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge;	Trust compliant at: 22 July 2022	None	N/A
That patients being discharged to a care facility within their 14 day isolation period are discharged to a designated care setting, where they should complete their remaining isolation; as per national guidance	No longer applicable: Isolation period 10 days in line with current UKHSA guidance. Trust compliant at 22 July 2022	None	N/A

There is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.	Trust compliant at: 22 July 2022	None	N/A

8. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

No changes to any of this section as of July 22

9. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing.	From 7 July 2022: Government change in relation to COVID-19 sickness absence arrangements. Global communication to staff. Twice weekly LFD testing with responsibility for ordering test kits and reporting results directly to .GOV portal by Clinical staff only All symptomatic staff can order LFD test kits and report results directly to .GOV portal	July 2022: Impact on COVID-19 related staff sickness absence arrangements and staff testing/ absence	To encourage staff to continue LFD testing: Clinical staff twice weekly and all staff if symptomatic to reduce risk of transmission to patients and staff

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Appointment of Senior Independent Director
Presented to:	Board of Directors
On:	03 August 2022
Presented by:	N/A - consent agenda
Prepared by:	Director of Corporate Affairs
Contact details:	E: paul.howard@wwl.nhs.uk

Executive summary

Both the NHS Foundation Trust Code of Governance, and the draft Code of Governance for NHS Provider Trusts which will shortly supersede it, include a provision that the board should appoint one of the independent non-executive directors to be the Senior Independent Director in consultation with the Council of Governors. The role of the Senior Independent Director is to provide a sounding board for the Chair and to serve as an intermediary for the other directors when necessary. The Senior Independent Director also takes a lead role in the Chair's annual appraisal.

The Senior Independent Director role was previously held by Lynne Lobley, who has now been appointed as Vice-Chair by the Council of Governors. Having consulted with the Council of Governors on the proposed approach to the Senior Independent Director role and received its support, the board is recommended to appoint Lady Rhona Bradley as Senior Independent Director with immediate effect.

Link to strategy

There is no direct link to the organisational strategy, however the Senior Independent Director role is a recommended post for all foundation trusts.

Risks associated with this report and proposed mitigations

The provisions of the Code of Governance are best practice advice and therefore non-compliance is not in itself a breach of Condition FT4 of the NHS Provider Licence. That said, any non-compliance with the provisions must be explained and it would be for the foundation trust to demonstrate how its actual practices are consistent with the principle to which the provision relates. The appointment of a Senior Independent Director mitigates any risks associated with this, as the foundation trust will be able to declare full compliance with the relevant provision of the Code of Governance.

Financial implications

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

Legal implications

There are no legal implications associated with this report.

People implications

Lady Bradley has indicated her willingness to serve in this role.

Wider implications

Paragraph 12.8 of the foundation trust's constitution confirms that it is for the Board of Directors to appoint the Senior Independent Director, in consultation with the Council of Governors. This consultation took place on 19 July 2022 and the Council of Governors unanimously supported Lady Bradley's appointment.

Recommendation(s)

The board is recommended to appoint Lady Bradley as Senior Independent Director with immediate effect