Public Board Meeting

Wed 08 June 2022, 13:30 - 16:15

Boardroom, Trust Headquarters.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Agenda

13:30 - 13:30
0 min

11. Declarations of Interest

Information *Mark Jones*

13:30 - 13:32
2 min

12. Minutes of Previous Meeting

Approval *Mark Jones*

- 12. Minutes - Public Board - Mar 2022.pdf (4 pages)
- 12a. Minutes - Public Board - April 2022.pdf (10 pages)

13:32 - 13:40
8 min

13. Chair's Opening remarks

Information *Mark Jones*

Verbal Item

13:40 - 14:00
20 min

14. Staff Story: 'Working to full scope of practice'

Discussion *Alison Balson*

Verbal

14:00 - 14:10
10 min

15. Chief Executive's report

Information *Silas Nicholls*

- 15. Board Report_CEO_June 2022_FINAL.pdf (4 pages)

14:10 - 14:30
20 min

16. Committee chairs' reports

Information *NEDs*

16.1. Audit

Ian Haythornthwaite

- 16.1. AAA Audit - May 2022.pdf (2 pages)

16.2. Quality and Safety

Francine Thorpe

- 16.2. AAA QS - May 2022 - FT.pdf (2 pages)

16.3. Finance and Performance

Alison Tumilty

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

14:30 - 14:40
10 min

17. Board assurance framework

Discussion *Paul Howard*

17. BAF - Jun 2022.pdf (38 pages)

14:40 - 14:50
10 min

18. Safe nurse staffing report

Discussion *Rabina Tindale*

18. Safe staffing report April Final Board June 2022.pdf (12 pages)

14:50 - 15:00
10 min

19. Maternity Reports

Discussion *Rabina Tindale*

19. Ockenden 2 Report update. MAY 22 docx.pdf (6 pages)
19. Mat CoC Building Blocks Plan May 2022 update.pdf (10 pages)
19. Update to Q&S PICKER MATERNITY SURVEY.pdf (6 pages)
19. Perinatal Quality Surveillancve report June Q4.pdf (23 pages)

15:00 - 15:10
10 min

20. Q4 2021/22 learning from deaths report

Information *Sanjay Arya*

20. Mortality Report Q4 20212022 Final.pdf (7 pages)

15:10 - 15:15
5 min

21. University teaching hospitals update

Information *Sanjay Arya*

21. UHS Board Update Paper June 2022 v2.pdf (6 pages)

15:15 - 15:30
15 min

22. Review of well-led action plan

Information *Paul Howard*

22. Well-led action plan - Jun 2022.pdf (10 pages)

15:30 - 15:40
10 min

23. Q4 2021/22 Complaints Report

Discussion *Rabina Tindale*

23. Q4 report final report Board June 22.pdf (15 pages)

15:40 - 15:45
5 min

24. Infection Prevention and Control Board Assurance Framework

Information *Rabina Tindale*

24. IPC BAF v1.8..pdf (64 pages)

15:45 - 16:00
15 min

25. Integrated performance report

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

25. Board of Directors M1 2122 Scorecard.pdf (4 pages)

16:00 - 16:15
15 min

26. Consent Agenda

Information

26.1. Finance Report

26.1. Trust Financial Report 22-23 April month 1 Public.pdf (2 pages)

26.2. Guardian of Safe Working Hours report

26.2. QTR 3 Jan 2022 Quarterly Report (Template) 3.pdf (7 pages)

26.3. Self-Certification against Provider Licence Condition FT4

Approval

26.3. FT4 self-certification.pdf (7 pages)

26.4. Update on cyber-security

26.4. Cyber_Security_Briefing_Update_June_22.pdf (11 pages)

26.5. Risk appetite statement

26.5 Risk Appetite Statement - Jun 2022.pdf (11 pages)

16:15 - 16:15
0 min

27. Date, time and venue of next meeting

Information *Mark Jones*

Wednesday 03 August 2022, 12:15pm, THQ Boardroom

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

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

HELD ON 30 MARCH 2022, 1.00PM

BY VIDEOCONFERENCE

Present:	Mr M Jones	Chair (in the Chair)
	Prof C Austin	Non-Executive Director
	Mrs A Balson	Director of Workforce
	Mr I Boyle	Chief Finance Officer
	Lady R Bradley DL	Non-Executive Director
	Ms M Fleming	Deputy Chief Executive
	Mr P Howard	Director of Corporate Affairs (minutes)
	Mrs L Lobley	Non-Executive Director
	Mrs A-M Miller	Director of Communications
	Mr R Mundon	Director of Strategy and Planning
	Mr S Nicholls	Chief Executive
	Mrs F Thorpe	Non-Executive Director
	Mrs A Tumilty	Non-Executive Director
In attendance:	Mrs A Luxon	Deputy Chief Nurse
	Ms G Price	Graduate Management Trainee (observer)

18/22 Chair and quorum

Mr Jones took the chair and noted that due notice had been given to all directors and that a quorum was present. He therefore declared the meeting duly convened and constituted.

19/22 Apologies for absence

Apologies for absence were received from Dr Elliot (Non-Executive Director) and Ms R Tindale (Chief Nurse).

20/22 Declarations of interest

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

21/22 Gender pay gap report

The Director of Workforce presented a report which had been circulated with the agenda to set out the foundation trust's gender pay gap as at 31 March 2021. She confirmed that the gap had improved when compared with the previous year but noted that the foundation trust had a 30.21% mean average pay gap. She confirmed that the report had been reviewed in detail by the People Committee and briefed the board on work being done to address the gap.

In response to a question from Mrs Thorpe around the gap in relation to administrative and clerical staff, note was made of the fact that there are more males in the higher earning roles whilst the overall staff cohort is predominately comprised of female staff. The benefits of ensuring flexible working arrangements across all areas of the organisation were acknowledged, and the Director of Workforce provided an example where there are currently very few flexible working arrangements in place for senior staff at Agenda for Change Band 8c and above.

The Director of Workforce cautioned that some elements of the gender pay gap would necessarily take some time to address, for example in the medical workforce, as an increase in the number of female students entering medical education and subsequently moving into consultant posts would not impact on the overall position for a number of years.

The Board **APPROVED** the gender pay gap report as presented and directed that it be published on the foundation trust's website.

ACTION: Director of Workforce to arrange

22/22 Modern slavery statement

The Director of Corporate Affairs presented a report which had been circulated with the agenda to set out the foundation trust's proposed statement required under the Modern Slavery Act 2015 and confirmed that the document had been endorsed by the executive team.

In response to a question from Francine Thorpe, the Director of Corporate Affairs confirmed that the statement did not include patients who may be subject to modern slavery or human trafficking due to the required statement being generic rather than sector-specific, but confirmation was provided that significant focus on this exists across the organisation and highlighted the actions that have been included in the statement for the coming year, such as a requirement for key staff, including safeguarding teams, to undertake specific modern slavery training.

The Board **APPROVED** the slavery and human trafficking statement as presented and directed that it be published on the foundation trust's website.

ACTION: Director of Corporate Affairs to arrange

23/22 Use of the common seal during FY2021/22

The Director of Corporate Affairs presented a report which had been circulated with the agenda to advise the board of the occasions on which the foundation trust's common seal had been applied during the latter part of financial year 2020/21 and financial year 2021/22.

The Board noted the occasions on which the common seal has been applied.The Board also **RESOLVED** that attestation of the use of the common seal by any two members of the Board of Directors shall be deemed to be affixing the seal under the board's authority.

24/22 Resolution to exclude members of the press and public

The Board **RESOLVED** that representatives of the press and other members of the public be excluded from the meeting, having regard to the confidential nature of the business to be transacted.

25/22 Date time and venue of the next meeting

The next meeting of the Board of Directors will be held on 6 April 2022, 12.00 noon, in the Boardroom at Trust HQ.

Action log

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
30 Mar 2022	17/22	Gender pay gap report	Arrange for the statement to be published on the foundation trust's website	Director of Workforce	31 Mar 2022	Statement published. **Action complete.**
30 Mar 2022	18/22	Modern slavery statement	Arrange for the statement to be published on the foundation trust's website	Director of Corporate Affairs	ASAP	Statement published. **Action complete.**

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

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

HELD IN PUBLIC ON 6 APRIL, 1:15PM

BY VIDEOCONFERENCE

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

The Board reconvened following an adjournment.

39/22 Declarations of interest

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

40/22 Minutes of the previous meeting

The minutes of the last meeting held on 2 February 2022 were APPROVED as a true and accurate record.

41/22 Chairs opening remarks

The Chair welcomed members of the public to the meeting. He noted that the elective recovery plan is now underway and that he was pleased to see the positive progress being made. He described recent visits to several areas across all of the Trust sites with Cllr D Molyneux as well as other Non Executive Directors (NEDs) and added that he has spoken with many members of staff, who, in spite of having worked tirelessly throughout the pandemic, are resilient and keen to continue working. He summarised

that the day's agenda would see the approval of the corporate objectives for the year ahead, as well as the revised committee terms of reference and the new format 'AAA' NED reports, which have been provided in line with recommendations from Deloitte's review, conducted in line with the CQC's 'well led' key line of enquiry. He was pleased that these recommendations have been acted upon so quickly and will all aid WWL's journey to outstanding.

The Board received and noted the update.

42/22 Patient story

The Chief Nurse introduced the patient story. The Board of Directors viewed a video of a previous patient who had visited the Trust on Pemberton Ward, following conclusion of her cancer treatment. She provided positive feedback and noted the compassionate care that she had received from the team, thanking them for their work.

The Board received and noted the patient story.

43/22 Chief Executive's report

The Chief Executive thanked colleagues working across the Trust in every division and department, clinical and non clinical, for their efforts throughout the pandemic period.

He set out the key highlights of WWL's elective recovery plan, including the aim to remove all patients waiting 104 weeks from lists by the end of July 2022 and to begin reducing the number of patients waiting 52 weeks. He reported on the organisation's success in securing funding for a new CT scanner at the Wrightington site and to develop ward 7 to improve facilities for both staff and patients. In terms of the current demand on urgent care services, he reminded the Board that the A&E department was designed to provide care for 270 patients per day at most but is currently seeing as many as 300 people per day. He urged members of the public to consider alternative services where appropriate.

He reported that the Jean Hayes Reablement Unit will begin operating as a discharge to assess facility now, as it was originally intended to. He was pleased to report on WWL's pioneering virtual wards, which care for over 80 patients who are being treated in their own homes, through this initiative. He went on to note WWL's commitment to research and development as a teaching hospital and that that Trust is currently working with the British medical Journal on several national projects.

In respect of the recent staff survey results, he advised that staff have expressed concerns around a lack of facilities for them to use at hospital sites. He described how new staff areas, providing lockers, showers and breakout facilities for staff will be opened shortly and communications issued to advise staff that their feedback was listened to and acted upon.

He noted sympathies with the current situation in Ukraine and that WWL staff are repurposing medical equipment which is not being used and sending this over in medical aid packages to Ukraine.

The Board received and noted the update.

44/22 Committee Chairs' reports

The Chair begun by highlighting that, in line with recent recommendations made following Deloitte's Well Led review, new format AAA reports have been provided by the Non Executive Directors and will be provided going forwards, after being drafted at the end of each assurance Committee meeting.

(a) Quality and Safety Committee

Mrs F Thorpe, Chair of the Quality and Safety Committee noted that the last Committee meeting was shorter than usual, due to the need to free up staff capacity during the pandemic surge. She provided a summary of the report which had been provided in advance of the meeting, highlighting the Committee's strong focus on maintaining safe staffing.

Dr S Elliot queried the progress made to achieve the required reduction in pressure ulcers. The Chief Nurse reported that the Trust have now achieved the 67% reduction target, although acknowledged that progress has been more difficult within the community division, as was expected, due to lack of resource to support this. That division have achieved a 37% reduction and hope to get to 50% in the near future. He asked how this was achieved. The Chief Nurse advised that this begun with a root cause analysis, followed by an action analysis, staff training and additional support for and engagement with the relevant clinical teams.

Dr S Elliot congratulated the Chief Nurse on this incredible progress and the Chair asked that this be passed on to her team.

(b) 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 noted that the Committee is yet to review the progress made with international nurse recruitment and consider benefits realisation in line with the original business case. She advised that the Committee would retain an overview of the programme and was pleased with current retention levels within this staff group. She highlighted that the 2022/23 budget had not been approved, as was planned but that an additional meeting is being arranged to facilitate this once the national planning round has concluded.

Dr S Elliot queried what action is taken if recruits leave the Trust within the initial three year period and noted recent negative press coverage of nurses choosing to leave early facing financial struggles due to having to pay back a significant amount in fees, in accordance with their contracts of employment. He wondered whether this would deter foreign nurses from wanting to work with WWL.

The Chief Nurse advised that WWL have never had need to enforce such a clause and if the need did arise, would consider the circumstances on a case by case basis. The Chief Finance Officer added that the team running the Global Training and Education Centre

have been asked to investigate more fully the reasons why nurses may choose to leave, although clarified that the purpose of the scheme is that of its namesake, for nurses to "earn, learn and return" to their countries of origin. Although the Trust are happy to offer these nurses permanent positions in many cases, they are also happy to support them to return home where they wish to do so.

(c) People Committee

Mr L Lobley, Chair of the People Committee provided a summary of the report which had been provided in advance of the meeting, highlighting the positive elements of the staff story, being that WWL are considered a passionate organisation as well as the areas of concern, including personal development.

The Medical Director noted that himself and the Director of Workforce have begun a piece of work to reduce the gender pay gap, although it was noted that any improvement is expected to materialise at a steady pace, over a long period of time.

Mrs F Thorpe asked for assurance around staff access to psychological support services, considering the significant backlog nationally.

The Director of Workforce advised that there is now fast track access for staff to Improving Access to Psychological Therapies (IAPT) services and that assessment formulation and triage is accepted as the official route for IAPT access.

45/22 Board assurance framework

The Chair introduced the item, noting that this would be the final review before the document is updated to line up with the 2022/23 corporate objectives and that many of the objectives set during the current year have been achieved and will therefore be removed.

The Chair asked whether both doctors and nurses provide cross cover in tackling the issues of sepsis and acute kidney injury.

The Medical Director noted that the two do work together and that medical support is currently being provided in terms of AKI, since the dedicated nurse in this areas is on sick leave. Achievement of the reduction in sepsis cases has been rolled over to the next year - a plan is in place to address this and achieve the associated 2022/23 corporate objective.

Mrs A Tumilty queried whether the Trust have identified what prevented achievement of this target. The Medical Director noted that, in order to reduce rates, initial monitoring of sepsis must begin within the first 60 minutes of a patient presenting at A&E, however, during the pandemic period, the department has been so busy that this has not been achieved in some cases. He further pointed out that the Trust only have one sepsis nurse. He was positive that lessons learned from this year will be taken forwards to ensure improvement within the next 12 months.

The Chief Nurse reported in respect of C05 that human factors training is on track and that this objective will be achieved before the next meeting. She reiterated that a 67% reduction in hospital acquired pressure ulcers had been achieved.

Mrs A Tumilty questioned whether risks 7.1 and 7.2 are articulated accurately, since they centre on processes rather than the WWL position.

The Director of Workforce advised that this will be picked up in the new document to ensure that it is iterative and agile. She added that, in respect of CO7, a comprehensive learning needs analysis has been conducted and a plan will come soon be brought to the Executive Team for approval.

The Chair noted that the revised BAF would be presented at the next meeting with the 2022/23 objectives.

The Board received and noted the update.

46/22 Well led action plan

The Director of Corporate Affairs reported on the review which had taken place by the Trust's external auditors, Deloitte, as a matter of best practice, as recommended every three years. He explained that each of their 15 recommendations has been summarised here in an action plan which was presented for approval by the Board of Directors. He clarified that the plan will be provided at every meeting going forwards and the actions RAG rated.

The Chair was pleased with the work which has taken place to date and added that many of the actions would be closed off in the coming weeks. He thanked the Corporate Affairs team for their work on this.

The Director of Corporate Affairs noted that a review team would be brought back within the next 18 months, to ensure that best practice has been embedded and progress made. The review team may then will be asked to focus on key areas, to ensured continued development.

Mrs A Tumilty queried when the next Care Quality Commission (CQC) inspection would be likely.

The Chief Executive advised that he has observed a more risk based approach being taken by the CQC in that they are focussing on organisations around which they have concerns. He therefore did not consider that WWL would be subject to inspection in the near future.

The Board of Directors APPROVED the action plan provided.

47/22 Corporate objectives 2022/23

The Director of Strategy and Planning gave a summary of the report provided in advance of the meeting. He noted the intention for the objectives to be provided in a 'plan on a page'' format ultimately.

48/22 Prof C Austin queried how CO6 would be achieved, given the low response rate to the staff survey.

The Director of Workforce noted the initial aim to get to a 50% response rate and to include response rates within BAF updates so that these can be monitored.

Mr I Haythornthwaite noted CO10, being to deliver the financial plan, providing value for money services. He predicted that the amount of resource provided in year would be insufficient to achieve the targets set for the Trust and queried whether WWL will need to secure a significant amount of additional funding to achieve this.

The Chief Finance Officer advised that the wording of this objective is set intentionally to allow the Trust to conclude ongoing work and reach an agreed planning position. The Chair summarised that the wording would remain until the system wide funding intention is confirmed.

Mrs L Lobley was concerned that the 'partnerships' objectives are focussed on the locality but appear to give minimal consideration to the upcoming move towards an Integrated Care System (ICS).

The Chief Executive noted that as the objectives are rolled out internally, the language will be amended as appropriate. He advised that the Integrated Care Board will not be in creation until closer to the end of the financial year and that the objectives can be reconsidered in light of this at the appropriate time. A discussion ensued around the importance of including partners in the work to achieve the objectives set and the difficulty that the Trust would face in trying to do this alone.

The Chief Finance Officer noted CO14 and queried whether WWL are not currently paying a real living wage.

The Director of Workforce advised that this is the case and that a programme of work is underway to understand the socio economic impact that this is having on staff and the financial implication on the organisation of remedying this issue.

Mrs A Tumilty noted a lack of comment around the prevention of healthcare problems and partnerships with organisations on schemes to help people to stay healthy, rather than providing treatment for illness which may be preventable. She felt that as a system and as a Trust this should be an area of future focus.

The Chief Executive was supportive of this but noted that these kind of objectives must be set at the appropriate time, when those relationships with the right partners have been established.

The Board of Directors APPROVED the revised corporate objectives for the financial year 2022/23, as presented.

49/22 Safe nurse staffing report

The Chief Nurse presented the report which had been circulated in advance of the meeting. She drew the Board's attention to the fact that usually, incidents are not

related to the shortage in staffing but that this month, early review does suggest a correlation between the two.

Mrs L Lobley asked at what point in the day staffing is reviewed. The Chief Nurse advised that this is done at lunchtime and now includes the maternity team.

The Board received and noted the report provided.

50/22 Maternity dashboard

The Chief Nurse presented the set of reports which had been circulated in advance of the meeting. She highlighted that often, the issues in this area are categorised in to one of four recurring themes, being around safe staffing, well trained staff, learning from incidents and listening to patients. Improvements in all of these areas at WWL are aided by the positive staff culture across the organisation.

The Chief Executive advised that he has asked the Chief Nurse to formally acknowledge the fifteen national recommendations made through the Ockenden and report back to the Board on this in due course.

Dr S Elliot felt reassured by the data provided overall, although expressed concern around the low figures shown in terms of breastfeeding, noting the health benefits that this offers to both mother and baby. It was noted that a cross borough and system effort would be required to increase the figure here, particularly given that the trend in the Wigan borough has been to favour bottle feeding.

Mrs L Lobley asked whether mock inspections could be run within the department.

The Chief Nurse responded to advise that the culture of safety across the organisation is widespread and should not focus on individual teams. The Ockenden recommendations do include a recommendation for educational sessions to be run with staff and the WWL ASPIRE ward accreditation scheme includes mock inspections being run on a ward by ward basis, to assess accreditation levels. She noted that the maternity ward will be part of that going forwards.

Mrs A Tumilty noted that the self assessment highlighted some of the areas in which WWL could improve. She queried the issues highlighted with staff induction and asked how the threshold would be met for a detailed review to take place.

The Chief Nurse advised this would happen when the figure is identified as low compared to other organisations. A review of the nursing leadership team has been concluded, which includes maternity and both ward leaders and matrons are included in succession planning.

The Chair requested that going forwards, reports include a more focused introduction to highlight key matters. He noted that the format will be revised once the accreditation scheme is more developed.

ACTION: Chief Nurse

The Board felt adequately assured on receiving and noting the paper.

51/22 Infection control board assurance framework

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

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

52/22 Staff survey report

The Deputy Chief Executive introduced the item, noting that the staff survey result is used as part of a set of tools, including WWL's pulse survey results, to inform work around improving staff experience and culture.

The Director of Workforce provided a summary of the report which had been circulated in advance of the meeting.

The Chief Executive highlighted that moving forwards, there will be competition in terms of retaining good staff and that in order to do this, staff must be able to appreciate the tangible differences offered by WWL over other employers. He congratulated the Executive Team on the progress made with the 'Our Family, Our future, Our Focus' initiative, which was begun as a shared corporative objective.

The Chair noted that the response rate was low and asked that the People Committee consider how views of additional staff who had not participated in the survey can be ascertained moving forwards. He was pleased to see that morale rates are so high and was hopeful that other staff do feel the same, despite not having completed the survey.

ACTION: Director of Workforce

The Board received and noted the update and thanks were offered to the staff engagement team for their work on the survey throughout the pandemic.

53/22 Integrated performance report

The Deputy Chief Executive provided a supplementary update to the score card provided.

Dr S Elliot queried the low figures in terms of cancer performance.

The Deputy Chief Executive conceded that WWL have not performed as well as was hoped in this area, and that this is a key area of concern. The Trust has seen an 80% increase in colorectal referrals in and increase in breast referrals. She highlighted that more 'one stop clinics' are required to allow breast referral patients to be stepped down much more quickly and effectively and that a business case has been developed to address this issue.

The Medical Director also provided a supplementary update, presenting for the Board a copy of the summary hospital-level mortality indicator data. He advised that WWL have improved drastically in this area. In respect of the hospital standardised mortality ratio WWL are the third best rated in region. The target around sepsis has not been achieved but will be addressed through the corporative objectives for 2022/23.

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

54/22 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 Board diversity policy be APPROVED as presented.

2. THAT the chances to GTEC governance arrangements be APPROVED as presented.

3. THAT the finance report be received and noted.

4. THAT the committee terms of reference for 2022/23 be APPROVED as presented, save for those pertaining to the Quality and Safety Committee, which were requested to be removed from the consent agenda and amended following discussions between the Committee Chair, Deputy Chief Executive and the Committee's Executive Leads.

The Chair thanked both NEDs and Executive Directors for assisting with the review of committee terms of reference. He noted that going forwards, attendance has been streamlined in accordance with recommendations made by Deloitte's Well Led review, to ensure that meetings are more assurance focussed. He summarised the general changes made across all committees and asked for support in ensuring that the terms of reference are embedded throughout committee operation moving forwards.

55/22 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.

56/22 Date time and venue of the next meeting

The next meeting of the Board of Directors will be held on 8 Jun 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
6 April 2022	50/22	Maternity dashboard	Include a more focused introduction to highlight key matters in future reports	Chief Nurse	8 Jun 2022	
6 April 2022	52/22	Staff survey report	Ensure that the People Committee consider how views of additional staff who had not participated in the survey can be ascertained moving forwards	Director of Workforce	8 Jun 2022	

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	08/06/22
Presented by:	Chief Executive
Prepared by:	Director of Communications and Stakeholder Engagement
Contact details:	T: 01942 822170 E: anne-marie.miller@wwl.nhs.uk

Executive summary

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

Link to strategy

There are reference links to the organisational strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

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

Legal implications

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

People implications

There are no people risks associated with this report.

Wider implications

There are no wider implications associated with this report.

Recommendation(s)

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

The WWL Way

Report

The teamwork, togetherness, and expertise of WWL staff continues to strengthen even further, despite continued, significant pressures on our services as attendances to our hospitals over the past months continue to be above average. Our staff continue to work incredibly hard to provide care and treatment to patients as quickly as possible, particularly those with life-threatening conditions and I would like to thank them for their support. Our priority, as always, is to provide safe and high-quality care for people across the Wigan Borough and to always be there for people who need our help, in emergency, urgent and non-urgent situations. It is down to the adaptability, patience and resilience of our teams that we have been able to maintain the progress with our Elective Recovery Plan and our pursuit to end the 104-week waits for patients, whilst reducing the 52-week wait overall. At the time of this report being published, I am delighted to say we are well on track to be able to achieve both of these targets.

As we continue to progress, several changes have been made regarding visiting restrictions for patients within our hospitals, and we have also adapted our infection prevention and control (IPC) guidelines to accommodate 'living and working with COVID-19'. This has created a major positive for our patients and those who care for them, as we have been able to increase the number of visitors for inpatients from one to two. We know how beneficial being able to visit loved ones during their time in hospital can be, both for the patient and for their friends, families and caregivers, so we're extremely pleased to see this change. As the rules on face masks in public settings was removed some time ago, face masks must continue to be worn in all clinical areas within our hospitals, community sites and where care is given to patients in community settings. Reducing the spread of any infections is high on our priority list, which is why we must maintain the high levels of IPC practice, in line with the latest guidance and we thank our patients and visitors for their cooperation.

In the face of our challenges, both new and old, and the continued need to adapt to the demands being placed on our services, we at WWL have always put emphasis on celebrating our staff and their achievements, but equally as importantly, we advocate who our staff are, what they do and why they do it. Earlier this month, colleagues Trust-wide celebrated International Day of the Midwife and International Nurses Day. Led by our Chief Nurse, Rabina Tindale, and her nurse leadership team, wards, and departments from across WWL came together to celebrate both days, and I was pleased to see such inclusive celebrations, with many teams extending their gratitude to colleagues who support our nurses. International Nurses Day also saw the annual presentations of several awards for nursing colleagues, as well as an evening of recognition for our Accreditation System Providing Improvement and Recognition in the care Environment (ASPIRE) programme. Due to the success of the programme, 21 wards are now in scope, with 15 of WWL's wards achieving bronze status, and six accomplishing silver status. This is a real achievement and is just the beginning of the Trust-wide objective of ensuring all areas and departments across WWL are ASPIRE certified. The ASPIRE system was created to stimulate the improvement of the care delivered and strengthen the community's confidence in our hospitals and, in addition, enhances leadership across the Trust by recognising and sharing good practice.

In May we also recognised colleagues on Operating Department Practitioners Day and Human Resources Day, as well as providing support to a number of awareness initiatives such as Mental Health Awareness Week, Dementia Action Week, Global Accessibility Day and International Day Against Homophobia, Biphobia and Transphobia to name just a few. Days such as these are key moments in our calendar at WWL, as they give us the opportunity to highlight the day-to-day achievements of colleagues across a wide variety of services and departments, whilst highlighting important social topics and strengthening our views on being an equal, diverse, and inclusive organisation to our staff, our patients and the wider public, locally, regionally and nationally.

At the time of publishing this report, we are currently supporting NHS Sustainability Day, which serves to highlight the impact WWL has on our environment and the health of our community and patients. A number of our teams are promoting Greener WWL initiatives on a daily basis, but I'd like to highlight our Catering Team who have produced a season menu of locally grown produce to

help to reduce food waste and carbon emissions and contribute to healthier lifestyles. All of this sits within the WWL Green Plan - a strategic document to supports the Trust's delivery of net zero carbon emissions and sustainable healthcare over the next three years. Climate change, pollution and environmental degradation are major contributors to the significant health challenges of the 21st century and now, thanks to our staff, partners, and suppliers, we are already well on our way to addressing these issues. Recently, the Trust successfully secured a significant grant from Transport for Greater Manchester (TfGM) to provide more modern cycle parking facilities. This will come in the form of cycle hubs and cycle lockers at Royal Albert Edward Infirmary, Wrightington Hospital, Leigh Infirmary and Thomas Linacre Centre. You can find out more about how other green initiatives on our website.

Another big part of our future as an organisation is the way in which we use research to shape and underpin the safe and effective treatment of our patients, and our progress in this field continues to know no bounds. At this time I'd like to congratulate Professor Adam Watts on being appointed to the role of WWL's Clinical Director for Research, Innovation and Clinical Trials. Professor Watts has a wealth of knowledge and expertise which will enable him to lead the development and growth of our academic research portfolio and integration of research into the overall activity of WWL. Alongside this, our new Research Strategy has now been published and outlines our aims to develop partnerships which will maximise our research potential, nurture a culture that embeds research as a core component of high quality service delivery, and develops a sustainable research workforce. This strategy is available to view in full on our website.

Our commitment to advancing our technology has developed even further in recent months with the launch of pioneering gastrointestinal artificial intelligence (AI) software at Leigh Infirmary. The endoscopy unit has become the UK's first site to pilot this software from American company, Argus, which will improve the quality of endoscopy procedures, enhancing our ability to detect and size polyps during a procedure. We hope improved polyp detection can reduce the risk of developing bowel cancer in the future and improve outcomes for our patients. Equally, further improving our services for patients is the arrival of a new online booking system for blood test appointments and the pilot of a text reminders service is soon to be rolled out across most services within the next few weeks. These are all excellent examples of where our digital journey is taking us, and in the coming months we will be publishing our new Digital Strategy, which will outline our aim to digitally enhance healthcare for all, as well as the mechanisms we will put in place to achieve this.

Not only are we improving and innovating to provide our colleagues with the tools to provide the best possible services and care to our patients, but we are also actively investing in how we make WWL the best possible environment for our staff to work in. Staff wellbeing is central to this, which is why I am extremely pleased to announce the completion of the Wellness at Work Lounge on the Royal Albert Edward Infirmary site, giving colleagues a place to rest and recuperate, with the use of shower facilities, lockers and bicycle storage, as well as areas for debriefings and wellbeing meetings to take place. Our Chief People Officer, Alison Balson, will be officially opening this new addition to our site on Tuesday 28th June.

It's important to take a moment to thank all our staff at the Thomas Linacre Centre (TLC) who celebrated its 20th Anniversary last month. Our TLC building is home to many of our key services and clinics for outpatients and the community not least, antenatal, phlebotomy, paedeatrics and cardiology. It was important that myself and the Executive Team attended the week-long celebrations, with visits across one week, to each of the departments to celebrate this significant milestone and engage with staff who call the centre their home. I look forward to celebrating many more achievements and milestones as the year progresses, and I would like to actively encourage our staff, patients and the public of the Wigan Borough to join WWL in any celebrations to come.

Finally, I want to highlight important changes to the NHS system that come into place on 1 July 2022. Integrated care systems and partnerships are being set up across the country to help organisations work better with the public to keep everyone healthier; plan and deliver health services more effectively; make sure everyone is treated equally and fairly; help the NHS become as efficient as possible, and also help it contribute to the wider economy. The Health and Care Act 2022, which includes plans to establish Integrated Care Systems (ICS) on a statutory footing as of 1 July 2022, has completed the parliamentary process and is now law after it received Royal Assent on 28 April. This is a welcome and important step in the journey towards establishing 42 ICSs across the whole of England. Regionally, it means that plans to form a new statutory organisation, NHS Greater Manchester Integrated Care, can continue to progress as expected with a launch date of 1 July 2022. In addition to the arrangements at a Greater Manchester level, there will be integrated care partnerships in each of our 10 districts or localities. NHS England currently have three draft documents out for Trust consultation that will sit under a revised Provider Licence (currently in development) which will soon apply to all Trusts; the documents reflect the passing of the Health and Care Act 2022, updating governance arrangements where relevant.

The Board is fully committed to partnership working and we will continue to work in collaboration with the Healthier Wigan Partnership, our neighbouring Trusts and NHS Greater Manchester to ensure our communities are provided with high-quality, equitable treatment and care that they need and deserve.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Audit Committee
Date of meeting:	5 May 2022
Chair:	Ian Haythornthwaite

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

ALERT

- A limited assurance report was received in respect of private patients and overseas visitors – the Committee have asked for a further action plan and update to be presented at a future meeting

ASSURE

- Moderate assurance reports were received in respect of conflicts of interest, payroll (control design) and clinical governance. Substantial assurance was affirmed in respect of control operation and the assurance framework met NHS requirements although some improvements were suggested. The Committee will track follow up of recommendations with management.
- The Committee noted that Trust's compliance with the NHS FT code of governance.
- The Committee are pleased to advise of the substantial assurance received through the head of internal audit opinion from 2021/22.
- The counter fraud workplan was approved.
- Risk deep dives carried out in three areas and the Committee were assured about the level of risk management in place in these three areas:
  - Depleted Microbiology Service
  - RAEI theatre staffing
  - Symptomatic breast imaging request: waiting times
- The Committee holds assurance on the Trust's BAF and risk register and reviewed latest version.

ADVISE

- The legal services annual report was deferred until the next meeting.
- The external audit plan was received and approved.
- The Committee noted that the BAF is being reviewed in light of recent developments and the new financial year. It was noted that this will be considered at the risk session in the NED workshop on 25 May 2022 by the NED members of the Board.
- The Committee received the revised terms of reference for 2022/23 which have been approved by the Board.

▪ The Committee received the draft annual accounts and noted that they will now be subject to audit by KPMG. ▪ The Committee reviewed minutes of the Risk Management Group from March 2022.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
▪ As noted above.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Quality and Safety Committee
Date of meeting:	24th May 2022
Chair:	Francine Thorpe

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

ALERT

- Non-achievement of the objective for 2021/22 in relation to a 25% reduction in sepsis related mortality. This objective will be rolled over into 2022/23
- Workforce challenges were hihglighted in relation to the Trust's ability to meet the Continuity of Care (CoC) standards within maternity services. Plans outliend did confirm that the most vulnerable patients would be seen as a priority for CoC once re-established.
- Complaints response times remain a challenge; however this is an area of focus for 2022/23 and actions have already begun to improve the timeliness and quality of complaints responses
- IPC report confirmed 53 cases of C Difficile for 20/21, against a threshold of 46 as set by NHSE. This is in keeping with other organistions and the thresholds for 2022/23 are likley to be reviewed to reflect this.

ASSURE

Year end reports received for 2020/21 BAF objectives noted the following acheivements:

- 50% reducton in mortality related to AKI agaisnt a target of 25%
- Trust SHMI position is now within the expected range (data to January 2022)
- Hospital Standardised Mortality Rate (HSMR) is now lower than expected and a notable improvement seen in weekend HSMR
- 67% reduction in Hospital Acquired Pressure Ulcers (HAPU) and a 37.5% reduction in Community Acquired Pressure Ulcers (CAPUs).
- Reduction of Serious Incidents reported in relation to pressure ulcers, both HAPU and CAPU are 66%.
- 21 wards assessed as part of the revised accreditation process; 15 rated as bronze, 6 rated as silver
- 71% Ward Managers attended Human Factors training against a target of 50%

- Maternity services presented a gap analysis in relation to the recommendations outlined in the Ockenden 2 report. RAG rating was reviewed. Links maintained with the national and local matenity networks

- Thematic analysis presented in relation to complaints and PALs enquiries including evidence of assurance of actions taken following negative service user feedback. High numbers of concerns raised to PALs being resolved "on the spot"
- The Trust has now implemented the National Standards of Healthcare Cleanliness (NSHC), evidenced by the appropriate auditing of the clinical areas.
- IPC report confirmed zero Trust–assigned MRSA Bloodstream infection cases in Q4.

ADVISE

- The committee received a verbal update on the investigation into treatment delays as the formal report has not yet been validated. This will be presented at the next meeting with a focus on issues identified, recommendations and actions taken along with timescales for implementation.
- A presentation was received in relation to actions being implemented to re-introduce patient experience feedback. This included links with Wigan Healthwatch, and Wigan Borough Council. Improvement actions were outliend in response to service user feedback including the revision of the carers passport. In response to a request from the Governor Observor at the meeting the presentation will be taken to the next Governors meeting. The Q&S Committee will retain oversight of progress in this area through regular reports.
- The ward accreditation report whilst positive in many areas did hightligt a number of areas where improvements are required across the organisation. Assurance was sought that these would be addressed and the Committee asked for further information to be presented at future meetings.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- 8 risks remain open against the 2021/22 BAF objectives these were discussed and will be reviewed and mapped against the 2022/23 objectives for presentation at the next meeting

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. ▪ 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 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.

Title of report:	Board Assurance Framework (BAF) Report
Presented to:	Board of Directors
On:	8 June 2022
Presented by:	Director of Corporate Affairs
Prepared by:	John Harrop, Head of Risk
Contact details:	E: john.harrop@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 The 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 bimonthly 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, by:

- 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. Board Assurance Framework review

2.1 The format of the BAF has been reviewed against the 360 Assurance, Audit Yorkshire and MIAA 2020/21 Provider Board Assurance Frameworks Benchmarking exercise and the following changes have been incorporated for 2022/23:

- Risks have been mapped to the new corporate objectives 2022/23;
- Risks statements are written clearly, in such a way as to identify the cause, the uncertain event and the resulting effect/impact upon the relevant objective(s) of the trust;
- Gaps in controls and assurances are included, together with current controls and assurances;
- Scores are tracked over time including the original date that the risk was identified;
- Target scores are spilt into the optimal risk score (green dotted line - what we are aiming for) and tolerable risk score (yellow dotted line - what we are willing to accept given current constraints);
- Golden thread links to the corporate risk register are included;
- Assurances are mapped to the three lines of defence model (1st line: Divisional - functions that own and manage the risks; 2nd line: trust wide - functions that oversee or specialise in compliance or management of risk; and 3rd line: function that provide independent assurance); and
- An overall assurance level has been included.

3. Risk rating matrix

3.1 Each risk in the Board Assurance Framework is rated at various levels – inherent, current, optimal and tolerable – using the following matrix:

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 Extreme	20 Extreme	25 Extreme
Likely (4)	4 Moderate	8 High	12 High	16 Extreme	20 Extreme
Possible (3)	3 Low	6 Moderate	9 High	12 High	15 Extreme
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: Risk rating matrix

3.2 The **inherent** risk score indicates the level of risk prior to the application of control measures or in the event that current controls fail.

3.3 The **current** risk score indicates the current level of risk considering the application of controls, assurances and progress made since the last review.

3.4 The **optimal** risk score indicates our appetite for an individual risk, i.e., the level of risk that we are aiming to achieve in pursuit of our strategic objectives.

3.5 The **tolerable** risk score indicates our appetite for tolerating an individual risk, i.e., the level of risk we are willing to accept given current constraints.

3.6 There are five categories of response to risks available to us – to terminate, transfer, treat, tolerate or take the opportunity.

4. Board Assurance Framework review

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

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

5. New risks recommended for inclusion in the Board Assurance Framework and updates to existing risk assessments

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

6. Risks accepted and de-escalated from the Board Assurance Framework since April 2022

6.1 The current risk score for the following risk has been reduced to 8, the same score as its target risk score:

- Risk 5.1 (3277) Human Factor Training – Releasing Ward Managers to undertake training.

7. Review date

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

8. Recommendations

8.1 The Board of Directors is recommended 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

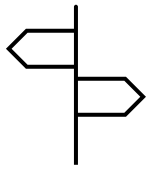
2022/23

The content of this report was last reviewed as follows:

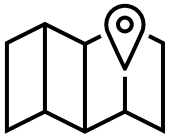
Quality and Safety Committee:	May 2022
Finance and Performance Committee:	May 2022
People Committee:	April 2022
Audit Committee:	May 2022
Executive Team:	May 2022

> **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

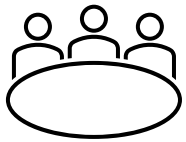


Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how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

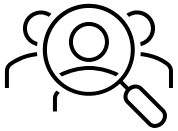


Corporate objectives: Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives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

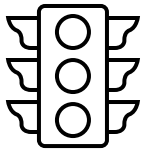
Board Assurance Framework: The board assurance framework provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains risks that are most likely to materialise and those that are likely to have the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

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

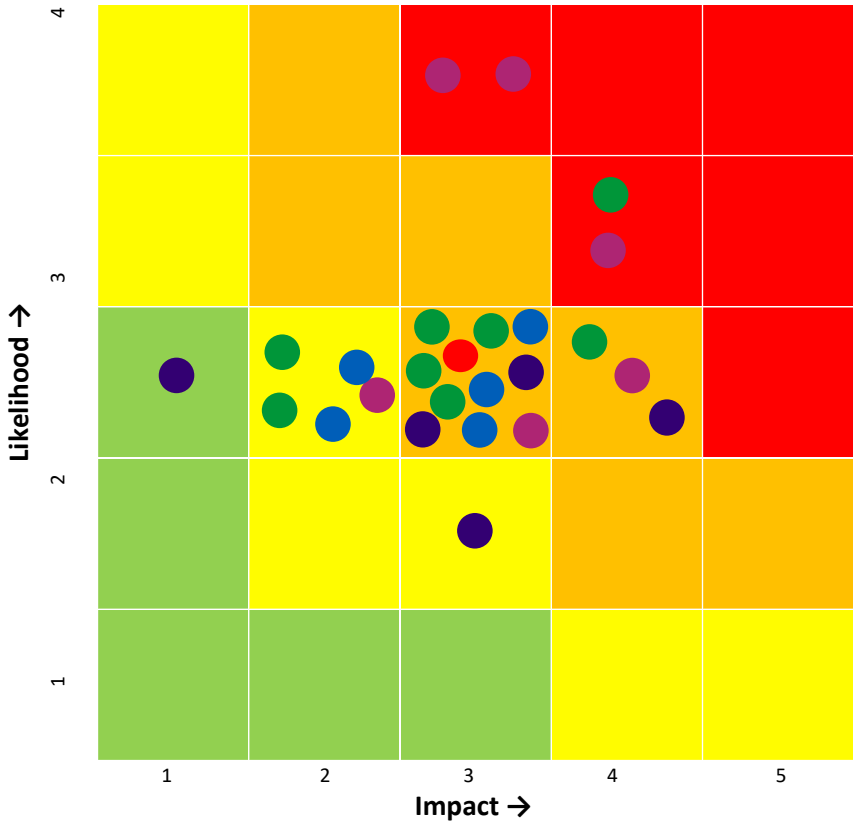
We will…
- Positively impact on the social and economic factors of our Borough
- Develop effective relationships within Wigan Borough and Greater Manchester for the benefit of our patients
- Make progress towards becoming a University Teaching Hospital

Risk management

Our risk appetite position is summarised in the following table:

Risk Category	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 25 strategic risks based on their current scores:



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

Patients

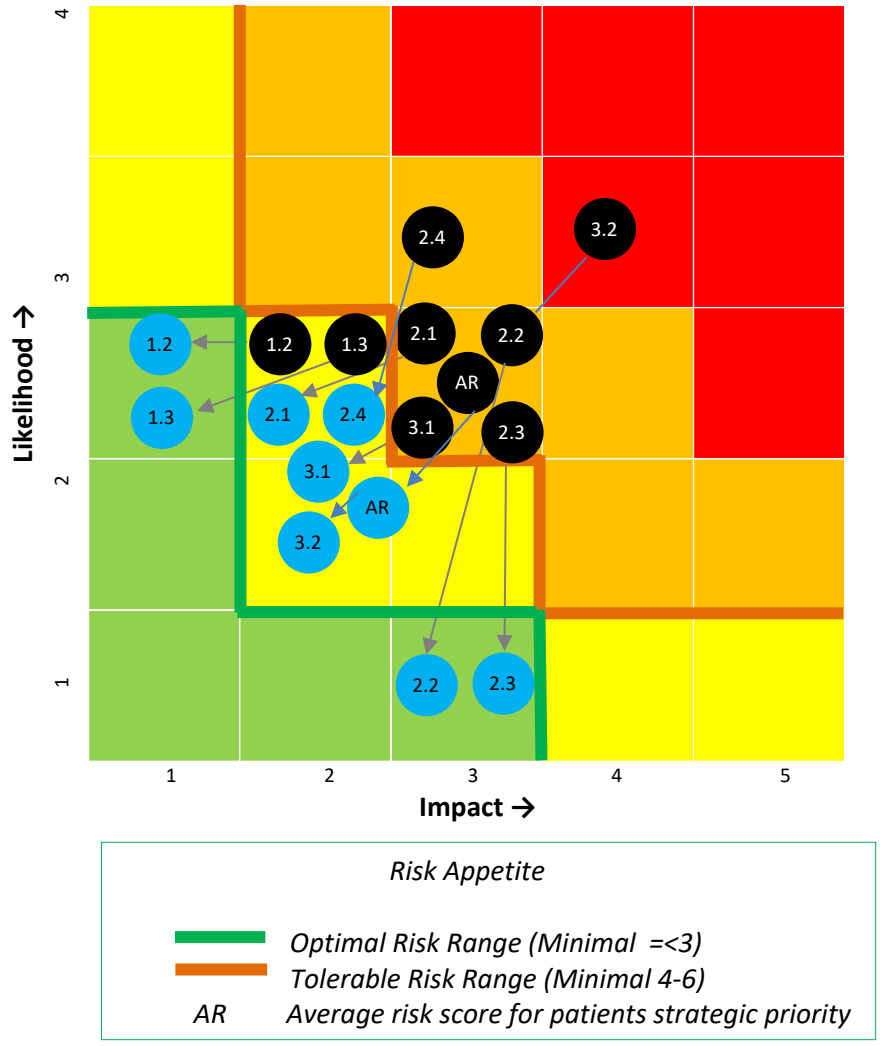
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

Monitoring: Quality and Safety Committee

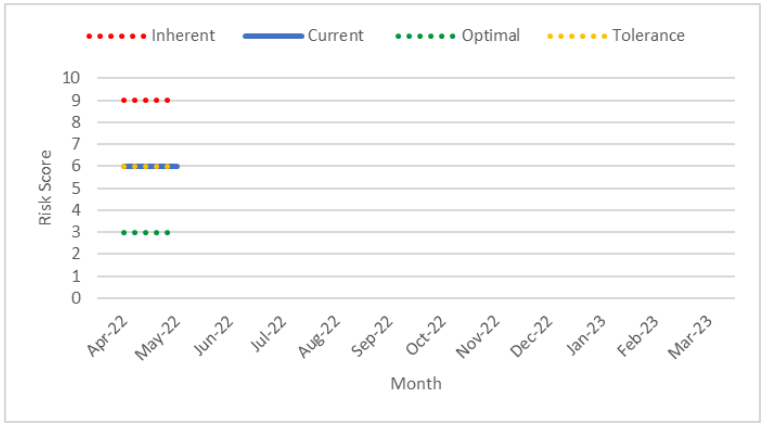
The following corporate objectives are aligned to the **patients** strategic priority:

Ref.	Headline objective
CO1	Improve the safety and quality of clinical services by reducing mortality related to sepsis and sustaining improved mortality relating to Acute Kidney Injury (AKI).
CO2	Ensure patients and their families receive personalised care in the last days of their life, including working with partners to ensure that patient choice on their preferred place of death is honoured.
CO3	Improve the delivery of harm free care by achieving zero preventable category 3 and 4 pressure ulcers in both hospital and community settings.
CO4	Reduce the risk of failure to recognise a deteriorating patient through accurate recording and human factors training.
CO5	Pursue our journey of excellence through our accreditation programme by maintaining bronze rating for all our wards, achieving silver in seven and extending through clinical areas.
CO6	Improve patient experience by listening, acting upon and providing timely responses to complaints raised by patients, friends and family.

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

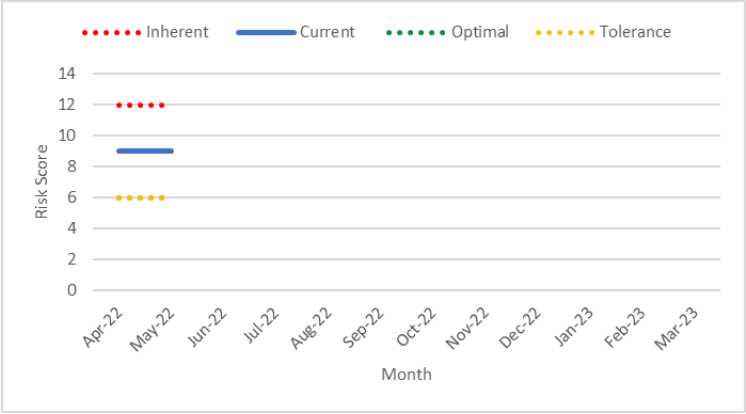


Corporate Objective: **CO1** Improve the safety and quality of clinical services by reducing mortality related to sepsis and sustaining improved mortality relating to Acute Kidney Injury (AKI).							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic	**Risk Title:**	**PR 1: SHMI - Primary and Secondary Care Pathway**			**Risk Appetite**	Minimal		
	Risk Statement:	There is a risk that patients will present late or be readmitted following discharge due to the lack of a joined-up pathway between primary and secondary care.						
Lead Committee	**Quality and Safety**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**9. High**	
Lead Director	**MD**	**Likelihood**	2. Unlikely	1. Rare	2. Unlikely	**Risk category**	Safety, quality of services and patient experience.	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	-	
Date of last review	**27.05.22**	**Risk Rating**	6. High	3. Low	6. Moderate	**Risk treatment**	Treat	



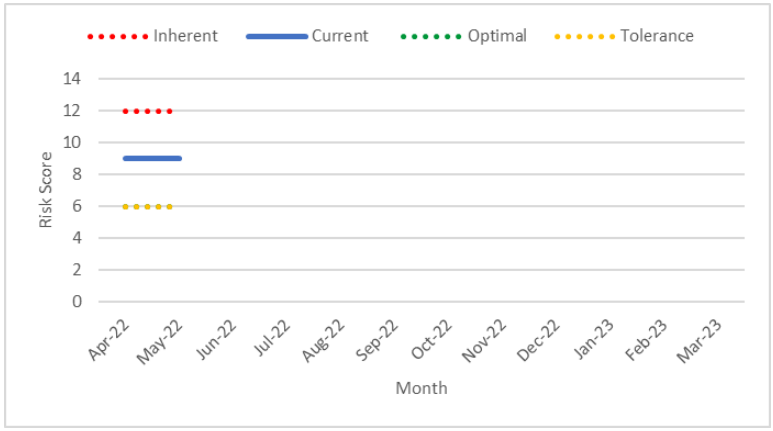
Strategic Opportunity / Threat	**Existing controls**	**Gaps in existing controls**	**Assurances (and date)**	**Gap in assurances**	**Risk Treatment**	**Due Date / By Whom**
Threat: **1.2 (ID 3266)**	• Dedicated resource now in post to provide a link between primary and secondary care and a joint Mortality Improvement Plan has been developed. Progress is reviewed at Mortality Group. • The Trust has moved over from Dr Foster to HED and setup of the system has been completed • Mortality Board in place • Mortality mandatory agenda item at Divisional Clinical Cabinet	• A pathway for common conditions with high mortality needs to be developed and monitored through the Mortality Board	**2nd Line:** • Community AKI pathway live (16/11/21) • Quality & Safety Committee May 22	• No gaps currently identified.	• Community AKI pathway devised; further training requirement identified for community staff before launch. • Community sepsis pathway currently under development. Meetings commenced to develop audit tools to measure quality priorities and tests of change. LD and Community Paediatrics education planned.	31.08.22 MD 31.08.22 MD

Corporate Objective: **CO1** Improve the safety and quality of clinical services by reducing mortality related to sepsis and sustaining improved mortality relating to Acute Kidney Injury (AKI).							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic	**Risk Title:**	**PR 2: SHMI - Discharge and return to hospital**			**Risk Appetite**	Minimal		
	Risk Statement:	There is a risk that patients will return to hospital following a period of admission as a result of being discharged prematurely.						
Lead Committee	**Quality and Safety**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**12. High**	
Lead Director	**MD**	**Likelihood**	3. Possible	2. Unlikely	2. Unlikely	**Risk category**	Safety, quality of services & pat. ex.	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	-	
Date of last review	**27.05.22**	**Risk Rating**	9. High	6. Moderate	6. Moderate	**Risk treatment**	Treat	



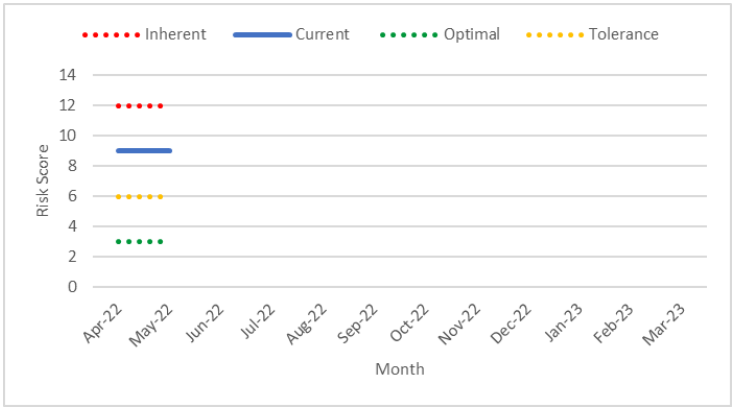
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **1.3 (ID 3267)**	• Dedicated resource now in post to provide a link between primary and secondary care and working on a joint Mortality Improvement Plan. • Monthly meetings with BI/Dr Foster/HED in place to review data • Mortality Board in place • Mortality mandatory agenda item at Divisional Clinical Cabinet • Audit of deaths 30 days post discharge showed 98% patients discharged appropriately	• Review of deaths in community to be undertaken to identify those which have adversely impacted on SHMI.	**2nd Line:** • Oct 21 – Audit of Deaths 30 Days Post Discharge completed – 98% patients discharged appropriately • Further audit completed in September to explore link between length of stay and sepsis - pulling report together.	• No gaps currently identified.	• Audit completed and further workstreams identified to include linking with the discharge letter audit, upskilling in palliative care needs for A&E and education around completion of a comprehensive discharge letter. • Further audit completed in September to explore link between length of stay and sepsis - pulling report together • Community Division Clinical Director (Dr Malhotra) working on reviewing deaths in community • Medical Examiner within the community role out to advert with funding allocated for post	24.03.22 Complete 24.03.22 Complete 31.08.22 MD 31.08.22 MD

Corporate Objective: **CO1** Improve the safety and quality of clinical services by reducing mortality related to sepsis and sustaining improved mortality relating to Acute Kidney Injury (AKI).							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 3: Clinical Services - Recognition, screening and treatment of the deteriorating patient**				**Risk Appetite**	Minimal	
	Risk Statement:	There is a lack of recognition, screening and treatment of the deteriorating patient across the foundation trust						
Lead Committee	**Quality and Safety**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**12. High**	
Lead Director	**MD**	**Likelihood**	3. Possible	2. Unlikely	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**	-	
Date of last review	**27.05.22**	**Risk Rating**	9. High	6. Moderate	6. Moderate	**Risk treatment**	Treat	



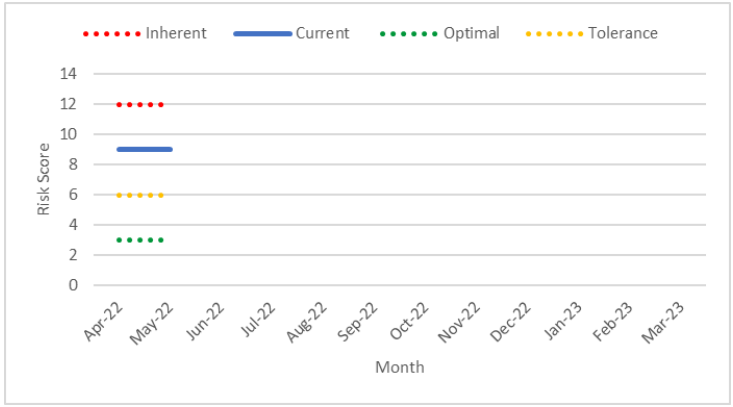
Strategic Opportunity / Threat	**Existing controls**	**Gaps in existing controls**	**Assurances (and date last seen)**	**Gap in assurances**	**Risk Treatment**	**Due Date / By Whom**
Threat: **2.1 (ID 3268)**	• This is a dedicated corporate objective for FY2022/23 • Rapid Improvement Group • Sepsis QI group • Sepsis Improvement Plan • Visibility of AKI and Sepsis Nurse in clinical areas • AKI and sepsis audits undertaken • Themed SIRI panel on sepsis in Sept 2021 focused on improvement work and highlighted achievements to date	• 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.	• Deteriorating Patient Improvement Group continues to meet monthly, themed SIRI to take place on 23 Sept 2021 focusing on improvement work. • Sepsis in HIS now live.	24.03.22 Complete 24.03.22 Complete

Corporate Objective: **CO1** Improve the safety and quality of clinical services by reducing mortality related to sepsis and sustaining improved mortality relating to Acute Kidney Injury (AKI).							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 4: Clinical Services -Limited resources in relation to training and development for staff**				**Risk Appetite**	Minimal	
	Risk Statement:	Limited resources in relation to training and development for staff.						
Lead Committee	**Quality and Safety**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**12. High**	
Lead Director	**MD**	**Likelihood**	3. Possible	1. Rare	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**	-	
Date of last review	**27.05.22**	**Risk Rating**	9. High	3. Low	6. Moderate	**Risk treatment**	Treat	



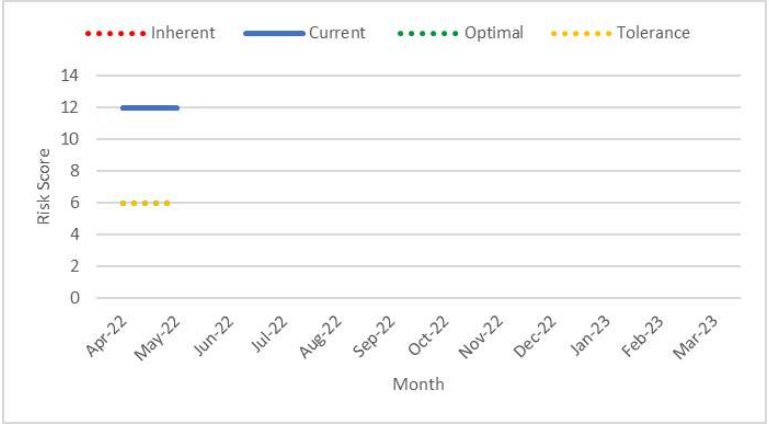
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **2.2 (ID 3269)**	• AKI/Sepsis nurse attends all corporate sessions • AKI/Sepsis nurse attends clinical audit • AKI/Sepsis Bulletins • Learning from incidents • Monthly AIMS • Blood cultures training every 2 weeks via in house trainers who have now undergone train the trainer education programme.	• Workload demands for AKI and sepsis nurses • Reduced AIMS faculty members to support the programme • Reduced number of blood culture trainers	**2nd Line:** • Quality & Safety Committee May 22	• No gaps currently identified.	• In addition to monthly AIMS sessions there is a plan in place for AIMS to be added to Clinical induction programmes once training returns to face to face. • Two blood culture train the trainer role now in place with a further 2 to undergo this training.	31.08.22 MD 31.08.22 MD

Corporate Objective: CO1 Improve the safety and quality of clinical services by reducing mortality related to sepsis and sustaining improved mortality relating to Acute Kidney Injury (AKI).							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR5: Clinical Services -No consultant cross-cover from Salford Royal for the AKI service**				**Risk Appetite**	Minimal	
	Risk Statement:	There is a risk that there may be no consultant cross-cover from Salford Royal for the AKI service.						
Lead Committee	**Quality and Safety**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**12. High**	
Lead Director	**MD**	**Likelihood**	3. Possible	1. Rare	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**	-	
Date of last review	**27.05.22**	**Risk Rating**	9. High	3. Low	6. Moderate	**Risk treatment**	Treat	



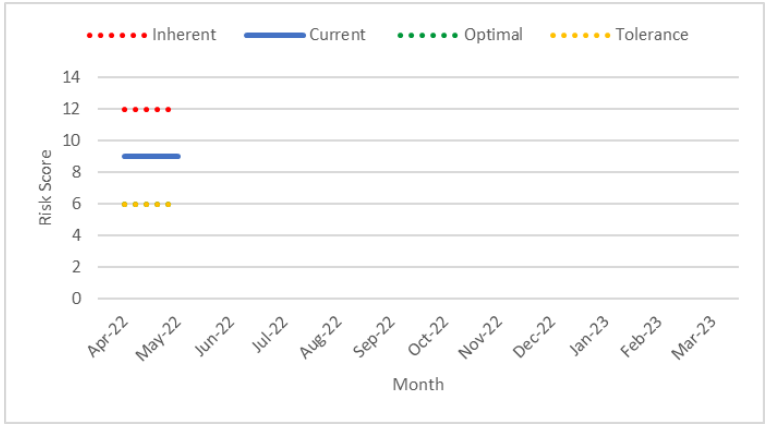
Strategic Opportunity / Threat	**Existing controls**	**Gaps in existing controls**	**Assurances (and date)**	**Gap in assurances**	**Risk Treatment**	**Due Date / By Whom**
Threat: **2.3 (ID 3270)**	• No existing controls listed.	• 52 week cover needed as not currently in place and on-call and annual leave by Salford Royal not currently covered.	**2nd Line:** • Quality & Safety Committee May 22	• No gaps currently identified.	• Clinical lead identified at WWL with an interest in AKI who is able to provide support when required. • SLA being drafted between WWL and NCA to provide 52 week cover	31.08.22 MD 31.08.22 MD

Corporate Objective: CO1 Improve the safety and quality of clinical services by reducing mortality related to sepsis and sustaining improved mortality relating to Acute Kidney Injury (AKI).							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic	**Risk Title:**	**PR 6: Clinical Services - AKI and sepsis services**				**Risk Appetite**	Minimal	
	Risk Statement:	There is a risk that the AKI and sepsis services are currently single nurse led over a 5-day working week.						
Lead Committee	**Quality and Safety**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**12. High**	
Lead Director	**MD**	**Likelihood**	4. Likely	2. Unlikely	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**	-	
Date of last review	**27.05.22**	**Risk Rating**	12. High	6. Moderate	6. Moderate	**Risk treatment**	Treat	



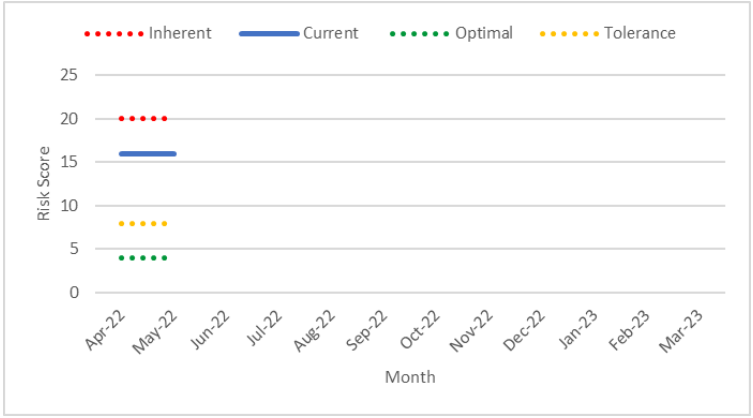
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **2.4 (ID 3271)**	• Separate clinical leads in place • Support is provided by the Critical Care Outreach Team • Information is cascaded through attendance at corporate and divisional meetings • There is a policy and SOP in place • Separate clinical leads in place • Support is provided by the Critical Care Outreach Team • Information is cascaded through attendance at corporate and divisional meetings • There is a policy and SOP in place	• No cover is in place during annual leave, Bank Holidays or other absence. • There is no contingency plan in place for patient safety nurses.	**2nd Line:** • Quality & Safety Committee May 22	• No gaps currently identified.	• AKI and sepsis nurse to work collaboratively to provide cross-cover and ensure that work plans are more aligned. • Business case for Harm Free Care Services had initial review – further information requested and to be re-presented in Feb 2022. This team will include additional resources to support both Sepsis and AKI	31.08.22 MD 31.08.22 MD

Corporate Objective: **CO3** Improve the delivery of harm free care by achieving zero preventable category 3 and 4 pressure ulcers in both hospital and community settings							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 7: Harm Free Care - Avoidable Pressure ulcers**				**Risk Appetite**	Cautious	
	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**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**12. High**	
Lead Director	**CN**	**Likelihood**	3. Possible	2. Unlikely	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**	-	
Date of last review	**27.05.22**	**Risk Rating**	9. High	6. Moderate	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: **3.1 (ID 3322)**	• Training package • Grade 2/DTI Pressure ulcer Panels in place • New pressure ulcer rapid Review template launched for pressure ulcers • New Pressure ulcer policy and procedure now approved	• Staff being able to be released to undergo training. • Package not yet live • Junior workforce • Investigation of developed ulcers are not investigated to a level to allow for full identification of learning • Equipment issues • Beds owned by individual Divisions	**2nd Line:** • Quality & Safety Committee May 22	• No gaps currently identified.	• Pressure ulcer improvement plan update • Datix improvements started to better capture pressure ulcer management.	31.08.22 CN 31.08.22 CN

Corporate Objective: **CO3** Improve the delivery of harm free care by achieving zero preventable category 3 and 4 pressure ulcers in both hospital and community settings							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 8: Tissue Viability Team capacity**				**Risk Appetite**	Cautious	
	Risk Statement:	There is a risk that the Tissue Viability Team are not able to undertake key improvements such as supporting with validation of ulcers, investigations, training and education programmes due to capacity within the Team						
Lead Committee	**Quality and Safety**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**12. High**	
Lead Director	**CN**	**Likelihood**	4. Likely	2. Unlikely	2. Unlikely	**Risk category**	Staff capability & capacity	
Date risk opened	**19.10.21**	**Impact**	4. Likely	2. Moderate	3. Moderate	**Linked risks**	-	
Date of last review	**27.05.22**	**Risk Rating**	16. Extreme	4. Moderate	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: **3.2 (ID 3323)**	• Community and Acute TVN team amalgamated within the corporate Nursing structure. • Care Business Case drafted and submitted to BCOG	• Lack of resilience within the team to support both community and acute services.	**2nd Line:** • Quality & Safety Committee May 22 • Harm Free Measures implemented to date are working effectively. We have seen a 67% reduction in HAPU, and a 37.5% reduction in CAPU in total the reduction of SI reported pressure ulcers, both HAPU and CAPU are 66%.	• No gaps currently identified.	• Further information has been requested before considerations can be made.	31.08.22 CN

People

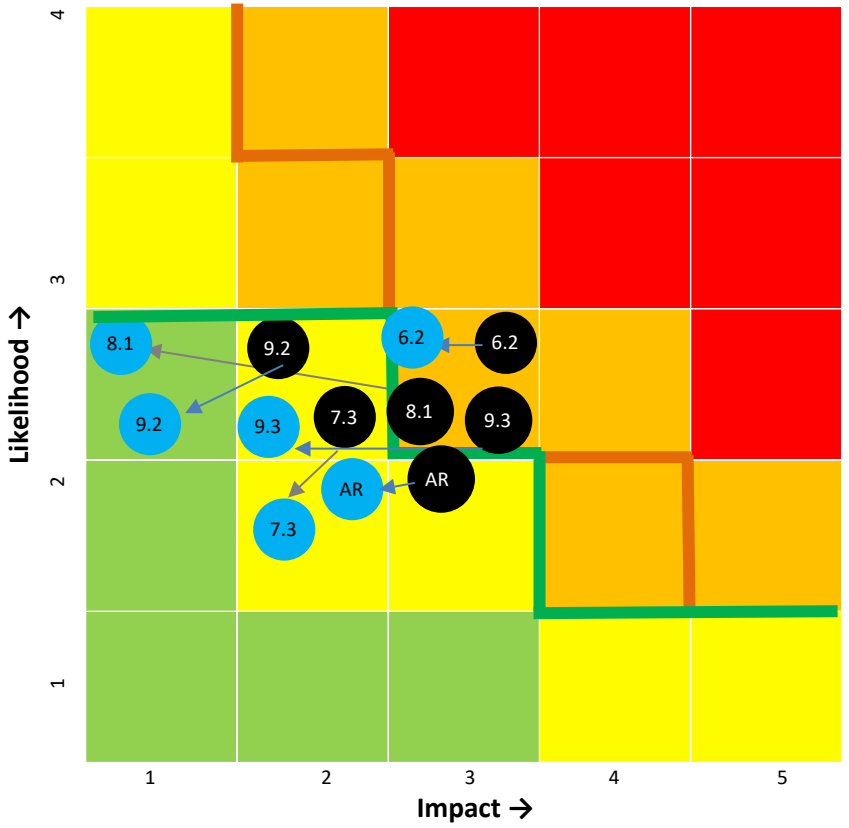
To create an inclusive and people-centred experience at work that enables our WWL family to flourish

Monitoring: People Committee

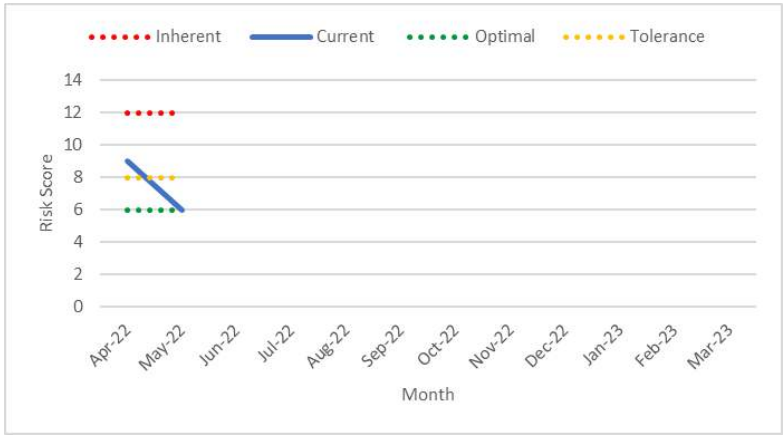
The following corporate objectives are aligned to the **people** strategic priority:

Ref.	Headline objective
CO7	Make working at WWL a positive experience where everyone has a voice that matters through advancing and embedding our just and learning culture programme.
CO8	Support the physical and mental and wellbeing of our WWL family through a range of accessible wellbeing activities.
CO9	Ensure inclusion and belonging for all by increasing diversity and accessibility, reducing inequality and improving experience of protected groups.
CO10	Create an environment where we are always learning by prioritising personal and professional development to enable our people to flourish.

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

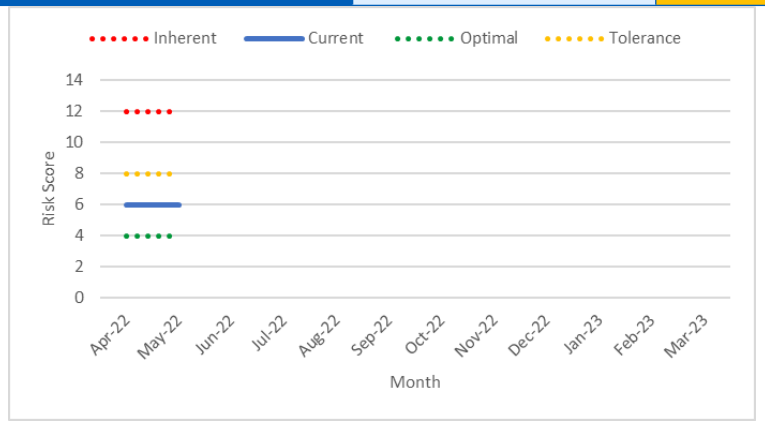


Corporate Objective: CO8 Support the physical and mental and wellbeing of our WWL family through a range of accessible wellbeing activities.						**Overall Assurance Level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 9: Participation in preventative and restorative wellbeing activities**				**Risk Appetite**	Cautious
	Risk Statement:	There is a risk that, because of workload pressures, sufficient time is not available for staff to participate in preventative and restorative wellbeing activities within working hours, meaning that engagement levels will be lower and evidence suggests this will reduce the success of the programme.					
Lead Committee	**People**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**12. High**
Lead Director	**DW**	**Likelihood**	2. Unlikely	2. Unlikely	2. Unlikely	**Risk category**	Staff Wellbeing
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	4. Major	**Linked risks**	
Date of last review	**11.05.22**	**Risk Rating**	6. Moderate	6. Moderate	8. High	**Risk treatment**	Treat



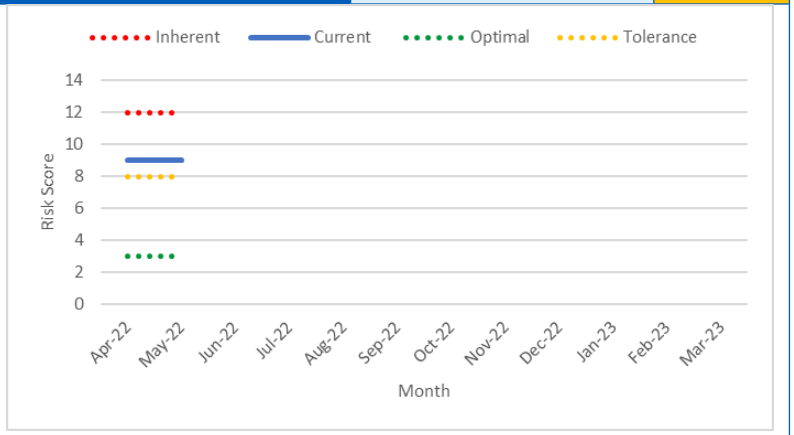
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **6.2 (ID 3279)**	• Targeted in-reach activities in high-risk areas. • Current focus on returning redeployees and critical care. • Feedback from wellbeing walkabouts • Demand for services is outstripping capacity. Evaluation data provided to People Committee and recruitment activity is reducing the vacancy gap. • Well-being measures included in Your Voice Survey, includes knowledge of and accessibility of services • Re-prioritisation and amendment of offers during pandemic wave – well-being report to People Committee	• Commitment to roster time for people to be released as needed. • Colleagues do currently appear to be supported to engage with activities - DNA rates are low and there has been positive engagement with the Theatres stress management team pilot	**2nd Line:** • Information shared at Trust Board Away Day. • People Committee and Trust Board considered National Survey results Mar/Apr 22	None identified.	• Divisional leadership teams Colleagues do currently appear to be supported to engage with activities - DNA rates are low and there has been positive engagement with the Theatres stress management team pilot • Service offers have been amended during the Omicron Wave. Will be reviewed fortnightly to ensure that staff needs are being met. Significant focus on in-reach activities, taking well-being services to teams in their place of work. • A strategic needs assessment will be completed when the Consultant Clinical Psychologist is in post. This will include liaison with divisions regarding finding the balance between operational service delivery and meeting employee well-being needs.	Complete 11.05.22 30.06.22 30.06.22

Corporate Objective: CO10 Create an environment where we are always learning by prioritising personal and professional development to enable our people to flourish.							**Overall Assurance Level**	**Medium**
Principal risk What could prevent us achieving our strategic	**Risk Title:**	**PR 10: Recruitment and Retention – LNA requirements**				**Risk Appetite**	Cautious	
	Risk Statement:	There is a risk that Learning Needs Analysis requirements may not meet the funding criteria set by HEE resulting in gap in funding.						
Lead Committee	**People**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**12. High**	
Lead Director	**DW**	**Likelihood**	3. Possible	2. Unlikely	2. Unlikely	**Risk category**	Staff Capacity & Capability	
Date risk opened	**19.10.21**	**Impact**	2. Minor	2. Minor	4. Major	**Linked risks**		
Date of last review	**11.05.22**	**Risk Rating**	6. Moderate	4. Moderate	8. High	**Risk treatment**	Treat	



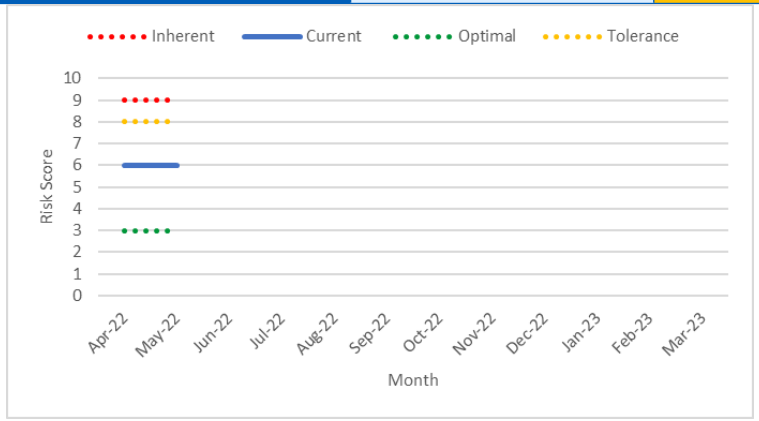
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **7.3 (ID 3283)**	• Full LNA analysis from Divisions being compiled – to be reviewed against available funding sources and provision methods. Update provided to Education Governance Group • LNA reports at Education Governance Committee and People Committee reports • LNA report to education governance – further discussion at NMALT before recommendations presented to ETM • Education Governance - Review of Learning Needs Analysis completed and arrangements in place to maximise use of available HEE funds this year and next. • LNA has prioritisation process has been completed in March by NMALT and Education Governance as final scrutiny stage.	• Ability to roll forward HEE funding allocations (3 year funding, may not be equally distributed over the 3 years).	**2nd Line:** • People Committee Apr 2022	None identified.	• Full detailed review to be completed (CNO, DCNO, DW and education leads) • 2021/22 HEE allocations have not been able to be used due to staffing and operational pressures restricting the ability to release staff. National staff survey raw data shows personal development as our outlying area – to be added as a 5th theme for priority action under Our family, Our future, Our focus • LNAA recommendations to be taken to ETM, following scrutiny at education governance and NMALT. • Prioritisation options paper to be taken to ETM regarding LNA funding gap.	31.08.22 DW 31.08.22 DW 30.06.22 DW 30.06.22 DW

Corporate Objective: CO8 Support the physical and mental and wellbeing of our WWL family through a range of accessible wellbeing activities.							**Overall Assurance Level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 11: Culture - Participation in the programmes**				**Risk Appetite**	Cautious	
	Risk Statement:	There is a risk that participation in the programmes will not be prioritised as a result of other service pressures.						
Lead Committee	**People**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**12. High**	
Lead Director	**DW**	**Likelihood**	3. Possible	1. Rare	2. Unlikely	**Risk category**	Staff Wellbeing	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	4. Major	**Linked risks**	-	
Date of last review	**11.05.22**	**Risk Rating**	9. High	3. Low	8. High	**Risk treatment**	Treat	



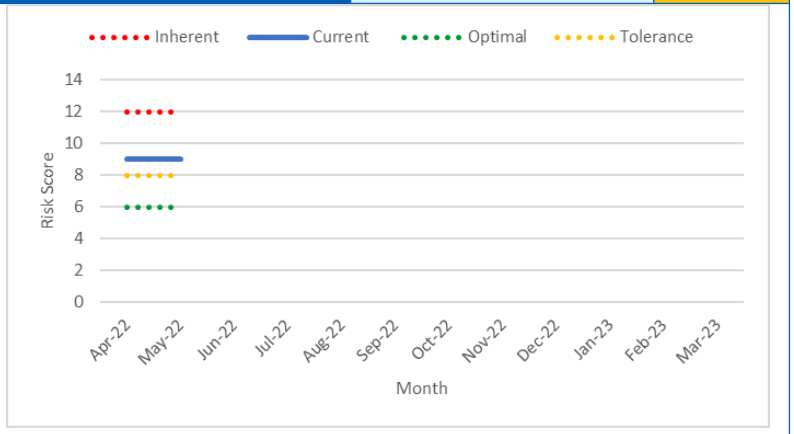
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **8.1 (ID 3284)**	• "Our family – Our future – Our focus" engagement reset programme under DCE leadership • Board visibility of programme • Launch events for Our FFF and associated programmes of work • Prioritisation programme during Omicron Wave - ETM • Commitment to restart of culture and engagement programmes – discussed linked to National Staff Survey	• Metrics to be reported via Board.	**2nd Line:** • People Committee Apr 22	None identified.	• Workforce team to report metrics to board. • Activities to restart in April 2022. • Support Circles for leaders / staff members are being run – these are about creating safe space for leaders / staff members to share. • Leadership and culture programmes restarting March -April 2022	31.08.22 DW 30.06.22 DW 30.06.22 DW 30.08.22 DW

Corporate Objective: **CO9** Ensure inclusion and belonging for all by increasing diversity and accessibility, reducing inequality and improving experience of protected groups.							**Overall Assurance Level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 12: Fairness and compassion - workforce EDI expertise and supporting infrastructure**				**Risk Appetite**	Cautious	
	Risk Statement:	There is a risk that the organisation does not have workforce EDI expertise nor any supporting infrastructure.						
Lead Committee	**People**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**9. High**	
Lead Director	**DW**	**Likelihood**	2. Unlikely	1. Rare	2. Unlikely	**Risk category**	Staff Capacity and Capability	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	4. Major	**Linked risks**	-	
Date of last review	**11.05.22**	**Risk Rating**	6. Moderate	3. Low	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: **9.2 (ID 3287)**	• Workforce EDI specialist recruited (fixed term contract) • EDI strategy update and governance proposal – ETM & People Committee • EDI strategy approved • Expanded staff networks commencing in Q4. Training in place for network sponsors and EDI Champions. • Three independently assessed schemes approved for implementation – Rainbow Badge, Disability Confident & Race Equality Scheme	• No ongoing funding commitment.	**2nd Line:** • Discussions across GM HRDs commenced March 2022, given scarcity of workforce EDI expertise regarding potential shared solutions. • People Committee Apr 2022	No substantive EDI workforce resource to support delivery against strategic aims set out in the strategy.	• EDI strategy to be approved at Board November 2021. • Staff network remit to be expanded (FAME network) and additional networks launched in January 2022 for disability / long term conditions and LGBTQIA.	31.08.22 DW 31.08.22 DW

Corporate Objective: **CO9** Ensure inclusion and belonging for all by increasing diversity and accessibility, reducing inequality and improving experience of protected groups.							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic	**Risk Title:**	**PR 13: Fairness and compassion - Locality-wide workforce EDI strategy**				**Risk Appetite**	Cautious	
	Risk Statement:	There is a risk that we will not get buy-in or funding for a locality-wide workforce EDI strategy.						
Lead Committee	**People**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**12. High**	
Lead Director	**DW**	**Likelihood**	3. Possible	2. Unlikely	2. Unlikely	**Risk category**	Staff Wellbeing	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	4. Major	**Linked risks**	-	
Date of last review	**11.05.22**	**Risk Rating**	9. High	6. Moderate	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: **9.3 (ID 3288)**	• Proposed EDI governance structures that include links to HWP • EDI strategy – Trust Board	• No gaps currently identified.	**2nd Line:** • People Committee Apr 22	• No gaps currently identified.	• Discussions around locality-wide approach required at HWP (Chief Executive and Deputy Chief Executive) • Engagement is still needed with locality partners through Healthy Wigan Partnership. This will form part of the anchor institution work programme.	31.08.22 DW 31.08.22 DW

Performance

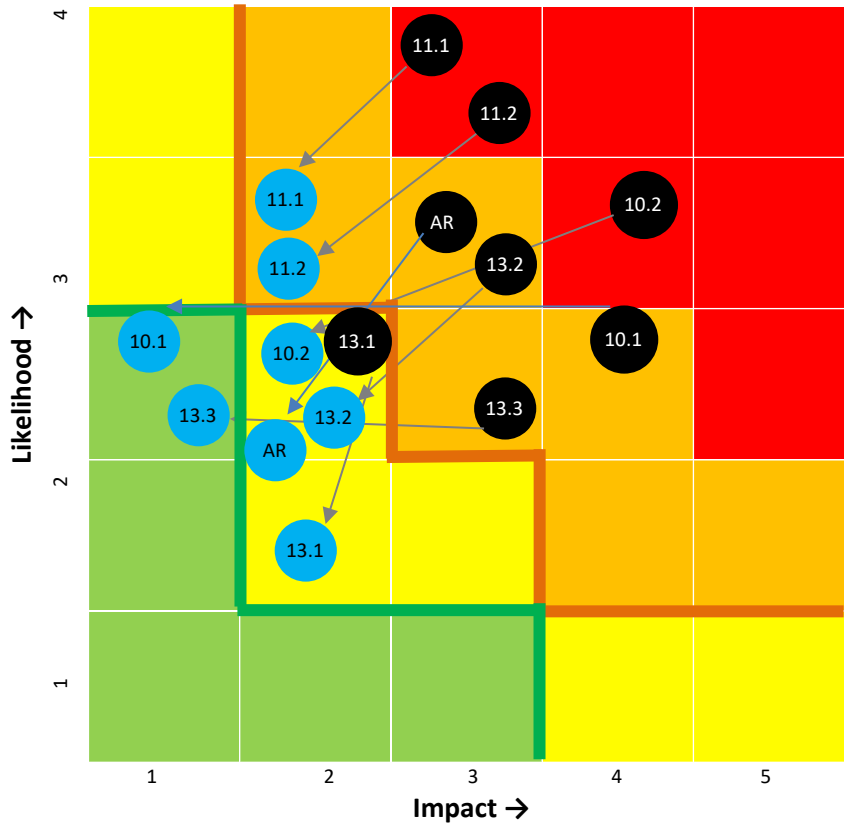
Our ambition is to consistently deliver efficient, effective and equitable patient care

Monitoring: Finance and Performance Committee

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

Ref.	Headline objective
CO11	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.
CO12	Minimise harm to patients in recovering and restoring our elective services.
CO13	PERFORMANCE-Improve our community and urgent emergency care services and pathways.
CO14	PERFORMANCE-Bring our Green Plan to life and make progress towards becoming a Net Zero healthcare provider.

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



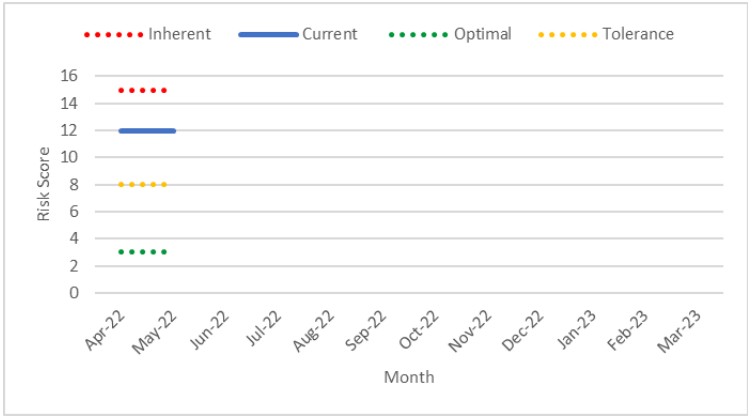
Risk Appetite

Optimal Risk Range (Minimal = <3)

Tolerable Risk Range (Minimal 4-6)

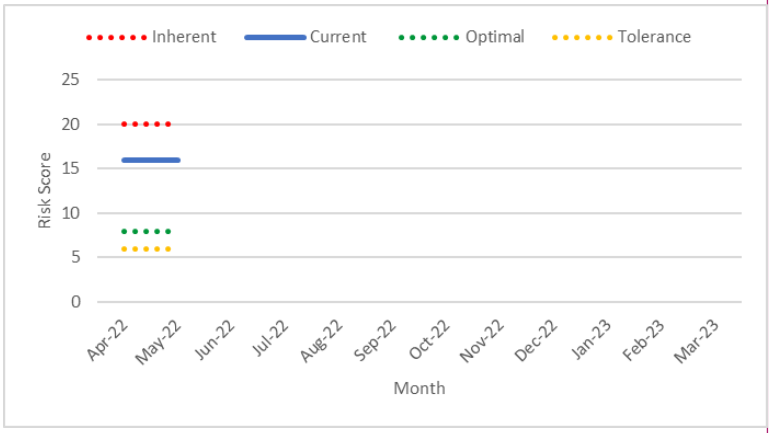
AR *Average risk score for performance strategic priority*

Corporate Objective: **CO12** Minimise harm to patients in recovering and restoring our elective services.							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 14: Elective services - Waiting List**			**Risk Appetite**	Cautious		
	Risk Statement:	There is a risk that because the overall waiting list is growing due to increased numbers of referrals, the waiting list is growing more quickly than we are able to address the backlog which would lead to us not being able to reduce the backlog in a timely way across all three indicators.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**15. Extreme**	
Lead Director	**DCE**	**Likelihood**	4. Likely	1. Rare	2. Unlikely	**Risk category**	Performance Targets	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	4. Major	**Linked risks**	-	
Date of last review	**27.05.22**	**Risk Rating**	12. High	3. Low	8. High	**Risk treatment**	Treat	



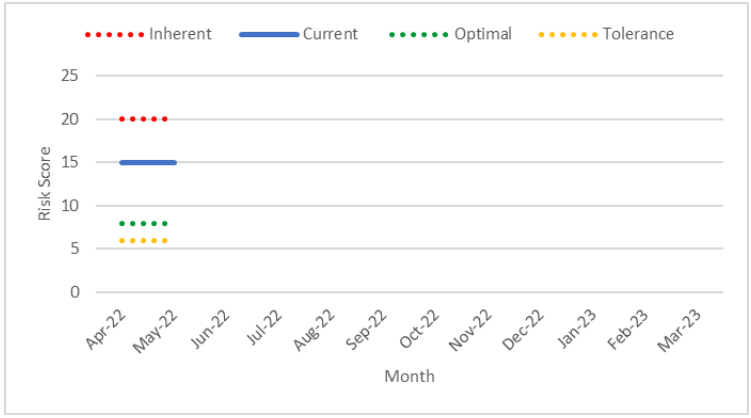
Strategic Opportunity / Threat	**Existing controls**	**Gaps in existing controls**	**Assurances (and date)**	**Gap in assurances**	**Risk Treatment**	**Due Date / By Whom**
Threat: **10.1** **(ID 3289)**	• Regular reviews of risk stratification are undertaken according to clinical priority in accordance with Royal College recommendations. • Additional clinical check has been introduced in Div. of Surgery where largest volume of long waits are. • Patient lists managed by risk stratification • National communications being issued around how patients will be contacted for review (Ext)	• Lack of capacity to undertake reviews of allocated risk stratification across all specialties. • Patients to be given mechanism for getting in contact with GP or WWL if deteriorating.	**2nd Line:** • Finance & Performance Committee May 22	• No gaps currently identified.	• Currently being reviewed by senior leadership teams. Harm reviews undertaken for patients waiting 104 weeks on elective pathways and 104 days on cancer pathways. • Joint correspondence from WWL and CCG being sent to every patient to update them and provide contact information.	31.08.22 DCE 31.08.22 DCE

Corporate Objective: CO12 Minimise harm to patients in recovering and restoring our elective services.							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 15: Core (or core +) activity exceeding the funding available**				**Risk Appetite**	Minimal	
	Risk Statement:	There is a risk that the value of core (or core +) activity exceeds the funding available because we have to use additional bank/agency or independent sector provision, or we are unable to access ERF funding if we exceed our trajectory, meaning that all work cannot be undertaken.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**20. Extreme**	
Lead Director	**DCE**	**Likelihood**	4. Likely	2. Unlikely	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	**27.05.22**	**Risk Rating**	16. Extreme	8. Moderate	6. Moderate	**Risk treatment**	Treat	



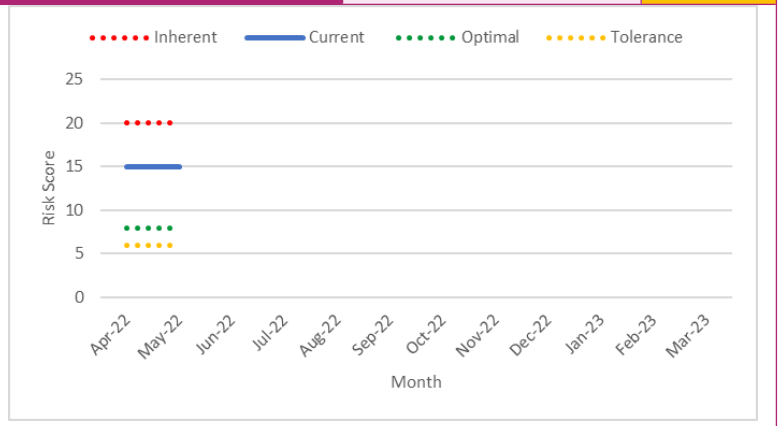
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **10.2** **(ID 3290)**	• Work is ongoing to value the plan that we have submitted and to triangulate that with the activity plan. • GM Elective 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 May 22	• No gaps currently identified.	• No further actions currently identified.	

Corporate Objective: **C11** 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.							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic	**Risk Title:**	**PR 16: Financial Sustainability: Efficiency targets**			**Risk Appetite**	Minimal		
	Risk Statement:	There is a risk that efficiency targets will not be achieved, resulting in a significant overspend						
Lead Committee	**Finance & Performance**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**20. Extreme**	
Lead Director	**CFO**	**Likelihood**	3. Possible	2. Unlikely	2. Unlikely	**Risk category**	Financial Duties	
Date risk opened	**19.10.21**	**Impact**	5. Critical	4. Major	3. Moderate	**Linked risks**	-	
Date of last review	**27.05.22**	**Risk Rating**	15. Extreme	8. High	6. Moderate	**Risk treatment**	Treat	



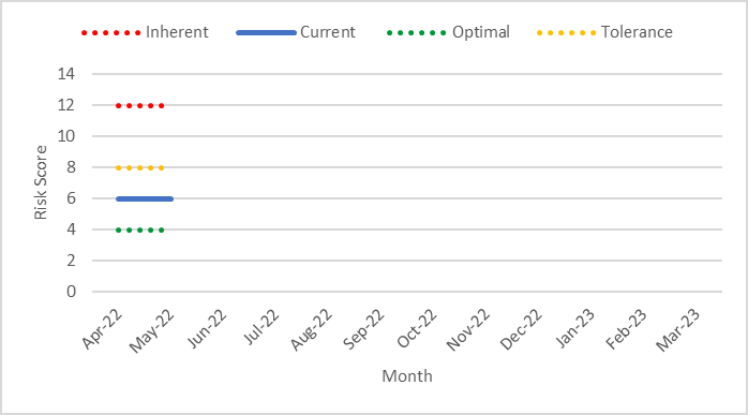
Strategic Opportunity / Threat	**Existing controls**	**Gaps in existing controls**	**Assurances (and date)**	**Gap in assurances**	**Risk Treatment**	**Due Date / By Whom**
Threat: **11.1 (ID 3291)**	• Revised CIP delivery approach following review by Mersey Internal Audit Agency • Monitored via Divisional 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 and oversight	• No gaps currently identified.	**2nd Line:** • Finance & Performance Committee May 22	• Currently behind plan as at M1.	• RAPID recovery meetings held with surgery and medicine • Bi-weekly updates on CIP presented to Executive Team with regular updates at Trust Management Committee	31/03/23 CFO Deputy CFO

Corporate Objective: **C11** 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.							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 17: Financial sustainability: Allocations and efficiencies for H2**			**Risk Appetite**	Minimal		
	Risk Statement:	Final allocations for 2022/23 are unknown and the board-approved financial deficit plan has not been signed off by GM or NHSE/I. The trust will receive significantly less income than the previous financial year.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**20. Extreme**	
Lead Director	**CFO**	**Likelihood**	3. Possible	2. Unlikely	2. Unlikely	**Risk category**	Financial Duties	
Date risk opened	**19.10.21**	**Impact**	5. Critical	4. Major	3. Moderate	**Linked risks**	-	
Date of last review	**27.05.22**	**Risk Rating**	15. Extreme	8. High	6. Moderate	**Risk treatment**	Treat	



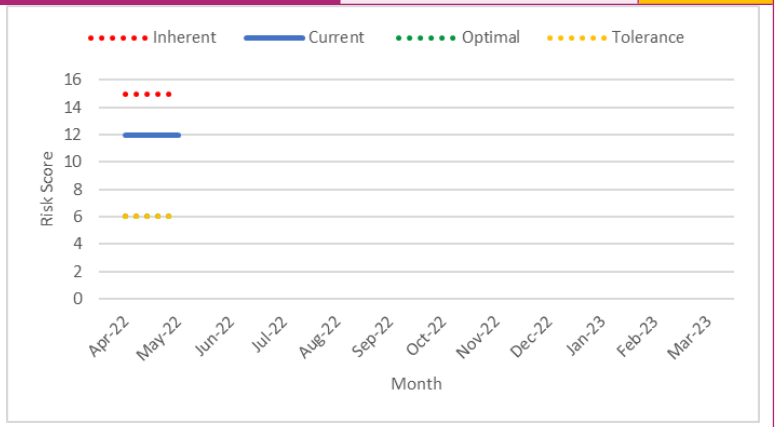
Strategic Opportunity / Threat	**Existing controls**	**Gaps in existing controls**	**Assurances (and date)**	**Gap in assurances**	**Risk Treatment**	**Due Date / By Whom**
Threat: **11.2 (ID 3292)**	• CIP in place with actions as described in PR16 • Continued lobbying via Greater Manchester in respect of additional funding which is appropriate for current clinical capacity (Ext) • Final plan deadline of 20 June 2022, with final Board sign-off anticipated on this date	• No gaps currently identified.	**2nd Line:** • Finance & Performance Committee May 22 • Trust Board 20 June 2022	• Planning ongoing as at June 2022.	• Ongoing negotiations with the GM system in respect of the level of inherent risk contained within the WWL financial plan for 2022/23	20/06/2022 CFO

Corporate Objective: **C11** 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.							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic	**Risk Title:**	**PR 18: Estates Strategy**			**Risk Appetite**	Cautious		
	Risk Statement:	There is a risk that because the clinical strategies are still under development the estates strategy may not address all elements of intended future delivery						
Lead Committee	**Finance & Performance**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**12. High**	
Lead Director	**CFO**	**Likelihood**	2. Unlikely	2. Unlikely	2. Unlikely	**Risk category**	Estates	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	2. Minor	4. Major	**Linked risks**	-	
Date of last review	**27.05.22**	**Risk Rating**	6. Moderate	4. Moderate	8. High	**Risk treatment**	Treat	



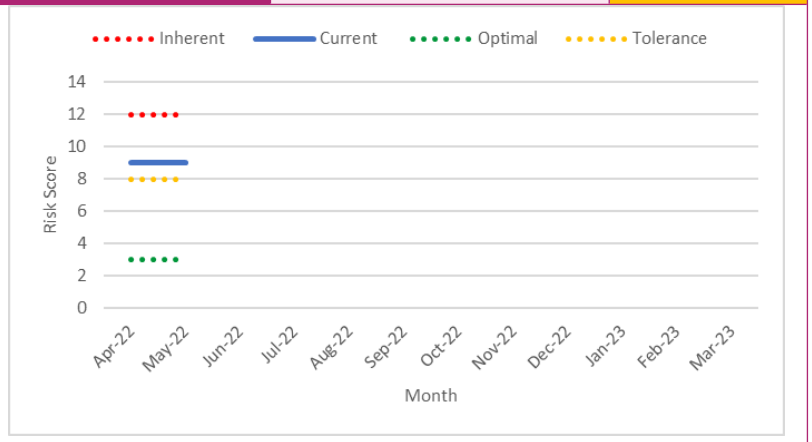
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **13.1 (ID 3294)**	• Capital prioritisation exercise undertaken which will inform the estate strategy and therefore link to the future development of clinical strategies.	• Group to discuss the development of the estates strategy alongside clinical strategy development	**2nd Line:** • Finance & Performance Committee May 22	• No gaps currently identified.	• Director of Strategy and Planning and Director of Estates and Facilities to coordinate	31.08.22 CFO

Corporate Objective: C11 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.							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic	**Risk Title:**	**PR 19: Estates Strategy - Capital Funding**			**Risk Appetite**	Minimal		
	Risk Statement:	There is a risk that because of uncertainties around capital funding arrangements the strategy may assume that more investment can be made than is available.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**15. High**	
Lead Director	**CFO**	**Likelihood**	3. Possible	2. Unlikely	2. Unlikely	**Risk category**	Financial Duties	
Date risk opened	**19.10.21**	**Impact**	4. Major	3. Moderate	3. Moderate	**Linked risks**	-	
Date of last review	**27.05.22**	**Risk Rating**	12. High	6. Moderate	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)	• No gaps currently identified.	**2nd Line:** • Finance & Performance Committee May 22	• No gaps currently identified.	• No further actions currently identified.	

Corporate Objective: C14 Bring our Green Plan to life and make progress towards becoming a Net Zero healthcare provider.							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic	**Risk Title:**	**PR 20: Estate Strategy - net carbon zero requirements**				**Risk Appetite**	Cautious	
	Risk Statement:	There is a risk that the estates strategy will not fully address the net carbon zero requirements						
Lead Committee	**Finance & Performance**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**12. High**	
Lead Director	**CFO**	**Likelihood**	3. Possible	1. Rare	2. Unlikely	**Risk category**	Sustainability/Net Zero	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	4. Moderate	**Linked risks**	-	
Date of last review	**27.05.22**	**Risk Rating**	9. High	3. Low	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: **13.3 (ID 3296)**	• Sustainability Officer in place who can provide expert input • Net Zero Champion appointed	• Need to develop Green Strategy for WWL	**2nd Line:** • Finance & Performance Committee May 22	• No gaps currently identified.	• Director of Estates and Facilities working with external company to undertake this work	31.08.22 CFO

Partnerships

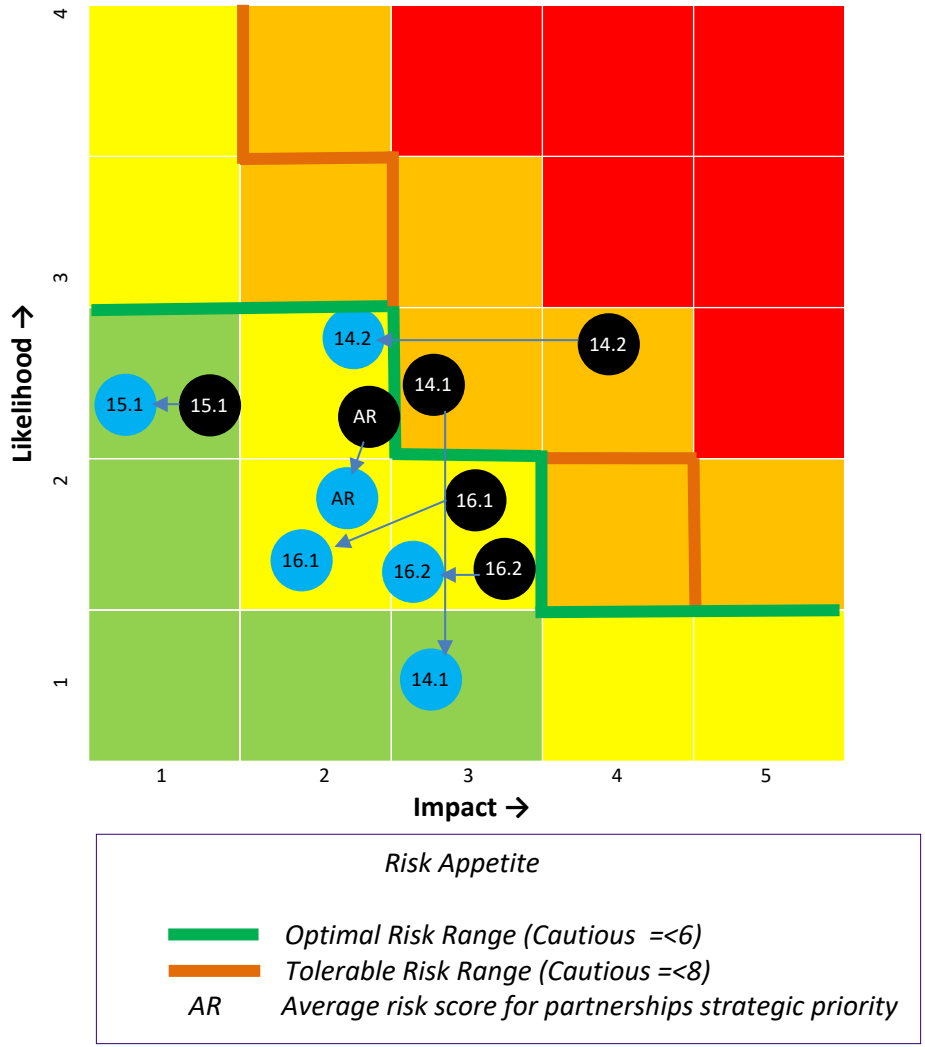
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

Monitoring: Board of Directors

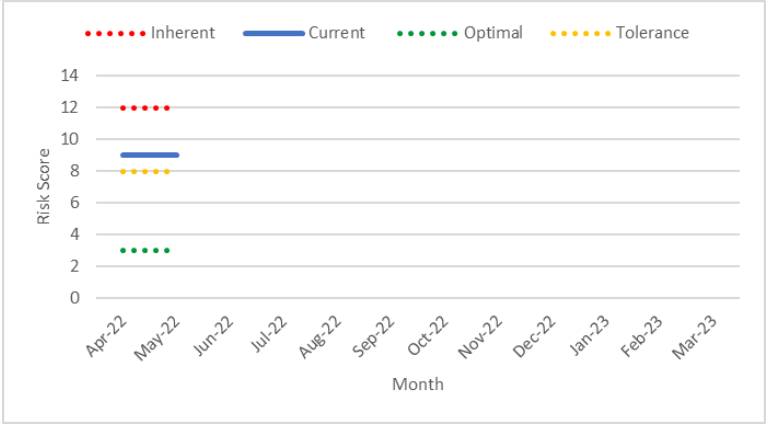
The following objectives are aligned to the **partnerships** strategic priority:

Ref.	Headline objective
CO15	Develop our role as an anchor institution, increasing access to employment for local people and spending more locally.
CO16	Develop effective relationships within Wigan Borough and GM for the benefit of WWL and our patients.
CO17	Continue to make progress towards our ambition to become a University Teaching Hospital.

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

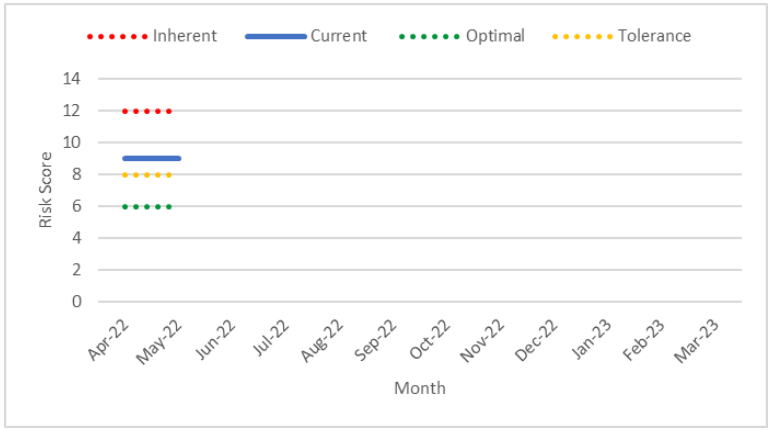


Corporate Objective: **CO16** Develop effective relationships within Wigan Borough and GM for the benefit of WWL and our patients.							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic	**Risk Title:**	**PR 21: Elective Hub - Staffing**				**Risk Appetite**	Cautious	
	Risk Statement:	There is a risk that there will be insufficient staff available to undertake the levels of additional activity.						
Lead Committee	**Board of Directors**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**12. High**	
Lead Director	**DSP**	**Likelihood**	3. Possible	1. Rare	2. Unlikely	**Risk category**	Strategy	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Possible	4. Major	**Linked risks**	-	
Date of last review	**27.05.22**	**Risk Rating**	9. High	3. Low	8. High	**Risk treatment**	Treat	



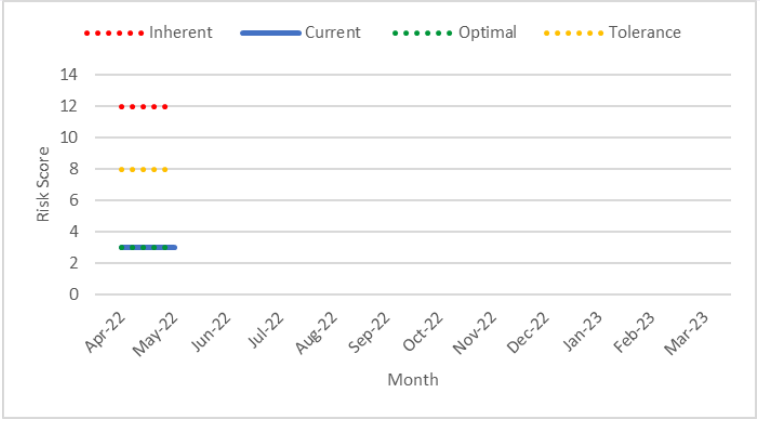
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **14.1** **(ID 3297)**	• Additional funding secured to recruit additional staff and proactive recruitment campaign underway.	• National workforce constraints impacting on ability to increase establishment in key clinical posts. • Ability to protect elective capacity during future surges of COVID.	**2nd Line:** • Board of Directors March 22	• No gaps currently identified.	• Proactive approach to recruitment campaign being taken • SRO member of the orthopaedic CRG and influencing the system principles around elective hubs	31.08.22 DSP 31.08.22 DSP

Corporate Objective CO16 Develop effective relationships within Wigan Borough and GM for the benefit of WWL and our patients.							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic	**Risk Title:**	**PR 22: Elective Hub - Capital**				**Risk Appetite**	Minimal	
	Risk Statement:	There is a risk that WWL will be both restricted in the amount of capital it is able to spend and capital availability.						
Lead Committee	**Board of Directors**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**15. Extreme**	
Lead Director	**DSP**	**Likelihood**	4. Likely	2. Unlikely	2. Unlikely	**Risk category**	Finance	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	-	
Date of last review	**27.05.22**	**Risk Rating**	12. High	6. Moderate	6. Moderate	**Risk treatment**	Treat	



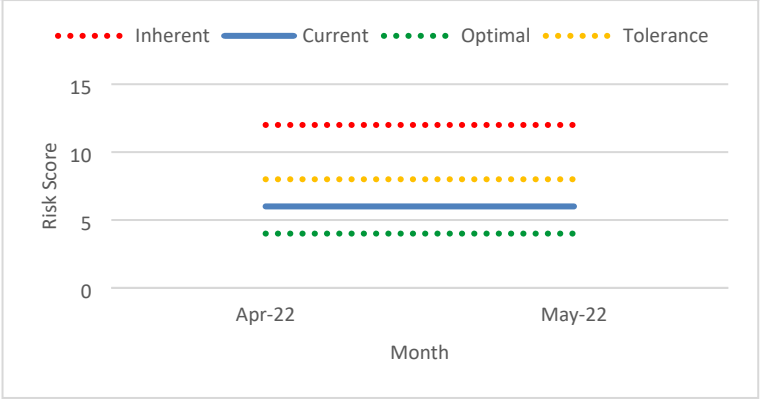
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **14.2** **(ID 3298)**	• Submission made to Greater Manchester	• No gaps currently identified.	**2nd Line:** • Board of Directors March 22	• No gaps currently identified.	• Reviewing ability to deliver within capital slippage one element of the CM capital submission.	31.08.22 DSP

Corporate Objective: **CO17** Continue to make progress towards our ambition to become a University Teaching Hospital.							**Overall Assurance level**	**High**
Principal risk What could prevent us achieving our strategic	**Risk Title:**	**PR 23: University Teaching Hospital - RCF**			**Risk Appetite**	Cautious		
	Risk Statement:	There is a risk that the organisation will not generate sufficient RCF in 2021/22 to qualify for University Hospital Association membership due to a change in criteria.						
Lead Committee	**Board of Directors**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**12. High**	
Lead Director	**MD**	**Likelihood**	1. Rare	1. Rare	2. Unlikely	**Risk category**	Strategy	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	4. Major	**Linked risks**	-	
Date of last review	**27.05.22**	**Risk Rating**	3. Low	3. Low	8. High	**Risk treatment**	Accept	



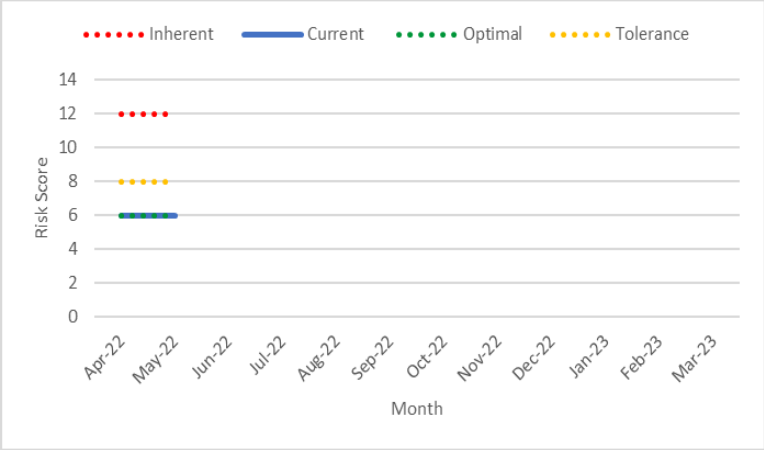
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **15.1** **(ID 3299)**	• Monitoring of NIHR grant research funding	• No gaps currently identified.	**2nd Line:** • Board of Directors March 22	• No gaps currently identified.	• University Hospital Programme Board being established, which will report into the newly established Research Committee	31.08.22 MD

Corporate Objective: **CO16** Develop effective relationships within Wigan Borough and GM for the benefit of WWL and our patients.							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic	**Risk Title:**	**PR 24: Partnership working - CCG changes**				**Risk Appetite**	Cautious	
	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**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**12. High**	
Lead Director	**DSP**	**Likelihood**	3. Possible	2. Unlikely	2. Unlikely	**Risk category**	Strategy	
Date risk opened	**19.10.21**	**Impact**	2. Minor	2. Minor	4. Major	**Linked risks**	-	
Date of last review	**27.05.22**	**Risk Rating**	6. Moderate	4. Moderate	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: **16.1** **(ID 3300)**	• Locality meeting structures in place to support lasting corporate knowledge.	• No gaps currently identified.	**2nd Line:** • Board of Directors March 22	• No gaps currently identified.	• No further actions currently identified.	

Corporate Objective: **CO16** Develop effective relationships within Wigan Borough and GM for the benefit of WWL and our patients.							**Overall Assurance level**	**High**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 25: Partnership working - Decision Making**			**Risk Appetite**	Cautious		
	Risk Statement:	There is a risk that we will not get buy-in or funding for a locality-wide workforce EDI strategy. There is a risk that the ambiguity around the future structure, governance and financial flows within the locality slows down decision making and decisions on investments.						
Lead Committee	**Board of Directors**	**Risk rating**	**Current**	**Optimal Risk**	**Tolerable Risk**	**Inherent risk score**	**12. High**	
Lead Director	**DSP**	**Likelihood**	3. Possible	2. Unlikely	2. Unlikely	**Risk category**	Strategy	
Date risk opened	**19.10.21**	**Impact**	2. Minor	3. Moderate	4. Major	**Linked risks**	-	
Date of last review	**27.05.22**	**Risk Rating**	6. Moderate	6. Moderate	8. High	**Risk treatment**	Accept	



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **16.2 (ID 3301)**	• Locality meeting structures in place.	• No gaps currently identified.	**2nd Line:** • Board of Directors March 22	• No gaps currently identified.	• No further actions currently identified.	

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	April 2022 Safe Staffing Report
Presented to:	Trust Board
On:	8 June 2022
Presented by:	Rabina Tindale; Chief Nurse
Prepared by:	Divisional Director of Nursing and Allied Health Professionals Surgery, Julie Barrett. Deputy Chief Nurse Allison Luxon
Contact details:	E: julie.barrett@wwl.nhs.uk T: 01942 778840

Executive summary

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

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

The Board are asked to note

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

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

- Overall vacancies have decreased in month. Although reduced, these vacancies continue to impact on the ability of the workforce to respond to workload increases and in turn is negatively impacting on staff wellbeing, patient care and experience, and waiting times. The Trust continues to mitigate the impact of this with the use of temporary staff and some block bookings to promote continuity of care and team building.

The WWL Way

- The Trust participated in a GM wide recruitment event hosted by NHSEI, in April 2022 for B2 staff. 31 applicants were offered posts. 12 are going through pre-employment checks; 6 vacancies are awaiting TRAC authorisation; 6 applicants have student visas and have restrictions on how many hours they can work (20 hours per week term time and 37.5 hours per week in half term) and 1 did not respond, to post event communications.

- The full benefits of the approval of the Supernumerary Ward Leader Business Case are yet to be realised. Ward leaders have increased the amount of supernumerary time where staffing rosters have allowed.

- Maternity services continue to suspend the Continuity of Carer (CoC) pathway to address staffing gaps in higher risk areas of the service which have arisen through vacancy and short notice absence of staff. Recruitment remains ongoing. They have recruited to 10wte Band 5 posts who will only qualify in September 2022 therefore the staffing deficit is predicted to have an impact over the summer months when births usually increase and peak holidays.

- District Nurses continue to have high vacancies and their caseloads continue to be above optimal levels. A risk stratification approach remains in place to reduce the frequency of face-to-face visits, and other community services were asked to provide a wraparound service to assist in maintaining patient safety. Several staffing risks have been placed on the Community risk register in month.

- In April, 6 CDTs were reported, all have been subject to investigation and are scheduled to have Executive review to identify if there are any lapses in care.

- There were 2 reported falls in month resulting in moderate/ severe harm. 1 fractured neck of femur on Swinley ward, and a head injury on Winstanley ward. Both were subject to review at the falls scrutiny panel which evidenced that there were no lapses in care and correct falls prevention processes had been followed. Therefore, no escalations to STEIS were made.

- Pressure ulcers reported for the month of April - 1 x category 3, no lapse in care identified after presentation at the pressure ulcer panel and 1 x category 4 which to date has not yet been reviewed at panel.

- There was 1 medicine administration error that resulted in moderate/severe harm to patients reported in month. This has undergone a rapid review and is subject to a concise investigation.

- GTEC have offered posts to a further 26 IN’s following recruitment in April.

- **Link to strategy**

Delivery of safe care.

Risks associated with this report and proposed mitigations

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

Financial implications

- Temporary staffing costs related to sickness/absence and vacancy levels, and backfill requirements, and to support additional staffing to support patient flow within ED, the escalation ward, and the acuity of patients on the CPAP medical area.

Legal implications

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

People implications

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

Wider implications

- Increased scrutiny from Commissioners and Regulators

Recommendation(s)

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

Safe Staffing Report – April 2022.

1.0 INTRODUCTION

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

2.0 CURRENT POSITION – April 2022

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

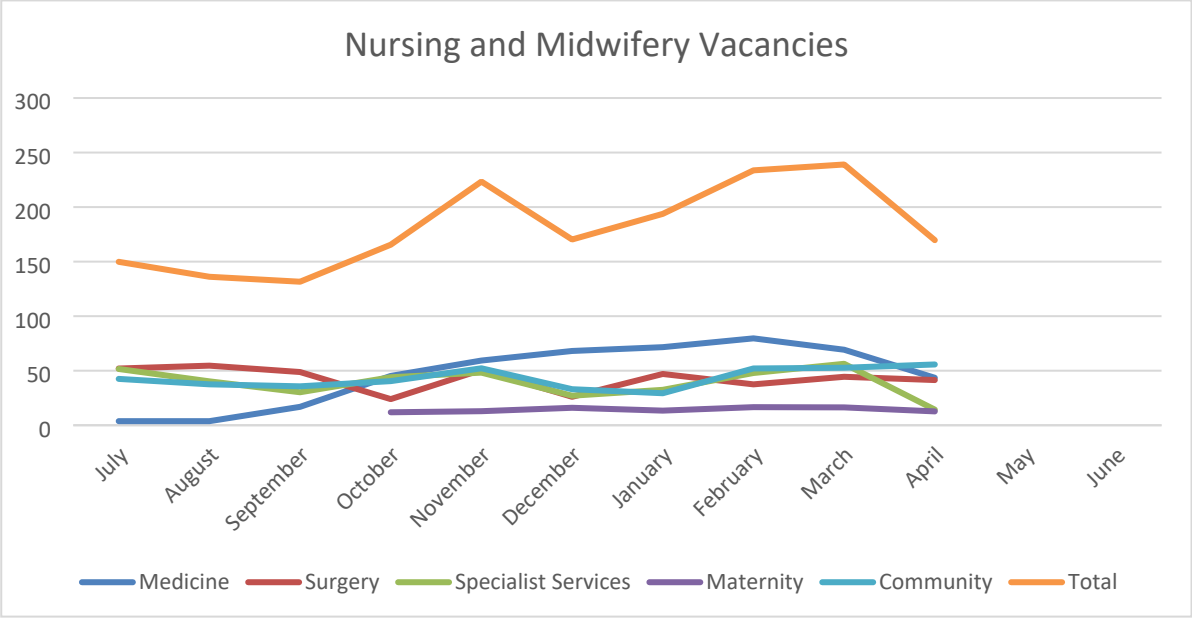
2.2 The ratio of registered nurses to unregistered remains 55:45 as agreed by Trust Board in 2018 except for the assessment areas which are staff at a ratio of 60:40. This ratio remains out with national recommendations of 70:30, with SNCT recommended levels of no less than 65:35 within inpatient areas.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

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

2.4 The RCN (2015) also recommended that Ward Leader posts should be fully supervisory to clinical practice to ensure adequate time for leadership, management, patient safety and experience, and quality improvement. The Trust funded the uplift in Ward Leader time in October 2021 and proactive recruitment continues to allow the release of ward leaders for 100% supernumerary status, whilst not fully achieved, ward leaders are reporting increasing shifts worked as supernumerary.

3.0 Vacancies

3.1 Local Divisional data indicates that there were 169.68 WTE nursing and midwifery vacancies in April. This is a decrease of 69.37 WTE vacancies from the previous months report.



	July	August	Septembe	October	Novembe	Decembe	January	February	March	April
Medicine	3.74	3.74	16.87	45.22	59.31	68.09	71.58	79.65	69.23	43.52
Surgery	52	54.63	48.78	23.96	50.76	26.08	47	37.48	44.42	41.43
Specialist Service	51.59	40.24	30.25	44	48.23	27.08	32.46	47.9	56.33	14.31
Maternity				11.88	12.88	16	13.4	16.59	16.37	12.7
Community	42.49	37.51	35.68	40.45	52.21	33.04	29.34	52.05	52.7	55.72
Total	149.82	136.12	131.58	165.51	223.39	170.29	193.78	233.67	239.05	169.68

Chart 1

3.2 The greatest number of vacancies are at B5 and B2 level as seen in table 2 below. The majority of B6 vacancies are associated with Maternity Services. From the data obtained from the Divisions, there has been a 53 % decrease in the number of B2 vacancies in month.

Table 2

	October	Novembe	Decembe	January	February	March	April
8c	1		1	1			
8a	3.5	7.8	3.67	2.47	6	2	7
7	11.9	8.89	16.4	15.13	9.89	16.35	4.02
6	35.42	42.6	25.18	32.85	41.35	37.13	24.67
5	63.51	94.73	73.65	92.85	113.64	126.96	87.78
4	9.82	12.2	12.09	6.9	13.82	10.38	11.04
3	3.3	11.84	4.79	1.83	6.62	5.67	13.32
2	37.06	50.47	33.51	40.75	42.35	40.56	21.85
Total	165.51	228.53	170.29	193.78	233.67	239.05	169.68

3.3 Areas of particular concern remain in District Nursing Services, ED, Theatres and Maternity Services, mitigations are in place to manage the associated risks.

3.4 Vacancies within Maternity Services continue to impact on the ability of the service to deliver Continuity of Carer (MCoC) substantively. Recruitment is ongoing and their current vacancy is approximately 15 wte midwives including management roles across the service. However, there has been successful recruitment to 4 of these posts with staff due to have commenced in post by June 2022 and successful recruitment of students in training, who are due to qualify in September / October 2022. Once these remaining vacancies are filled and the current sickness levels are reduced, in line with the Ockenden Review published in March 2022, consideration of the reinstatement of MCoC will be planned when staffing levels indicate that this is safe to undertake.

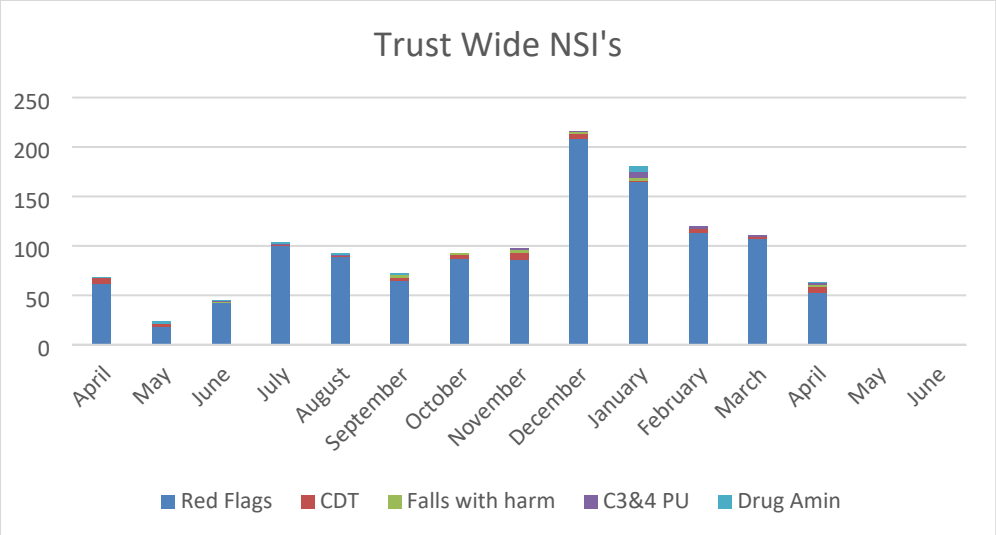
3.4 WWL is currently receiving support from NHSE/I due to the number of B2 vacancies across the Trust. A recruitment event was held at Trafford Park as part of a GM wide recruitment plan for this group of staff. The recruitment campaign was specifically targeting individuals with no experience within healthcare, an ethos that closely aligns to the Trust commitment to the Care Maker role introduced during the Pandemic. 31 applicants were offered posts. Status is as follows; 12 are going through the pre-employment checks; 6 are awaiting TRAC authorisation; 6 applicants have student visas and have restrictions on how many hours they can work, (20 hours per week term time and 37.5 hours per week in half term), and 1 did not respond post event communications.

4 Nurse Sensitive Indicators (NSI's)

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

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

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



	April	May	June	July	August	Septembe	October	Novembe	Decembe	January	February	March	April
Red Flags	62	18	42	100	89	65	87	86	208	165	113	107	52
CDT	6	3	0	1	1	3	4	7	5	1	4	2	6
Falls with harm	0	0	1	0	0	3	2	3	2	3	0	0	2
C3&4 PU	0	0	1	1	1	0	0	2	1	6	3	2	2
Drug Amin	1	3	1	2	2	2	0	0	0	6	0	0	1

Chart 3

4.4 Within the acute setting 52 Nursing Red Flags were notified and 1 Midwifery Red Flags which was due to the shift co-ordinator being unable to be supernumerary in April 2022. The red flags raised within Safe care are documented as being associated with a shortfall in the registered nurse workforce time due to multiple enhanced care level 3/4, missed intentional rounding, multiple fall sitters, and delays in administering pain relief.

4.5 Shortfalls in staffing was mitigated by the internal movement of staff where possible, with Winstanley ward and Bryn Ward North showing an increased redeployment of staff to support staffing in ED to maintain patient safety.

4.6 In April, 6 CDTs were reported which all have been subject to investigation and dates have been scheduled to have Executive review to identify whether there have been any lapses in care.

4.7 In month there were 2 falls reported that resulted in moderate or severe harm. 1 fractured neck of femur on Swinley ward, and 1 head injury on Winstanley ward. Both incidents were subject to presentation at the fall scrutiny panel which evidenced that there were no lapses in care.

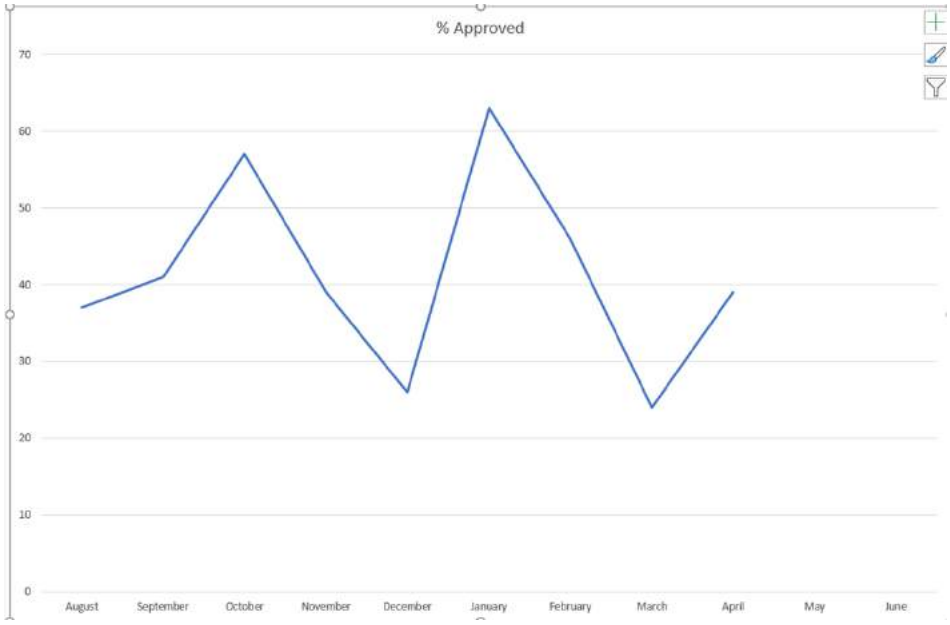
4.8 All pressures ulcers reported across the Trust are reviewed by a scrutiny panel to determine whether all appropriate actions to mitigate the risk of skin damage have been undertaken and to assist in determining whether a patient has come to avoidable harm whilst in our care. In April, pressure ulcers reported for the month - 1 x category 3: 1 x category 4. At the time of data collection, the reported Category 4 pressure ulcer is undergoing a review and has yet to be presented to panel.

4.9 Specialist Services commendably report that this month is the 8th consecutive month that they have had zero Category 3 or 4 pressure ulcers.

4.10 There was 1 medicine administration error that resulted in moderate harm to a patient reported in April.

5 Effective Rostering

5.1 Compliance with roster approval made a slight increase from 24% to 39% in month and is associated with the ongoing challenges with the redeployment of staff and ward leaders working clinically within their respective areas (Chart 4).



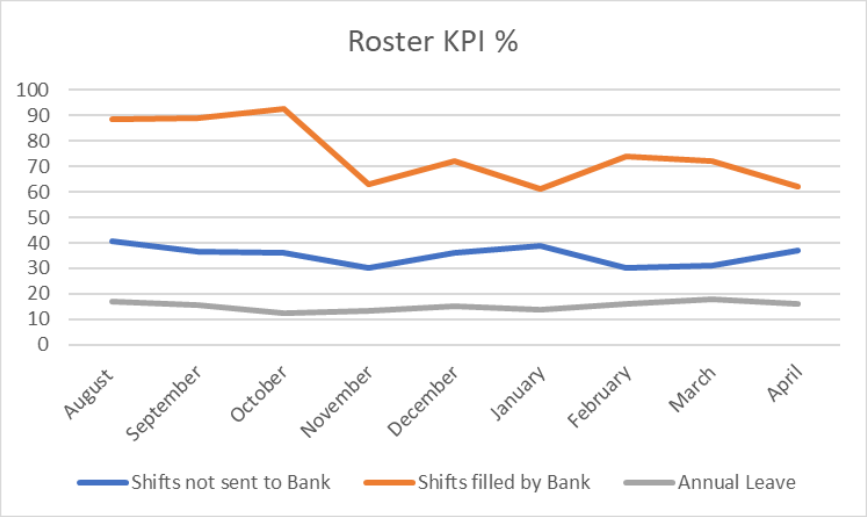
Rosters Approved Within 6 weeks									
	August	Septembe	October	Novembe	Decembe	January	February	March	April
% Approved	37	41	57	39	26	63	46	24	39

Chart 4

5.2 There has been a delay to the Roster Improvement Workstream which is now due to commence in July 2022 with Ward Leaders. This workstream is aligned to the Workforce Efficiencies' Group chaired by the Director of HRD.

5.3 ERoster meetings and NHSP meetings are now in place within the Divisions for Ward Leaders and Matrons to provide scrutiny and challenge. These meetings focus on effective rostering, especially compliance with 6 weeks sign off for rosters and KPI achievements.

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



	August	Septembe	October	Novembe	December	January	February	March	April
Shifts not sent to Banl	40.8	36.5	36	30	36	39	30	31	37
Shifts filled by Bank	88.7	89.2	92.6	63	72	61	74	72	62
Annual Leave	16.8	15.5	12.6	13.2	15	13.6	16	18	16

Chart 5

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

5.7 Bank fill rate, based on the shifts released to NHSP, was 62%. This reduced fill rate triangulates with an increase in the percentage of shifts not sent to Bank within the reporting period.

5.8 Annual leave for the month was 16% which is within acceptable parameters for leave.

6 International Nurse Recruitment (INR)

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

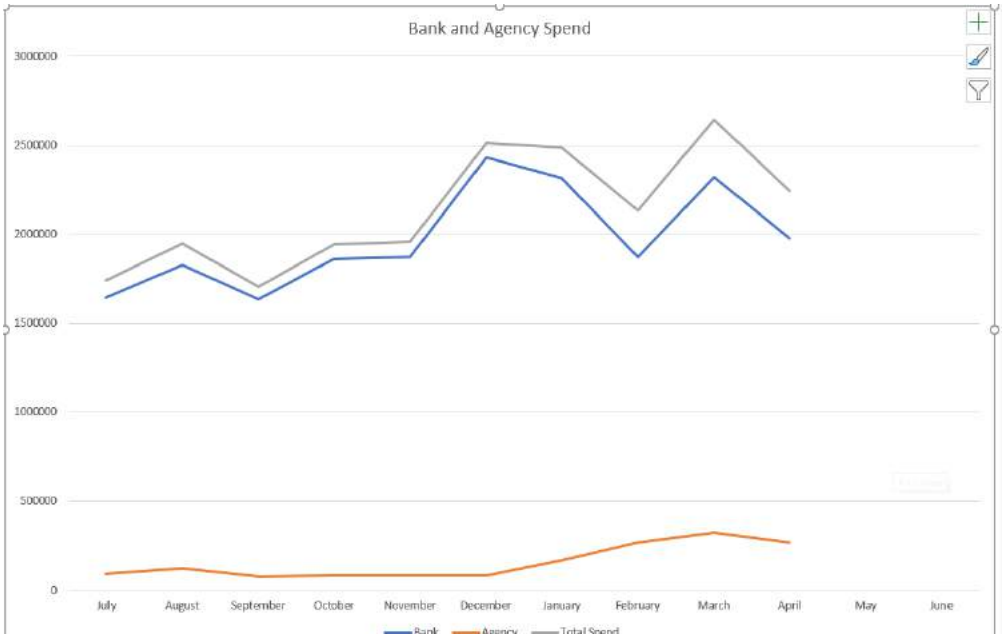
6.2 In April 26 offers were made. 13 International nurses arrived in the country in month. These staff had been interviewed between December 2021 and February 2022 and their OSCE dates have been scheduled for May and June.

6.3 NMALT have agreed that staff will complete their 6-week OSCE preparation in Crewe and then work clinically within their agreed placement areas as a B4 whilst waiting to undertake their assessment. This will assist staff transition and enable the review and assessment of competencies locally and provide parity with domestic recruits who join the Trust whilst awaiting allocation of their PIN from the NMC.

6.4 Nationally International Midwifery recruitment remains ongoing but is not proving to be as successful as the international nurse recruitment with limited suitable candidates. There have been no recruitments made within the Greater Manchester and Eastern Cheshire network. The Midwife to support the programme who was due to be allocated to WWL is now no longer available.

7 Bank and Agency Utilisation

7.1 Bank and Agency Spend decreased in April 2022 as demonstrated in Chart 6.



	July	August	September	October	November	December	January	February	March	April
Bank	1645934	1827818	1632970	1864093	1872876	2430015	2317199	1870124	2321908	1979104
Agency	93024	120000	74204	78799	82528	80133	168548	265776	322724	268494
Total Spend	1738958	1947947	1707174	1942892	1955404	2510148	2485747	2135900	2644632	2247598

Chart 6

7.2 Within the Medicine Division there are several RN Band 5 staff who are currently working as a cost pressure within ED and PECC, secondary to redeployment from ASU to support winter pressures as they were unfunded posts. Discussions are underway with finance to allocate these staff as a priority to vacancies.

7.3 Further expenditure has been incurred within the Division in April due to the escalation of additional areas (Ambulatory Assessment Area (AAA)) to support patient flow, the ongoing requirement for additional staff to support enhanced observations, and the requirement for additional staff for ED. As part of the Divisional actions taken to address the financial position for nursing spend, AAA was de-escalated from the 28th of April 2022 and remains de-escalated. The medical pool shifts were withdrawn with effect from the 4th of April 2022. In addition to this, the Division has been completing a weekly audit of enhanced care provision and has introduced a governance framework with the Ward Leaders and Matrons that ensures that 1-1 shifts are provided appropriately in line with the enhanced care policy and improvements have been seen as a result of this.

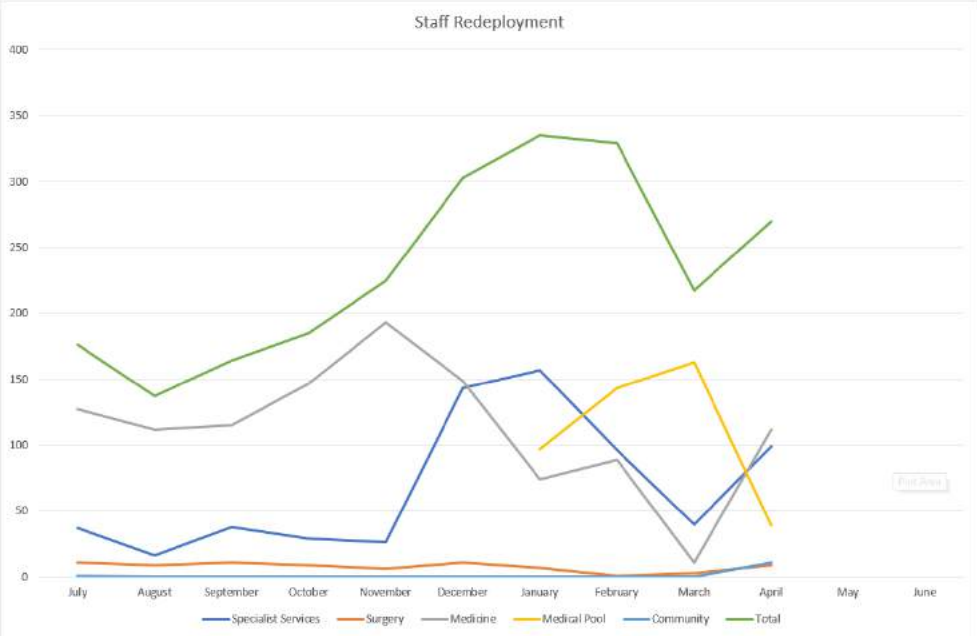
7.4 Temporary spend in the Emergency Department is partly offset by Winter Pressures monies allocated to the service, however it is noted that this funding will end from the 1st of June 2022. There continues to be a requirement for the segregation of symptomatic and asymptomatic patients within the department and a paper is in the process of being submitted to ETM for considering the amalgamation of resus into a single provision.

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

7.6 The Board approved the utilisation of an off-framework agency in January to support gaps in workforce and whilst there has been a drive to decrease and ultimately remove this off-framework agency spend, this remains a challenge in areas such as theatres whereby difficulties remain to recruit easily to skilled posts such as Scrub practitioners, particularly on the RAEI site. It is expected that temporary spend, and agency costs will continue to reduce as recruitment to establishments are achieved.

8 Staff Redeployment

8.1 Chart 7 provides detail of the numbers of staff redeployed and is now in response to divisional needs only and not organisational needs as previously reported.



	July	August	Septembe	October	Novembe	Decembe	January	February	March	April
Specialist Service	37	16	38	29	26	143	157	96	40	99
Surgery	11	9	11	9	6	11	7	1	3	9
Medicine	127	112	115	147	193	149	74	89	11	112
Medical Pool							97	143	163	39
Community	1	0	0	0	0	0	0	0	0	11
Total	176	137	164	185	225	303	335	329	217	270

Chart 7

8.2 Data on Safe Care indicates that there were 270 temporary redeployments of staff to other areas in response to vacancy, patient acuity, short notice absence. This is an increase of 53 redeployments from the previous reporting period.

8.3 This month, the Medicine division recorded the highest divisional volume of staff movement; however, it should be noted that this movement is now in response to divisional needs only.

8.4 There were only 39 shifts placed for staff on the Medical Pool via NHSP as the pool was removed in month.

9 Staffing Risks

9.1 Community have placed several staffing risks and the mitigations in place for each risk on their Divisional risk register in April 2022. Ranging from scores of 6-12 and include but are not absolute is the 'Inability to deliver time appropriate therapy interventions leading to delays in patient treatment (6) and Inadequate patient flow through CAU due to staffing levels/skill mix (8). Staffing challenges remain within District Nursing Services where caseloads remain above desirable levels. This risk has been scored at 15. There is a risk that the increased caseload numbers will impact on the ability to maintain the quality of service that would usually be expected, and the Division and service leads continue to risk stratify caseloads to ensure care is received by those most at risk. Additionally, there remain pressures around staffing for the Treatment Rooms.

Ongoing recruitment to vacant posts; Skill mix and resource management across all DN teams; daily staffing meeting with Operational Lead on Teams and Enhanced rates of pay NHSP in play until end of May 2022, are some of the mitigations in place.

9.2 Within Maternity the CoC model remains suspended. WWL had 2 Maternity Continuity of Carer (MCoC) teams in place, but these could not be continued due to ongoing midwifery vacancies, this will be reviewed again once vacancies have been filled.

Suspension of CoC model has been supported in the recent publication of the final Ockenden Report in March 2022. The leadership team will continue to work up sustainable, robust plans for the implementation of CoC.

All Trusts are to submit their MCoC building block plans to their Local Maternity System (LMS) however the date for submission has been extended to June 2022. This must include recruitment plans and how MCoC will be re-implemented. It must also include plans to target those women who are in the most deprived areas or from a Black Asian or other ethnic minority background, once the appropriate staffing levels are in place.

9.3 Theatre staffing remains a challenge with shortfalls of staff across anaesthetic and recovery services. Scrub staffing deficits are a particular problem on the RAEI site. Although business case approval for funding has been given to recruit, the theatre staffing risk remains at a 15. There has been a need to support the service by block booking of experienced staff which has hugely impacted upon temporary spend. Plans for recruitment events are underway, with longer terms plans for collaboration between Surgery and Specialist services regarding a larger recruitment event and potential for a grow your own strategy.

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

9.5 Within Specialist Services Division, there have been increasing requirements for Enhanced Care support on Aspull Ward. Level 3 enhanced care support has significantly increased over the last 6 months and is not reducing. The impact of this is increasing temporary spend and budget overspend. Work is underway with the Specialist services divisional accountant and ward team to understand the demand, appropriate application of policy and steps to support safe care in line with budgetary control. Theatres continue to have gaps in Anaesthetic and Recovery roles which continue to be challenging to recruit to. Supernumerary status of Ward Leaders has not been achieved due to unfilled vacancies and impacts mainly on Aspull and B ward.

9.6 Working alongside the staff engagement team to improve staff morale in theatre and focus on retention of staff. In division of Surgery increase scrutiny of Eroster management, NHSP, Safe care and correct application of enhanced care levels and acuity within Safer Nursing Care Tool has been a key focus because of high temporary spend and agency costs to ensure management of budgetary control.

10 Conclusion

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

Overall vacancies have decreased in month. These vacancies are impacting on the ability of the workforce to respond to workload increases which is negatively impacting on staff wellbeing, patient care and experience, and waiting times. CoC remains suspended within Maternity Services to mitigate risk within high-risk areas of the service.

Twenty-six offers were made following interviews to International Nurses. Commitment to ongoing recruitment collaboration with GTEC continues and is instrumental in our recruitment campaign.

Staffing shortages were mitigated with the use of temporary workforce or inter-divisional redeployment of staff. Whilst red flags were raised in line with NICE guidance, there were no immediate lapses in care linked to staffing shortages.

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

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Ockenden 2 Report Update
Presented to:	Board of Directors
On:	08 June 2022
Presented by:	Cathy Stanford
Prepared by:	Cathy Stanford Interim Divisional Director of Midwifery and Neonates
Contact details:	T: 01942 773107 E: cathy.stanford@wwl.nhs.uk

Executive summary

Ockenden Final Report

The final Ockenden report covers the review of the maternity care of 1,486 families at Shrewsbury and Telford Hospitals NHS Trust and, from these, 1,592 clinical incidents were reviewed) and follows on from the first report, which was published in December 2020.

The first report outlined the local actions for learning (LAfL) and immediate and essential actions (IEAs) to be implemented at Shrewsbury and Telford trust and across the wider maternity system in England. The second report builds upon the first in that all the LAfL and IEAs within that report remain important and must be progressed.

The review team identified a number of new themes which are now being shared across all maternity services in England as a matter of urgency to bring about positive and essential change.

The report describes thematic and repeated failures in care which included failures to safeguard mothers and babies, failing to investigate when things had gone wrong, and a lack of learning from adverse events and failure to make improvements.

Throughout the various stages of care the review team identified failings to follow national clinical guidelines and failures in care, governance, assurance, systems and processes, the review also found associated failures in clinical and corporate leadership at the Trust.

It describes that, had the care of a significant number of women and babies been managed differently, then the outcomes from them may have been different. It is stated that due learning and better adherence to approved procedures, practices and guidelines may have prevented further deaths of women and babies.

It was recognised that many of the issues highlighted within the report were not unique to Shrewsbury and Telford Hospital NHS Trust and have been highlighted in other local and national reports into maternity services in recent years, therefore the review team identified 15 essential actions(EA's) to be considered by all.

CS May 2022

Within the 15 Overarching Essential actions there are a total of 92 separate actions to demonstrate compliance against. The Division has started the self-assessment against all the recommendations and we are predominantly working towards or complaint with the recommendations.

It is recognised that there needs to be :

- significant investment in the maternity workforce and multi-professional training
- suspension of the midwifery continuity of carer model until – and unless – safe staffing is shown to be present
- strengthened accountability for improvements in care among senior maternity staff, with timely implementation of changes in practice and improved investigations involving families

The review supports and endorses **The Health and Social Care Committee report The safety of maternity services in England.(July 2021)**

- It agrees with the select committee that the budget for maternity services should be increased by £200 to 350 million a year with immediate effect, and that this funding increase should be kept under close review as more precise modelling is carried out on the obstetric workforce and as trusts continue to undertake regular safe staffing reviews of midwifery workforce levels.
- It agrees that the DHSC must work with the RCOG and Health Education England to consider how to deliver an adequate and sustainable level of obstetric training posts to enable trusts to deliver safe obstetric staffing over the years to come.

It agrees and endorses **the Health Select Committee** view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit, and also agree that NHS trusts must report this in public through their annual financial and quality accounts.

- The report endorses the Health Select Committee recommendation that the **Maternity Transformation Programme** board should establish what proportion of maternity budgets should be ring-fenced for training, but it must be sufficient to cover not only the provision of training, but the provision of back-fill to ensure that staff are able to both provide and attend training.
- A single set of maternity training targets agreed in all maternity services in England should be established by the **Maternity Transformation Programme board,** working in conjunction with and advised by the main Royal Colleges and the Care Quality Commission (CQC).

It recommends that training targets should be enforced by **NHSEI's Maternity Transformation Programme**, the RCM, the RCOG and the CQC through a regular

This work must also consider the anaesthetic and neonatal workforce, and be advised by the:

- Royal College of Anaesthetists (RCOA)
- Obstetric Anaesthetists' Association (OAA)
- Royal College of Paediatrics and Child Health (RCPCH)
- British Association of Perinatal Medicine (BAPM)

The 15 EA 's to be considered are outlined within the following categories with initial Rag Ratings

		Red	Amber	Green	National/ regional Action
EA1	Workforce planning and sustainability	2	7	2	
EA2	Safe staffing	1	5	3	1
EA3	Escalation and accountability	1	4	0	
EA4	Clinical governance-leadership	1	5	1	
EA5	Clinical governance – incident investigation and complaints	0	5	2	
EA6	Learning from maternal deaths	0	2	0	1
EA7	Multidisciplinary training	1	4	2	
EA8	Complex antenatal care	0	2	3	
EA9	Preterm birth	0	2	2	
EA10	Labour and birth	0	2	2	2
EA11	Obstetric anaesthesia	1	6	1	
EA12	Postnatal care	0	2	2	
EA13	Bereavement care	0	2	2	
EA14	Neonatal care	1	2	4	1
EA15	Supporting families	2	1	0	
	Total	10	51	26	5

On receipt of the report, the following actions have been taken:

- The maternity services senior team, supported by divisional colleagues, have a commenced a gap analysis (Ockenden 2 action plan) against all the new actions and this work will continue within the division fortnightly.
- The Local Maternity System (LMS) is supporting GM Trusts to complete the Gap analysis and will meet regularly to review progress against the recommendations.
- The first version of the Ockenden 2 action plan will be provided for Board review in June 2022, (or sooner if required) for the Board to consider the Trust's progress against the required actions.

A summary of the highlighted initial concerns that require either further investment or national support are detailed below.

Initial concerns rated as red on action plan

- Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.

Birth rate+ staffing review will be undertaken in the coming weeks which is being funded by the LMS for all GM Trusts. This will take into consideration the above criteria to provide an updated staffing baseline requirement. This will have funding implications if baseline staffing levels are increased

- The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction

MCoC was halted in WWL in November 2021 due to insufficient staffing levels to sustain a safe service. This is under constant review and staffing shortfalls still remain. Therefore,

Continuity remains on hold and will be re-introduced when fully recruited to current vacancies. The building blocks action plan has been completed and submitted as requested by the National and Regional Maternity teams, the LMS and to Trust in February 2022, and updated version to be submitted in June 2022

- In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.

WWL has a single Consultant on call rota for both areas, changes to this will require substantial financial investment and radical changes to Job plans.

- Trusts should aim to increase resident consultant obstetrician presence where this is achievable.

There are currently no residents Consultants in place as these were not continued in favour of traditional Consultant posts.

- Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services

Awaiting further clarification on this recommendation

- Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory

Plans are now being put in place for a robust process to ensure compliance.

- The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.

Anaesthetic team will need to review job plans for this recommendation

- Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.

This requires further discussion and review to implement and update guidance etc, however it would be usual that the Consultant would be attending the unit ASAP.

- There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.

This action will require investment and service development to implement

- Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.

This action will require investment and service development to implement

Recommendations

It is requested that the Board of Directors review the contents of this paper in order to be aware of the recommendations within the report and gain assurance of the progress towards compliance in reaching the Ockenden recommended actions (IEA's) from both reports which are continuing to be considered and implemented within the Division.

The full report is available at **Ockenden Report – Final. Findings, Conclusions and Essential Actions from the Independent Review of maternity Services at the Shrewsbury and Telford Hospital NHS Trust** March 2022. Crown Copyright

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Maternity Continuity of Carer Building Blocks Plan (updated May 2022)
Presented to:	Board of Directors
On:	08 June 2022
Presented by:	Cathy Stanford
Prepared by:	Cathy Stanford Interim Divisional Director of Midwifery and Neonates
Contact details:	T: 01942 773107 E: cathy.stanford@wwl.nhs.uk

Executive summary

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

In line with *Better Births* and the *NHS Long Term Plan*, all women should be offered the opportunity to receive the benefits of Continuity of Carer across antenatal, intrapartum, and postnatal care. However, not all women will be able to receive continuity of carer, through choosing to receive some of their care at another maternity service. In a small number of cases, women will be offered a transfer of care to a specialist service for maternal / fetal medicine reasons.
Maternity services and Local Maternity Systems (LMS's) are asked to prepare a plan to reach a position where midwifery Continuity of Carer is the default position model of care available to all women.
Additionally, Evidence of Board level oversight and discussion of this revised Continuity of Carer action plan is required by June 6, 2022.

Providing Continuity of Carer by default therefore means:

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

WWL had 2 MCoC teams in place but due to ongoing midwifery vacancies the intrapartum element of these teams is suspended, we are out to recruitment and will reinstate 2 teams to full MCoC models at the earliest opportunity. Recruitment is ongoing and our current vacancy is approximately 16wte, midwives across the service, which is inclusive of management roles, however, there has been successful recruitment to 4 of these posts with staff due to have commenced in post by June 2022. But additionally, we have also had staff leave or reduce hours. Nevertheless, we have successfully recruited our students in training who are due to qualify in

September / October 2022. Once these remaining vacancies are filled and the current sickness levels are reduced the intention is to implement further MCoC teams as per projection.

However, following the publication of the final Ockenden Report in March 2022 it has been recommended that the reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction.
Until such time that further guidance is received the plan is to continue with the building blocks and establish a time line for introduction once safer staffing levels allow.

As a first step, LMS's agree the local plan that includes putting in place the 'building blocks' so that Continuity of Carer is the default model of care offered to all women. or when sustainable models of Continuity of Carer can be offered by March 2024.

This plan will include:

- The number of women that can be expected to receive continuity of carer, when offered as the default model of care
- A midwifery redeployment plan into MCoC teams phased alongside the fulfilment of safe staffing levels.
- How MCoC teams are established in compliance with national principles and standards
- How rollout will be prioritised to those most likely to experience poor outcomes, including ensuring rollout to 75% of women from Black Asian and mixed ethnicity backgrounds and also from the most deprived 10% of areas
- How care will be monitored locally, and providers ensure accurate and complete reporting on provision of continuity of carer using the Maternity Services Data Set

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

This paper outlines:

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

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

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

Financial implications
There are no financial implications associated with this report

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

People implications
MCoC will affect current and future workforce planning

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

Recommendation(s)

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

Report

All Trusts are instructed to:

- **Continue with MCoC teams already in place and roll out new teams as appropriate:**

WWL had 2 MCoC teams in place but due to ongoing midwifery vacancies the intrapartum element of these teams is suspended, we are out to recruitment and will reinstate 2 teams to full MCoC models at the earliest opportunity. Recruitment is ongoing and our current vacancy is approximately 16wte , midwives across the service , inclusive of management roles, however, there has been successful recruitment to 4 of these posts with staff due to have commenced in post by June 2022. We have also recruited our students in training who are due to qualify in September / October 2022. Once these remaining vacancies are filled and the current sickness levels are reduced the intention is to implement further MCoC teams as per projection.

However following the publication of the final Ockenden Report in March 2022 it has been recommended that the reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction.

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

Staffing levels, and skill mix are key elements of a safe and high-quality service. In maternity, workforce planning is unique as each care 'episode' spans around 6-8 months, within both hospital and community settings, and involving a series of scheduled and unscheduled care and often involving unexpected inpatient admission as well as the birth itself.

Birthrate Plus was last undertaken in March 2020 and used in conjunction with the national continuity tool to provide a baseline of staffing requirements for MCoC**.** This information has been used to develop our Trust staffing papers the latest of which has been submitted to board and provides a template for our staffing action plan.(this is also attached as appendix A).

The local Maternity System (LMS) has agreed to fund a new Birthrate plus staffing review for all GM Trusts which will be commenced in Summer 2022. This will incorporate the recommendations for staffing from the Final Ockenden Report in order to get a revised baseline assessment which is in accordance with training requirements and patient acuity.

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

WWL intended to build upon the current enhanced offer of MCoC (Daisy Team), with a view to having a second team to reach our most vulnerable women, however in the first roll out of Continuity it proved very difficult to offer the intra partum element with this cohort of women due to the high levels of acuity for mental health and social care needs, therefore this will need to be given further consideration as to how this can be offered going forward and what this model will look like. With the implementation of full MCoC to all our eligible women all MCoC teams will have a mixed caseload of low and high-risk women which includes medical and social complexities; however, the Daisy team offer care to the most highly vulnerable women within the Borough and have a much-reduced caseload. This has been a model that has been offered for many years with excellent outcomes and is supported by the CCG.

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

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

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

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

Out of Area Bookings	**Budget**	**27% CoC**	**47% CoC**	**68% CoC**	**83% CoC**	**89 % CoC**	**100 % CoC**
Out of Area Births	641	641	641	641	641	641	641
Non CoC Bookings (Less 145 for attrition)	134	134	134	134	134	134	134
CoC Bookings	2,696	1,980	1,440	864	576	288	0
Total	104	716	1,256	1,832	2,120	2,408	2,696
% CoC	2,800	2,696	2,696	2,696	2,696	2,696	2,696
	4%	27%	47%	68%	79%	89%	100%

- **Staffing levels and recruitment plans: see Appendix A**

How MCoC teams are established and comply with national principles

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

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

As the teams develop the focus will be on women from Ethnic minorities and women from the most deprived areas within the borough The exception to this will be teams who are currently organised to care for the most vulnerable women, at the present time we have the Daisy Team who provide care for our most vulnerable women . Due to the complexities of care for these women the midwives on this team carry a reduced caseload of 1:20.which is under regular review.

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

obstetricians to have open communication with each other, facilitating a multi-disciplinary team approach.

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

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

Within the Greater Manchester Maternity footprint WWL have one of the highest overall rates of substantial levels of deprivation, safeguarding and high levels of poor perinatal mental health. WWL focus to date has been to roll out our first MCoC teams within areas identified as having high levels of vulnerability and were women have access to a neighbouring provider.

With the appointment of a Digital Midwife, the service is working on workflows which will identify from the Maternity Information System (MIS) the women who are more likely to experience poorer outcomes, including women and families from ethnic minority backgrounds and those residing within the most deprived areas of the borough. The next MCoC teams introduced will be prioritised to these areas of high deprivation and will include women from ethnic minority backgrounds.

How care will be monitored locally using MSDS

All MCoC teams will have in place regular audit and monitoring processes to ensure quality of care, this will feed into the established maternity services quality surveillance, audit and governance processes. Reports will be generated from the MIS where possible to reduce the burden of Midwives undertaking manual audits , however this is very reliant on good data entry and completing all care episode within the MIS , Data quality will continue to be monitored through the Maternity Service Data Set (MSDS) submissions.
Regular audit of activity and outcomes of all MCoC and core teams will continue to be facilitated in conjunction with the maternity governance team and digital midwife. Reporting any adverse outcomes and embedding learning within the MCoC teams and wider maternity service .
A standard operating procedure will be developed for the MCoC teams, clearly outlining the pathway and model of care, which will be inclusive of the requirements for Personalised Care and Support plans (PCSPs)
With the support of the Clinical Director, we aim to facilitate linked obstetricians for all MCoC teams as they are introduced with regular team meetings to ensure multi-disciplinary communication and problem solving within our MCoC.

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

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

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

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

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

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

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

Summary.

MCoC Implementation has been limited here at WWL due to the existing challenges with midwifery establishment, and the challenges associated with bringing about wholescale change in midwifery staffing models. It is now recognised that all services need to be fully established to enable safe care before MCoC is implemented at scale as women will only be able to experience true MCoC in a well-established service.

Due to the ongoing national staffing issues across maternity services and the difficulties providers are facing with recruitment and retention, clear guidance has now been produced for the phased roll out of MCoC, which clearly states that the building blocks should be in place by March 2022 and teams are rolled out as appropriate when establishments allow.

The Consultation with staff as agreed by staff side and HR representatives will be commenced when the staffing establishment allows. The consultation paper will be shared with staff in order that they are aware of the process and plans going forward for implementation, with the 60-day consultation process formally commencing once the required numbers of staff are in place across all areas of the service

Ward / Department		Band	Current Budgeted WTE	WTE Required at 27%	WTE Required at 47%	WTE Required at 68%	WTE Required at 83%	WTE Required at 89%	WTE Required at 100%
Delivery Suite	Shift leader	7	5.38	5.38	5.38	5.38	5.38	5.38	5.38
	Core Midwives	6	5.38	5.38	5.38	5.38	5.38	5.38	5.38
	Core Midwives	6	5.38	5.38	5.38	5.38	5.38	5.38	5.38
	Induction Labour Bay	6	5.38	5.38	5.38	5.38	5.38	5.38	5.38
	Rotational M/W	6	5.38	5.38					
	Rotational M/W	6	5.38	5.38					
	Wigan North	6	5.38						
	Wigan South	6	5.38						
Delivery Suite Total			**43.04**	**32.28**	**21.52**	**21.52**	**21.52**	**21.52**	**21.52**
Maternity Ward	Rotation 5/6	6	5.38	5.38	5.38	5.38	5.38	5.38	5.38
	Core Midwives	6	8.07	8.07	8.07	8.07	8.07	8.07	8.07
	Elective C- Section	6	0.48	0.48	0.48	0.48	0.48	0.48	0.48
	Elective C- Section	6	0.98	0.98	0.98	0.98	0.98	0.98	0.98
Maternity Ward Total			**14.91**	**14.91**	**14.91**	**14.91**	**14.91**	**14.91**	**14.91**
Triage	Triage	6	7.06	7.06	7.06	7.06	7.06	7.06	7.06
Triage Total			**7.06**	**7.06**	**7.06**	**7.06**	**7.06**	**7.06**	**7.06**
Ante Natal	Ante Natal	6	8.10	8.10	8.10	8.10	8.10	8.10	8.10
Ante Natal Total			**8.10**	**8.10**	**8.10**	**8.10**	**8.10**	**8.10**	**8.10**
Infant Feeding Team	Infant Feeding Team	6	1.80	1.80	1.80	1.80	1.80	1.80	1.80
Infant Feeding Team Total			**1.80**	**1.80**	**1.80**	**1.80**	**1.80**	**1.80**	**1.80**
Community	Out of Area Births	6	6.68	6.68	6.68	6.68	6.68	6.68	6.68
	In Area Births 1:96	6	28.08	20.63	15.00	9.00	6.00	3.00	0.00
	balance	6	0.34						
Community Total			**35.10**	**27.31**	**21.68**	**15.68**	**12.68**	**9.68**	**6.68**
Continuity of Care Teams	Team 1- Daisy Team (1:20)	6	6.50	6.50	6.50	6.50	6.50	6.50	6.50
	Team 2 (1:36)	6	0.00	8.00	8.00	8.00	8.00	8.00	8.00
	Team 3 (1:36)	6		8.00	8.00	8.00	8.00	8.00	8.00

	Team 4 (1:36)	6			8.00	8.00	8.00	8.00	8.00
	Team 5 (1:36)	6			8.00	8.00	8.00	8.00	8.00
	Team 6 (1:36)					8.00	8.00	8.00	8.00
	Team 7 (1:36)					8.00	8.00	8.00	8.00
	Team 8 (1:36)						8.00	8.00	8.00
	Team 9 (1:36)							8.00	8.00
	Team 10(1:36)								8.00
Continuity of Care Teams Total			**6.50**	**22.50**	**38.50**	**54.50**	**62.50**	**70.50**	**78.50**
Grand Total			**116.51**	**113.96**	**113.57**	**123.57**	**128.57**	**133.57**	**138.57**

Management	Delivery Suite	7	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Maternity Ward	7	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Ante Natal	7	0.50	0.50	0.50	0.50	0.50	0.50	0.50
	Community	7	2.00	2.00	2.00	2.00	2.00	2.00	2.00
	Team 1- Daisy Team	7	0.50	0.50	0.50	0.50	0.50	0.50	0.50
	Team 2 Onwards	7	2.00	2.00	2.00	2.00	2.00	2.00	2.00
Management Total			**7.00**	**7.00**	**7.00**	**7.00**	**7.00**	**7.00**	**7.00**
Specialist Midwives	3RD Trimester scanning	6	0.70	0.70	0.70	0.70	0.70	0.70	0.70
	Bereavement Midwife	7	0.80	0.80	0.80	0.80	0.80	0.80	0.80
	Fetal Surveillance Safety Lead	8a	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Transformation and Project Lead	8a	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Practice Development Midwife	7	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Governance and risk midwife lead	7	1.00	1.00	1.00	1.00	1.00	1.00	1.00

	SBL champion	7	0.80	0.80	0.80	0.80	0.80	0.80	0.80
	Screening Midwife	6	0.60	0.60	0.60	0.60	0.60	0.60	0.60
	Screening Midwife	6	0.60	0.60	0.60	0.60	0.60	0.60	0.60
	Perinatal Mental Health Midwife	7	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Smoking Cessation Midwives	6	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Digital Midwife	7	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	PEF- Funded via income	7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Preceptorship Post - funded via income	7	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Daisy Team B6 - for Perinatal Mental Health Secondment	6	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Specialist Midwives Total			**11.50**	**10.50**	**10.50**	**10.50**	**10.50**	**10.50**	**10.50**
Managerial Roles	Director of Midwifery	8d	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	HOM	8c	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Matron	8a	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Matron	8a	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Head Of Governance	8b	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Total Managerial Roles			**5.00**	**5.00**	**5.00**	**5.00**	**5.00**	**5.00**	**5.00**

Total	**140.01**	**136.46**	**136.07**	**146.07**	**151.07**	**156.07**	**161.07**

Add specialist midwives roles funded via income	1.48	1.48	1.48	1.48	1.48	1.48	1.48
Total including income funding roles	**141.49**	**137.94**	**137.55**	**147.55**	**152.55**	**157.55**	**162.55**

Action Table for MCoC

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

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Picker maternity Survey Action Plan
Presented to:	Board of Directors
On:	08 June 2022
Presented by:	Cathy Stanford Interim Divisional Director of Midwifery and Neonates
Prepared by:	Angela Cropper Maternity Outpatient Matron
Contact details:	T: 01942 773107 E: cathy.stanford@wwl.nhs.uk

Executive summary

This action plan is based on the CQC Maternity survey report for Wrightington, Wigan and Leigh NHS Foundation Trust.

The 2021 maternity survey involved 122 NHS trusts in England. All NHS trusts providing maternity services that had at least 300 live births were eligible to take part in the survey. Women aged 16 years or over who had a live birth between 1 and 28 February 2021 (and January if a trust did not have a minimum of 300 eligible births in February) were invited to take part in the survey. Fieldwork took place between April and August 2021. Responses were received from more than 23,000 women, an adjusted response of 52%

A total of 300 Questionnaires were sent to mothers who birthed at Wrightington Wigan and Leigh. 297 were eligible for the survey, of which 109 returned a completed questionnaire, giving a response rate of 36.7%. This is an increase in the previous response rate of 34%.

The results show that despite the constraints of the Covid pandemic, our results are predominantly in line with other trusts, with 1 result worse, and 1 result somewhat worse, than most trusts.

The somewhat worse result is now actioned with the implementation of our Perinatal Mental Health Midwife and should see improvement in the next report.

The worse result continues to be worked on with the planning of implementation of continuity teams.

CQC Picker Action Plan 2021
Monitoring Committee – Obstetrics and Gynaecology Clinical Cabinet, DQEC, CQEC

REF	Issue Identified/ Recommendation	Actions to be taken (clear and specific identify resources where appropriate)	Lead Responsibility (Job Title)	Time Frame (date to be completed)	Progress towards Completion (include date the narrative relates to)	Date completed (RAG rate the column)	Evidence of completion
B12	Were you given enough support for your mental health during your pregnancy?	Perinatal Mental Health Midwife to be recruited. Training and support for staff to be provided by the PNMH midwife. Consultant PNMH for red RAG rated ladies with either PNMH midwife available, or their own Daisy team midwife. Additional PNMH clinic appointments to be commenced for Amber RAG rated ladies to be run by PNMH midwife	A Cropper Out- patient Matron	31/3/2023	Perinatal Mental Health (PNMH)Midwife recruited in 2021 and commenced in post September 2021. Policy for PNMH currently being developed and training provided to staff. All women with mental health concerns, to be screened by the PNMH midwife following referral at booking, in order that the most appropriate care by RAG rating is provided. Training by PNMH midwife being provided across maternity service regarding the new referral process.		**May 2022 Update** Due to the increasing demand and workload, there will now be a Band 6 secondment post to support the Perinatal Mental Health midwife . Pathways in place for screening with ongoing training for staff
B7	During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history? Worse	Ensure continuity of midwives at each antenatal appointment.	A Cropper Out-patient Matron	31/03/2023	**May 2020 Update** Midwives in the community have a named midwife and team approach to care. Piloting of new models of care to improve continuity and women experience. **August 2020 Update** Continuity of carer progressing well currently standing at 58% booked onto a pathway.		**May 2020 Update** Due to the Covid-19 Pandemic it is currently on hold **March 2022 Update** Continuity of carer teams currently suspended in order to maintain safety across the whole maternity service, due to the number of vacancies

REF	Issue Identified/ Recommendation	Actions to be taken (clear and specific identify resources where appropriate)	Lead Responsibility (Job Title)	Time Frame (date to be completed)	Progress towards Completion (include date the narrative relates to)	Date completed (RAG rate the column)	Evidence of completion
					Continuity teams being established within the community setting and core teams within the Delivery Suite. Work progressing on identifying vulnerable women and establishing a 'Vulnerable' team which will include BAME women with additional risk factors		and difficulties nationally with recruitment of midwives. When staffing levels improve MCoC teams will be recommenced. on-going recruitment remains in place. Staffing levels expected to improve significantly in Sept/ Oct with the recruitment of newly qualified Midwives Daisy, the team continue to provide care to the most vulnerable women, continues to provide ante and post-natal care.
					May 2020 Update Risk assessment tool has been fully revised and updated Assessment tool to be included within hand held records		**May 2020 Update** Risk assessment tool currently under ratification **August 2020 Update** Risk assessment risk assessment tool ratified June 2020  111 Appx 2 Antenatal risk factor i **March 2022 Update**

REF	Issue Identified/ Recommendation	Actions to be taken (clear and specific identify resources where appropriate)	Lead Responsibility (Job Title)	Time Frame (date to be completed)	Progress towards Completion (include date the narrative relates to)	Date completed (RAG rate the column)	Evidence of completion
		Midwives to ensure a full risk assessment is undertaken and updated at each contact					Risk assessment tool regularly updated as required.
F1	Choice about where postnatal care would take place. Increase 2.2	Identify appropriate premises for postnatal clinics.	A Cropper Out-patient Matron	31/03/21	**May 2020 Update** Work is ongoing within the community teams to identify premises/ rooms where postnatal clinics could be facilitated, thereby increasing choice for women. **August 2020 Update** Attend anywhere virtual platform being installed on all community Midwives lap tops which will give an additional option for review.		**May 2020 Update** Work has been halted due to Covid-19 pandemic **March 2022 Update** No change, escalated to CCG colleagues for support in obtaining permanent bases / Hubs for Midwifery teams which will allow the introduction of bespoke clinics . until suitable premises obtained this cannot be facilitated

Completed actions

B4 & B6	Given enough information about where to have baby or type of birth setting	Staff to now sign post women to the LMS Choices website. (Choice of provider)	A M Goodall Out-patient Matron	31/08/2021	**Feb 2020 Update** Staff currently using up stocks of Pioneer Choice leaflet. (stock will be depleted by 31/03/20)	April 2020	**May 2020 Update** Staff sign post women to NHS choices website at booking visit
B14	Availability of a telephone number during pregnancy that women could use to contact a member of the midwifery team. Decrease 0.3	Improve communication during the antenatal period Sticker to be placed on the front of the green antenatal records, which will contains the information of their 'Teams' name and their 'Named' midwife as well as the office and hospital contact numbers.	A Cropper Out-patient Matron	31/8/20	**May 2020 Update** All handheld notes have sticker in place with appropriate teams details and contact numbers	Ongoing/ continual	
B16	Need to reduce unnecessary jargon and abbreviations when communicating with women and that they understand what has been communicated. Decrease 0.2	Increase awareness within the Multidisciplinary Team regarding inappropriate use of abbreviations and medical jargon Highlight to staff re the appropriate use of interpreters.	A Cropper Out-patient Matron A Livesey In- Patient Matron	31/8/20	**May 2020 Update** Hand held notes provide clarity in regards to commonly used abbreviations Regular documentation audits are in place	Ongoing/ continual	
					May 2020 Update There is a Trust policy in place for interpreter services, all booking appointments will aim to have a face to face interpreter wherever possible as required. Language line can be used for all other routine appointments. Consent etc will be face to face whenever possible.	Ongoing/ continual	

D7	Found partner was able to stay with them as long as they wanted. 59% - 2019 46% - 2018 (National average 74%) Increase 1.4	Consideration is given for partners to remain with their partner whilst in labour if they are on the Maternity ward. Development of individualised care plans for ladies with special circumstances/ requirements.	A Livesey In-patient Matron	31/08/2020	**May 2020 Update** Women undergoing Induction of labour will be able to have partners for prolonged periods however there is no overnight sleeping accommodation.	Ongoing/ continual	
					May 2020 Update Individual personalised plans of care are implemented as required and available side rooms utilised.	Ongoing/ continual	
E2	Decisions about how to feed the baby were not respected by midwives. Decrease 0.1	To continue and monitor in order to identify any learning	A Livesey In-patient Matron	31/08/20	**May 2020 Update** Infant feeding team audit already this as part of their monthly audit with the information included into the UNICEF BFI quarterly compliance report.	Continual / Ongoing	Already in place as part of Infant Feeding Team work programme.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Maternity Perinatal Quality Surveillance (Report incorporating Q4 Data)
Presented to:	Trust Board
On:	8 June 2022
Presented by:	Rabina Tindale Chief Nurse
Prepared by:	Cathy Stanford Interim Divisional Director of Midwifery and Neonates
Contact details:	T: 01942 773107 E: cathy.stanford@wwl.nhs.uk

Executive summary

The Perinatal Quality surveillance report is to provide oversight and assurance to the Board that Maternity and Neonatal services are providing a safe and effective service to mothers and babies within our care. Any lessons learned from serious incidents are acted upon and that the relevant changes are made and sustained, this quarterly report will also provide updates on progression towards CNST compliance and Ockenden recommendations. Training compliance and update will include any modifications made as a result of the pandemic and identify any current challenges that may affect achievement of the standards.
The report is a CNST requirement of Safety Action 9. Where relevant additional reports will be submitted as required for The Maternity Incentive scheme and Continuity of Carer progress.

Ockenden Final Report

The final Ockenden report covers the review of the maternity care of 1,486 families at Shrewsbury and Telford Hospitals NHS Trust and, from these, 1,592 clinical incidents were reviewed) and follows on from the first report, which was published in December 2020.

The first report outlined the local actions for learning (LAfL) and immediate and essential actions (IEAs) to be implemented at Shrewsbury and Telford trust and across the wider maternity system in England. The second report builds upon the first in that all the LAfL and IEAs within that report remain important and must be progressed.

The review team identified a number of new themes which are now being shared across all maternity services in England as a matter of urgency to bring about positive and essential change.

The report describes thematic and repeated failures in care which included failures to safeguard mothers and babies, failing to investigate when things had gone wrong, and a lack of learning from adverse events and failure to make improvements.
Throughout the various stages of care the review team identified failings to follow national clinical guidelines and failures in care, governance, assurance, systems and processes, the review also found associated failures in clinical and corporate leadership at the Trust.

It describes that, had the care of a significant number of women and babies been managed differently, then the outcomes from them may have been different. It is stated that due learning and better adherence to approved procedures, practices and guidelines may have prevented further deaths of women and babies.
It was recognised that many of the issues highlighted within the report were not unique to Shrewsbury and Telford Hospital NHS Trust and have been highlighted in other local and national reports into maternity services in recent years, therefore the review team identified 15 areas for immediate and essential actions(IEA's) to be considered by all Trusts within the UK, some of these include:

- the need for significant investment in the maternity workforce and multi-professional training
- suspension of the midwifery continuity of carer model until – and unless – safe staffing is shown to be present
- strengthened accountability for improvements in care among senior maternity staff, with timely implementation of changes in practice and improved investigations involving families

On receipt of the report, the following actions have been taken:

- The maternity services senior team, supported by divisional colleagues, have a commenced a gap analysis (Ockenden 2 action plan) against all the new actions and this work will continue within the division fortnightly.
- The Local Maternity System (LMS) is supporting GM Trusts to complete the Gap analysis and will meet regularly to review progress against the recommendations.
- The first version of the Ockenden 2 action plan / Gap analysis is attached for Board review for the Board to consider the Trust's progress against the required actions.

Maternity Incentive scheme Compliance

The Maternity incentive scheme Year 4 has now recommenced effective from the 6 May 2022 following a 6 month pause in reporting. The scheme's submission deadline has been extended from June 2022 to 5 January 2023 to provide Trusts with extra time to achieve the standards. Interim timeframes within each of the safety actions have also been reviewed and extended In light of the publication of the Ockenden Report, some of the safety actions have been revised and new requirements added. This includes safety action 5, midwifery staffing; safety action 7, Maternity Voices Partnership; and safety action 9, safety champions.
Quarterly updates will be provided to demonstrate compliance against the standards, which is provided within the main body of the report.

The main issues to escalate are:
Safety Action 2
Completeness of submissions to the Maternity Services Data Set (MSDS).
This is reliant on the system provider having the correct reports within the system to capture the data. There are some delays with this at present, which we are escalating with them.

Safety Action 4
Can you demonstrate an effective system of clinical* workforce planning to the required standard?.
This action involves the Tier 1 rota within paediatrics which currently and historically has gaps.an action from Year 3 was to training 2 Advance Neonatal Nurse Practitioners which has been agreed in principle however funding has not been identified as yet for this.

Anaesthetic rota should be used to identify compliance with ACSA standard 1.7.2.1
Shortfall in rotas and training attendance

Safety Action 8
Can you evidence that a local training plan is in place to ensure that all six core modules of the core competency framework will be included in the unit training programme over the next 3 years from the launch of MIS Year 4

In addition, can you evidence that that at least 90% of each relevant staff group has attended an in house one day muti-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and new born life support.

90% compliance projected for midwifery and Obstetric staff ; however anaesthetic attendance may be problematic but compliance is increasing.

Maternity Continuity of Carer(MCoC)

WWL had completed its building blocks plan ready for submission to the Regional and National teams however new guidance was received from the national maternity transformation board via the regional team requesting further information to be included with each Trusts Building Blocks plans which is due for submission by the 15 June 2022, as per the letter received from Amanda Pritchard, Ruth May and Stephen Powis.

Therefore, the plan is now in the process of being revised and can be submitted to Board for approval following the deadline to submit to the national team.

Maternity services and LMS (or LMNS) are asked to prepare a plan to reach a position where midwifery Continuity of Carer is the default position model of care available to all women by March 2024.

The additional information that has been requested is to specifically identify the areas where enhanced Continuity Teams will focus care for women at greatest risk of poor outcomes from the most deprived neighbourhoods in the bottom most deprived decile, as defined by the Indices of multiple Deprivation (IMD) and those of Black, Asian and minority Ethnic backgrounds.

The roll out of enhanced continuity teams is linked to the Long-Term Plan to help improve outcomes for the most vulnerable mothers and babies which also now forms part of the Plus 5 interventions in the National CORE20PLUS5 strategy to reduce inequalities

Recommendations

It is requested that the Board of Directors and executives review the contents of this paper in order to be aware of the recommendations within the report and gain assurance of the progress towards compliance in reaching the Ockenden Immediate and Essential Actions (IEA's) from both reports which are continuing to be considered and implemented within the Division and that the Maternity Incentive scheme standards are on track for compliance.

Additionally, please be advised that a revised MCoC building blocks plan will be submitted at a later date which demonstrates how WWL intend to implement the next teams and that these will be targeted in the most vulnerable areas of the Borough.

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Maternity Perinatal Quality Surveillance Report January – April

CQC RATING	Overall	Safe	Effective	Caring	Well Led	Responsive
	Good	Good	Good	Good	Good	Good

Midwifery Red Flags.	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22
	4	0	0	1			
	Comments: All red flags in January due to Reduced staffing levels with increased Covid sickness across the service . April 2022 – shift leader unable to remain supernumerary for one shift due to staff shortage . (sickness) and high activity levels.						

STEIS reportable incidents	Jan 22	Feb 22	Mar 22	Apr 22	May 22	June 22	Jul 22
	0	0	1	1			

Comments:

The number of Serious Incidents which occur in any given year can vary considerably, due to SI data from Trusts not being published we are not able to benchmark this area. However, the chart below indicated the numbers of cases that are referred to HSIB, nationally and regionally as a whole.

It is important to note that WWL have a clear process for the identification and investigation of Serious Incidents and have an open and honest approach to this.

there are currently 3 concise investigations in progress 2 of which have been reported to STEIS

HSIB referrals	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22
	0	0	0	0			

Comments:
All of the cases reported to HSIB have been for Therapeutic Cooling for suspected Hypoxic Ischaemic Encephalopathy (HIE). The majority of babies are discharged in a short period with no ongoing neurological deficits however they remain under paediatric review. WWL has a low incidence of cases that meet the criteria for HSIB review.
Of the 2 cases reported in 2021 one had no safety recommendations and one recommended that :

1. The Trust to ensure that there is effective communication and collaborative multidisciplinary working to minimise delays in the provision of care.
2. The Trust to support staff to recognise and escalate concerns about fetal wellbeing.

To date 7 referrals have been made since 2019, 3 of which were rejected as they did not meet the HIE criteria for review .

Service	StEIS Ref/datix	Reported in line with policy	Summary of completed investigations
Maternity	2021/7495	Yes	An emergency admission at 38 weeks with a antepartum haemorrhage and spontaneous rupture of membranes with ongoing bleeding and a fetal bradycardia resulting in a category 1 caesarean section A massive postpartum haemorrhage of 6800mls ensued with the woman suffering a cardiac arrest The woman recovered following ICU admission. **Immediate Action Taken:** Support to the woman and her family Duty of Candour verbally and in writing undertaken. Full debrief and feedback from investigation given **Lesson Learnt:** • Delay in requesting FFP & platelets despite the massive haemorrhage and haemodynamic instability. • Delay in transfusion of blood products including packed red cells & FFP. • Rapid infuser was present in general theatres but not utilised to increase speed of fluid replacement • Initial management of PPH could have been more aggressive. Ergometrine could have been repeated when heamabate was not working. • Delayed escalation to consultant anaesthetist or critical care consultant for support in a very challenging situation. Despite being prompted several times by different members of the team, the anaesthetist was reluctance to call for help
Maternity	2021/20668	Yes	Never event where a Mirena Coil had been fitted at elective caesarean incorrectly by an inexperienced operator **Immediate Action Taken:** Reviewed of process for the insertion of the Mirena Coil Duty of Candour verbally and in writing undertaken **Lesson Learnt:** Insertion of a Mirena Coil at caesarean is difficult and should only be performed by an experienced operator. Further consideration has now

			been given and the procedure is no longer offered or advised at Caesarean section.
Maternity	2021/116202	Yes	28-year-old multiparous lady, was receiving care in her third pregnancy, booked for an elective caesarean section at her request due to anxiety, related to her history. Attended delivery suite in the early stages of labour at 38+3 gestation after spontaneous rupture of membranes (SROM). At this visit, a detailed discussion was had with the midwife about risks and benefits of aiming for a vaginal delivery versus having a caesarean section, she opted to aim for a vaginal birth. An augmentation of labour was booked the following day in case spontaneous labour did not follow the rupture of membranes. Attended the following morning in spontaneous labour and progressed to a normal vaginal delivery. A live female infant was born with poor colour and tone, and no respiratory effort. The Baby's Apgar's scores were 1 at 1 minute, 4 at 5 minutes and 6 at 10 minutes **Immediate Action Taken** Resuscitation was commenced, including stimulation, airway support and cardiac compressions. The baby was subsequently transferred to the Neonatal unit (NNU) and commenced on Continuous Positive Airway Pressure (CPAP). Cerebral Function Monitoring (CFM) was commenced and, following discussion with the level 3 Neonatal Unit (NNU), transfer to Bolton for therapeutic hypothermia or cooling was undertaken. **Lesson Learnt:** • No documentation of discussing the woman's anxiety and request for caesarean section with an obstetric consultant at the antenatal appointment. • As a medical plan for an elective caesarean section had already been made an obstetrician should have been directly involved in a change of plan for the mode of delivery.
Maternity	WEB117402	Yes	Baby was born at 41 weeks and 2 days gestation via Category 1 emergency caesarean section. At birth, the APGARS were 1 at 1 minute, 6 at 5 minutes and 7 at 10 minutes and required active resuscitation Baby was intubated and ventilated and, subsequently, transferred to The Royal Oldham Hospital Neonatal Unit (NNU) with suspected Meconium Aspiration Syndrome. Baby was also found to have a 28mm posterior vascular lesion with an associated area of bleeding, on their subsequent MRI scan, which may possibly have a related underlying vascular malformation but could be caused by infection, trauma, bleeding disorders, genetic causes or congenital disorders and can occur in the antenatal, intrapartum, or early neonatal period. It cannot be determined that this was caused during the time period after admission for induction of labour. **Immediate Action Taken** • The neonatal unit bleep system was amended, and the Neonatal shift coordinator bleep is now interlinked to the Paediatric Registrars bleep. If an emergency or Crash bleep is made to the registrar, the sister in charge will also receive the same information. This would facilitate earlier attendance of the neonatal team. • A review of the current Diabetes in Pregnancy Guideline was required, to ensure it reflects current practice when women have

			glycosuria in pregnancy including ensuring that follow-up is arranged from the specialist diabetes midwife and nurse. **Lesson Learnt:** • There were missed opportunities to assess growth velocity by both the community midwife from another trust who do not refer for slowing growth and at hospital appointment • There were no intrapartum 'fresh eyes' stickers used due to labour not being classified as established because of the absence of regular painful contractions. • Was referred for blood glucose monitoring in pregnancy but had no follow up from a diabetes specialist midwife or nurse
Maternity		Yes	P1 with a history of a previous caesarean, was admitted to maternity triage with uterine tightening's with suspected labour and feeling unwell. She had spontaneous rupture of membranes and was reviewed. On examination the cervix was 1-2 cm dilated and was keen for a VBAC (vaginal birth after Caesarean). The registrar counselled her about the risk of emergency Caesarean section if no progress and requested 15 minutes observations, continuous fetal monitoring, bloods and intravenous access and fluids and plan was to re-examine in 4 hours. Progressed quickly from 3 cm dilation and had an assisted vaginal delivery (forceps delivery) for a fetal bradycardia Baby E was born with low APGAR scores of 1 at 1 minute; 4 at 5 minutes; and 5 at 10 minutes. **Immediate Action Taken** Respiratory resuscitation and cardiac massage were commenced by the Neonatal team and Baby transferred to the neonatal intensive care unit. A recommendation was made for therapeutic cooling and transfer to a tertiary centre was subsequently arranged Diagnosis of mild or Grade 1 HIE (Hypoxic Ischaemic Encephalopathy). Cranial Ultrasound scan showed no intraventricular haemorrhage (IVH) or intracranial bleed and Magnetic Resonance Imaging of the brain indicated no abnormality detected. Baby also had respiratory distress syndrome, congenital lactic acidosis and presumed sepsis/septicaemia but negative microbiology results were received on screening for causes of sepsis. The CFM was normal throughout, and no seizure activity was witnessed leading to a conclusion that it is unlikely that Baby has had any seizures **Lesson Learnt:** • . All midwifery staff to be reminded to score MEOWS observations and act on them by escalating to shift coordinator and Obstetric staff. • We need further training on appropriate recognition and escalation of Sepsis. Sepsis should be considered even in absence of pyrexia if there is maternal tachycardia/ hypotension/ tachypnoea/ non reassuring CTG/ fetal tachycardia >160bpm as per WWL Obs 30 GL on Sepsis and sepsis six should be promptly initiated. • Incorporate sepsis and the effects on interpretation of the CTG into mandatory training. • Be aware that an FBS may be falsely reassuring in Sepsis and in presence of significant meconium. • An increased awareness is required to have a low threshold for delivery in presence of persistent non reassuring CTG in the presence of Sepsis red or amber flags signs and symptoms in labour.

Formal Complaints	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22
	1	1	0	1			

Comments:

in 2022 to date 5 formal complaints have been received for maternity services with 2 deescalated to a concern following meeting with the patient and family. No complaints have been received for NNU.

The main themes identified within the complaints are

- Poor communication
- Staff values and behaviours
- Clinical treatment

MVP Feedback.	A 2nd time Mother shared her story at the Wigan Borough Maternity Voices Partnership Group on the 29th March 2022 of her experience of her care during Covid. Her story provided mixed feedback for the maternity services and there were lessons to learn from her early pregnancy journey during Covid. The Mum highlighted her positive experience with the community midwifery services, she explained she had excellent care both in the antenatal and postnatal period with lots of support especially with breastfeeding . The Mum also commented that with addition of a perinatal mental health midwife was great and would support her in future pregnancies. Service user provided details of their care at the MVP meeting. Expressed that she had received excellent postnatal care from her community midwives but also reflected that she had experienced lack of compassion with her dating scan which led to her booking the rest of her antenatal and birth care at a neighbouring unit. Glowing report about the care received from a woman who has had a baby within the service recently and 6 years ago. Significant improvement in care this time. Would like to see a return to face to face antenatal parent education when possible

Risk register	Corporate	Divisional	Local
	0	4	5

Comments:

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

Midwifery Staffing Shortages
CTG Misinterpretation
Collection and submission of Maternity Services Data Set (MSDS)
Delivery Suite Co-ordinators should be supernumerary at all times

Risks continue to be pro-actively manged within the Division.

Ockenden Update	The final Ockenden report describes thematic and repeated failures in care which included failures to safeguard mothers and babies, failing to investigate when things had gone wrong, and a lack of learning from adverse events and failure to make improvements. Throughout the various stages of care the review team identified failings to follow national clinical guidelines and failures in care, governance, assurance, systems and processes, the review also found associated failures in clinical and corporate leadership at the Trust. It describes that, had the care of a significant number of women and babies been managed differently, then the outcomes from them may have been different. It is stated that due learning and better adherence to approved procedures, practices and guidelines may have prevented further deaths of women and babies. It was recognised that many of the issues highlighted within the report were not unique to Shrewsbury and Telford Hospital NHS Trust and have been highlighted in other local and national reports into maternity services in recent years, therefore the review team identified 15 areas for immediate and essential actions(IEA's) to be considered by all Trusts within the UK, some of these include: • the need for significant investment in the maternity workforce and multi-professional training • suspension of the midwifery continuity of carer model until – and unless – safe staffing is shown to be present • strengthened accountability for improvements in care among senior maternity staff, with timely implementation of changes in practice and improved investigations involving families Trusts are asked to pay particular attention to the reports four key pillars: • Safe staffing levels • A well-trained workfare • Learning from incidents • Listening to families **Please see Appendix 1 First draft of the Ockenden Final Report action plan which is being actively reviewed and update by the Division.** Within the 15 Overarching Immediate Essential actions there are a total of 92 separate actions to demonstrate compliance against. The Division has started the self-assessment against all the recommendations and we are predominantly working towards or complaint with the recommendations. A summary of the highlighted initial concerns that require either further investment or national support are detailed below.

The 15 IEA 's to be considered are outlined within the following categories with initial Rag Ratings

		Red	Amber	Green	National/ regional Action or n/a
IEA1	Workforce planning and sustainability	2	7	2	
IEA2	Safe staffing	1	5	3	1
IEA3	Escalation and accountability	1	4	0	
IEA4	Clinical governance-leadership	1	5	1	
IEA5	Clinical governance – incident investigation and complaints	0	5	2	
IEA6	Learning from maternal deaths	0	2	0	1
IEA7	Multidisciplinary training	1	4	2	
IEA8	Complex antenatal care	0	2	3	
IEA9	Preterm birth	0	2	2	
IEA10	Labour and birth	0	2	2	N/A
IEA11	Obstetric anaesthesia	1	6	1	
IEA12	Postnatal care	0	2	2	
IEA13	Bereavement care	0	2	2	
IEA14	Neonatal care	1	2	4	1
IEA15	Supporting families	2	1	0	
	Total	10	51	26	2

Initial concerns rated as red on action plan

- Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.

Birth rate+ staffing review will be undertaken in the coming weeks which is being funded by the LMS for all GM Trusts. This will take into consideration the above criteria to provide an updated staffing baseline requirement. This will have funding implications if baseline staffing levels are increased

- The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction

MCoC was halted in WWL in November 2021 due to insufficient staffing levels to sustain a safe service. This is under constant review and staffing shortfalls still remain. Therefore, Continuity remains on hold and will be re-introduced when fully recruited to current vacancies. The building blocks action plan has been completed and submitted as requested by the National and Regional Maternity teams, the LMS and to Trust in February 2022, and updated version to be submitted in June 2022

- In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.

WWL has a single Consultant on call rota for both areas, changes to this will require substantial financial investment and radical changes to Job plans.

- Trusts should aim to increase resident consultant obstetrician presence where this is achievable.

There are currently no residents Consultants in place as these were not continued in favour of traditional Consultant posts.

- Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services

Awaiting further clarification on this recommendation

- Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory

Plans are now being put in place for a robust process to ensure compliance.

- The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.

Anaesthetic team will need to review job plans for this recommendation

- Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.

This requires further discussion and review to implement and update guidance etc, however it would be usual that the Consultant would be attending the unit ASAP.

- There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.

This action will require investment and service development to implement

- Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.

This action will require investment and service development to implement

Maternity Incentive Scheme Progress Year 4.	The Maternity incentive scheme Year 4 has now recommenced effective from the 6 May 2022 following a 6 month pause in reporting. The scheme's submission deadline has been extended from June 2022 to 5 January 2023 to provide Trusts with extra time to achieve the standards. Interim timeframes within each of the safety actions have also been reviewed and extended In light of the publication of the Ockenden Report, some of the safety actions have been revised and new requirements added. This includes safety action 5, midwifery staffing; safety action 7, Maternity Voices Partnership; and safety action 9, safety champions. The scheme's conditions have also been reviewed and strengthened. The new conditions include the following additional requirements: • The declaration form to be submitted to Trust Board with an accompanying joint presentation detailing maternity safety actions by the Head of Midwifery and Clinical Director for Maternity Services • The CEO of the Trust will ensure that the Accountable Officer (AO) for their Clinical Commissioning Group/Integrated Care System (CCG/ICB) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution. From a financial perspective, Trusts' contributions towards year 4 of MIS will not be collected in the 2022/23 financial year but will be collected in 2023/24 financial year. Year 4 results and payments will also be shared with Trusts at the earliest in point possible in 2023/24 to enable Trusts to make best use of the funds available to them. **Progress against the Year 4 Maternity Incentive Scheme (CNST):** Where partial compliance has been declared this will be due to having to demonstrate compliance over the whole of the reporting period and is not necessarily a negative **Safety Action 1** Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard? **Current status. Fully compliant** **Safety Action 2** Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? **Current status. Partially compliant** **Safety Action 3** Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into the Neonatal units Programme? **Current status. Partially compliant**

Safety Action 4
Can you demonstrate an effective system of clinical* workforce planning to the required standard?
Current status. Partially compliant

Safety Action 5
Can you demonstrate an effective system of midwifery workforce planning to the required standard?
Current status. Fully compliant

Safety Action 6
Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Current status. Fully compliant

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

Safety Action 8
Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?
In addition, can you evidence at least 90% of each maternity unit staff group have attended an 'in-house' one day multi-professional training day
Current status. Partially compliant

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

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

Maternity Continuity of Carer (MC0C)

May 2022 Update

WWL had completed its building blocks plan ready for submission to the Regional and National teams however new guidance was received from the national maternity transformation board via the regional team requesting further information to be included with each Trusts Building Blocks plans which is due for submission by the 15 June 2022, as per the letter received from Amanda Pritchard, Ruth May and Stephen Powis.
Therefore, this is now in the process of being revised and can be submitted to Board for approval following the deadline to submit to the national team.

In line with *Better Births* and the *NHS Long Term Plan*, all women should be offered the opportunity to receive the benefits of Continuity of Carer across antenatal, intrapartum, and postnatal care. However, not all women will be in a position to receive continuity of carer, through choosing to receive some of their care at another maternity provider. Also, in a small number of cases, women will be offered a transfer of care to a specialist service for maternal / fetal medicine reasons.

Providing Continuity of Carer by default therefore means:

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

Maternity services and LMS (or LMNS) are asked to prepare a plan to reach a position where midwifery Continuity of Carer is the default position model of care available to all women by March 2024.

The additional information that has been requested is to specifically identify the areas where enhanced Continuity Teams will focus care for women at greatest risk of poor outcomes from the most deprived neighbourhoods in the bottom most deprived decile, as defined by the Indices of multiple Deprivation (IMD) and those of Black, Asian and minority Ethnic backgrounds.

The roll out of enhanced continuity teams is linked to the Long-Term Plan to help improve outcomes for the most vulnerable mothers and babies which also now forms part of the Plus 5 interventions in the National CORE20PLUS5 strategy to reduce inequalities.

Some funding has been allocated (£46,102) for every full team providing care to women in the eligible neighbourhoods, which will support the implementation of a Band 4 Maternity Support Worker (MSW). once plans are submitted a selection panel will review all proposed enhanced teams nationally, to ensure they meet the criteria and the overall quality of the implementation plan submitted.

Submitted plans are expected to include the recruitment plans to reinstate continuity teams at a later date and separate to the enhanced teams they must include the rollout of standards MCoC teams which should be prioritised to areas with a high proportion of Black, Asian and Mixed ethnicity women with the commitment for 75% of women from these groups to be provided with MCoC by March 2024.

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Training

Fetal Surveillance and Physiology							
	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22
Consultant Obs					82%	100%	
Obs Trainees					77%	89%	
Maternity HCA	81%	86%	90%	86%	93%	90%	90%

PROMPT							
	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22
Midwifery Staff	No	70%	70%	73%	81%	83%	89%
Consultant Obs	Training	36%	45%	45%	54%	72%	81%
Obs Trainees		64%	72%	90%	90%	81%	90%
Maternity HCA		48%	58%	63%	73%	80%	86%
Anaesthetists		26%	27%	33%	43%	52%	61%

Maternity Training Compliance Narrative

By September 2022 90% compliance will be achieved for all staff groups for fetal physiology and CTG training.
90% compliance will be achieved for all relevant staff groups for PROMPT (Practical Obstetric Multi-Professional Training) except for obstetric anaesthetists and this is a risk that we will not be compliant prior to submission on Jan 5 2023

The cancellation of PROMPT training in January due to COVID 19 sickness, has led to some backlog and additionally room capacity in the education centre and releasing staff from the clinical area due to workload pressures has also reduced attendance and therefore compliance in some months.

However, as room capacity has been relaxed we have been able to increase our numbers on training sessions to enable more staff to be compliant.
To meet full CNST compliance a third mandatory training day has had to be introduced for midwifery staff to cover all core competencies and training requirements.

Staffing

	Metric	Standard	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May
Workforce	1:1 care in labour	100%	100%	99.35%	100%	100%	99.49%	
	Supernumerary Shift Coordinator	100%	100	98.38	100	100	98.33%	
	Midwifery Sickness							
	Midwifery Vacancies						17wte	

	Comments: It is noted that in January and April there has been a slip below the 100% target for shift coordinator and 1:1 care in labour. 1:1 care in each of these months was just one woman reported to have not received 1:1 care. Likewise, the shift coordinator was unable to remain supernumerary for one shift each month due to staffing issues (sickness) and high activity and acuity. Currently there are approximately 17wte vacancies across maternity services with 3 further staff coming into post in June 22. There has also been successful recruitment to our students in training who will qualify in September. This still leaves approximately 4.6 wte vacancies to recruit against, which will mean a shortage of staff over the traditionally busy summer months for births until full recruitment has taken place.

Activity

	Metric	Standard	Dec 21	Jan 22	Feb 22	Mar 22	April 22	May 22
Activity	Number of bookings	>240 <200	233	271	235	255	267	
	Registerable births	>200 <180	213	198	187	211	203	
	Induction of Labour as % births	<38% >=42%	40.38%	34.34%	41.71%	36.49%	35.96 %	
	Instrumental deliveries	10.8%	11.11%	10.16%	9.48%	12.32%	12.32 %	
	Total C/S	34.27%	34.27%	36.36%	31.55%	38.39%	33.5%	
	Robson Criteria							
	1							
	2							
	3							
	4							
	5							
	6							
	7							
	8							
	9							
	10							
	3rd/4th degree tear as % of births	<3 >4	3.3%	2.05%	0.54%	0.97%	1.51%	
	PPH >2500 as % of births		0.00%	0.51%	0.53%	1.42%	0.49%	
	Comments: These are largely positive metrics with some amber data parameters. A reduction in births was noted in the same period in 2021 and improved from March onwards – this similar trend can be seen above.							

	Following an increase of 3rd/4th degree tears in 2021 we can see that there has been a significant decrease and WWL now has the lowest rate within GM. Post-Partum Haemorrhage levels continue to be significantly reduced and below the regional and national averages, which was also identified within the Annual regional dashboard review as a positive improvement. Robson criteria remains under development with the system provider and is near completion. This is a MSDS requirement and will need to be ready prior to the July maternity incentive scheme submission date. Concern has been escalated to the MIS Provider (Euroking).

Neonatal	Metric	Standard	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22
	Apgar's <7 at 5 minutes	<4	4	2	1	2	3	
	Unexpected term admissions to NNU (%)	3.5% >4.5%	3.16%	2.34%	1.16%	1.63%	2.11%	
	Babies readmitted within 28 days of birth	<16 >20	19	11	14	10	14	
	Shoulder dystocia as % of births		0.00%	0.51%	1.07%	1.90%	1.97%	
	HIE 2 & 3 >27 weeks		0	0	0	0	0	
	Stillbirths		2	0	0	1	0	
	Early NND		0	0	0	0	0	
	Singleton babies born <30 weeks		0	0	2	2	1	
	% Whose mother received MgSO4	100% 90%	N/A	N/A	0%	50%	100%	
	Singleton babies born <34 weeks		2	4	2	5	3	
	% Whose mother received full course steroids	100% 90%	25%	50%	33.33%	80%	66.67%	
	Mothers who did not receive full course and omissions in care noted		0	0	0	0	0	

	Comments: Predominantly positives metrics can be seen in the above data. Unexpected admissions to NNU remain consistently below expected levels as do readmissions within 28 days of birth. And there has been significant improvement in the number of babies with an Apgar score of less that 7 at 5 minutes. For maternal steroids, given to mature the fetal lungs when premature labour is suspected, or early delivery is required, it can be seen above that whilst we see that these areas are persistently red, when the reason behind the full course not being given is looked at, no omissions in care are noted. Delivery does sometimes need to be expedited and therefore there is no opportunity to give a second steroid dose or administer the magnesium sulphate loading dose. There was an annual review of Neonatal services undertaken in May by the North West Neonatal Operation Delivery Network (NWNODN). Overall, it was a very positive review and a positive report has been received from the NWNODN Director, which outlines the high standards of care and the excellent educational and quality improvement measures that have been put in place and the passionate team who deliver family focused neonatal care.

NNU optimisation data

	Standard	Jan 22	Feb 22	Mar 22	April 22	May 22	
Admissions under 27 weeks	<1 >2	0	1	2	0		
% Mothers expressing breastmilk in first 24hrs following admission to NNU (<32 weeks)	>58% <58%	37.5%	26.3%	32.1%	58.3%		
% Babies who receive human milk in first 24hrs following admission to NNU (<32 weeks)	>58% <58%	29.2%	26.3%	28.6%	50%		
% Babies receiving human milk when they leave the unit (<32 weeks)	>58% <58%	78.3%	47.8%	40%	52.2%		
% Mothers expressing breastmilk when their baby leaves the unit (<32 weeks)	>58% <58%	56.5%	39.1%	44%	56.5%		
% Mothers breastfeeding their baby when they leave the unit (<32 weeks)	>58% <58%	47.8%	39.1%	32%	52.2%		
Temperature in 1st hour recorded (<32 weeks)	>97% <97%	100%	100%	100%	100%		

Comments:	The Neonatal dashboard remains under development; however, the optimisation metrics have been included as these will be reported within the National Neonatal Audit Programme. It can bee seen that similar to the levels of breastfeeding with term babies the rate is lower than the national average however much work is being undertaken to improve this and encourage mothers to offer breastmilk as can be seen by the improvements noted in April. **Neonatal optimisation** Baby Friendly Initiative (BFI) standards recommend the facilitating of early breast milk expression as breast milk is beneficial in reducing adverse outcomes especially necrotising enterocolitis alongside having a positive effect on neurodevelopment. Metrics to be include once data capture is implemented electronically will be delayed cord clamping and normothermia. Pre-natal optimisation metrics are captured within the maternity neonatal table.

SBL – CNST

		Jan 22	Feb 22	March 22	April 22	May 22	June 22
Metric	Standard						
% Women with CO recorded at booking	90%	87.8%	91.06%	90.19%	86.14%		
% Women with CO recorded at 36 weeks	90%	38.38%	35.82%	86%			
% Of women SATOD	14% 17%	9.74%	16.75%	15.63%	12.56%		
Babies born <3rd centile at >38 weeks		7	3	4	6		
Number cases eligible for PMRT review	N/A	1	1	2	0		
Number PMRT reviews commenced during month	100%	1	1	2	0		
	Comments: Work continues to reduce the number of women smoking at time of delivery (SATOD) and following an increase in February and March we can see a reduction in April to normal levels. Co monitoring at booking ahs remained consistently compliant in the most part and just needs some further improvement to reach the 90% each month. Co recording at 36 weeks has proved more challenging due to data capture and measures are being put in place to improve this going forward						

Regional Maternity Dashboard Data conclusions (2021)

As a quality improvement tool, the Maternity Dashboard has proved useful in identifying both positive and negative outliers across the region.

2021 has seen improvements in most metrics across GM, and this is despite the continued impact of the pandemic on Maternity Care.

The population of GMEC is high risk in the context of complications of pregnancy but also high risk in terms of the impact of the COVID-19 epidemic. It is known that obesity, ethnicity, and deprivation all make significant contributions to COVID outcomes and the excess of such markers in the GM population isrelevant when interpreting the potential impact, the epidemic may have had on outcomes.

It can be seen from the spider diagram below that as a trust we are seeing many positive outcomes. In the coming year work will be done to focus on the metrics that are performing below the GM average and ensure that the improvement we have seen in early 2022 is sustained for 3rd/4th degree tears. Work will continue with regards to Smoking and breastfeeding which although has seen some improvements WWL remains an outlier across the region.

We will be focusing on reducing the Pre-Term Birth rates , however the increase in this metric is not unique to WWL, and work remains ongoing in identifying improvements and ensuring that the correct pathways are being followed as part of the Saving Babies Lives care bundle Element 5.

The above spider graph based on annual; 2021 data reported to the regional Dashboard team indicates that those metrics outside of the highlighted circle are better performing metrics, and those within require

further consideration for improvements measures.

Metrics for improvement

- 3rd/4th Degree Tears. In 2022 this has seen a significant improvement and WWL currently have the lowest rate across GM
- Initiation of Breastfeeding. This has been a persistent issue, and whilst it is recognised that this is not solely a WWL issue as it also sits under public health and education work continues to drive improvements
- Smoking at Time of Delivery. The introduction of a smoking cessation midwife has made significant improvements in WWL rates although we do remain an outlier within GM
- Induction of Labour. All Trusts within GM have similar induction rates, although 2022 has seen some reduction for WWL.
- Pre-Term Birth is reported as those births that took place before 37 completed weeks gestation. Work is ongoing to commence a dedicated pre-term birth clinic for those women who have been identified as high risk at booking, to ensure that they are on the appropriate pathways and birth is optimised and in the appropriate place.

The bar chart below is the same data but identifies what the GM mean is as indicated by the yellow line, and this shows the improvements made within the last 5 years of data submission.


Spider Chart
Bar Chart
GM/GMEC
Selected Provider
WWL
NB EC Inpatient services has been closed since March 2020 due to COVID, hence EC 2020 data only includes 3 months of data.
%
3rd & 4th Degree Tears
Admissions to neonatal unit, ≥37 weeks
Emergency LSCS
Pre-Term Births
Women smoking at time of delivery
Inductions
Women initiating breast feeding
Rates (%)
per 1000
Major haemorrhages >2500mls
Neonates with a diagnosis of HIE Grade 2 and 3, ≥37 weeks
Stillbirths
Total ENNDs
Neonates with apgars <7 at 5 minutes, ≥ 37 weeks
Rates (per 1000)
GM/GMEC (per 1000)

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Conclusion

Overall Q4 has predominantly identified positive outcomes for mothers and babies. A GAP analysis against the Final Ockenden report is underway with initial review identifying 10 red rated actions and 3 actions that will require regional or national support to deliver. The remaining recommendations are either amber or green.
There will be an Ockenden Assurance visit in July which will assess the unit against the progress of the 7IEA's from the first report.
The Maternity Incentive Scheme Compliance is largely positive with some identified areas that will require some support to achieve, however robust plans are in place with dedicated leads for each standard, and regular reviews are in place.
The number of serious incidents has not been high for this quarter and all have been reviewed appropriately and escalated in line with recommendations. Feedback will be given to patients , families and staff on completion of the investigations. Lessons learned from incidents will be cascaded through various channels such as newsletter direct feedback and mandatory training.
Dashboard metrics for maternity and Neonatal outcomes remain largely positive with several improving metrics. Overall WWL bench marked against all other bench marked trusts shows a positive picture of sustained improvements, with many positively below the regional average.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Mortality Review: Learning from Deaths Report
Presented to:	Trust Board
On:	08 June 2022
Presented by:	Dr S Arya
Prepared by:	Alison Unsworth, Clinical Audit and Effectiveness Manager **Contributors:** Dr M Farrier, Associate Medical Director Sarah Howard, Bereavement Midwife Lesley Timperley, Clinical Lead/ Community Learning Disability Nurse Andrew Barlow, Head of Governance, Community Division
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 Q4 2021/2022

- Total number of deaths: 407
- Total number of deaths reviewed: 317 (78%)
- Total number of potentially preventable deaths: 2
- Total number of patients with Learning disabilities submitted to LeDeR: 7 (2 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: 0
- Total number of Prevention of Future Deaths Notices: 0
- Current SHMI: 107.47 (Within expected level)
- Current HSMR: 91.10 (Within expected level)

Report produced 13th May 2022.

Risks associated with this report and proposed mitigations

None known

Financial implications

None known

The WWL Way

Legal implications

None known

People implications

None known

Wider implications

None known

Recommendation(s)

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

Mortality Review: Learning from Deaths Report

2021 – 2022 Quarter 4

1.0 Introduction

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

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

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

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

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

2.0 Total Number of Deaths (By Quarter)

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

2.1 Length of Stay

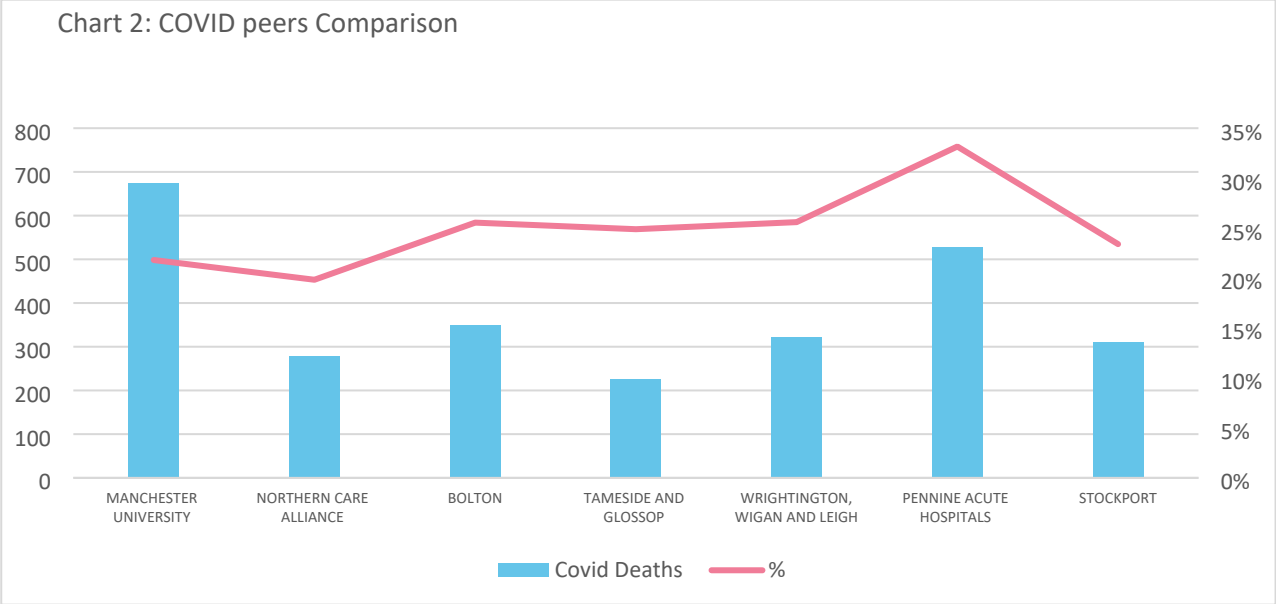
In the 356 inpatients who died, 42 died within 0 to 1 days of admission (11%).

2.2 COVID Cases

In Q4 2021 -2022, there were 99 patients with COVID 19 on the Medical Certificate Cause of Death.

2.3 COVID cases: Comparison

Chart 2 shows (on the left axis) the number of patients who died during 2021 with a confirmed or suspected covid coding. It also shows what that equates to as a percentage of all deaths within each trust. For WWL, COVID coded patients accounted for 26% of all deaths, a similar figure to that seen at Bolton, Tameside and Glossop, and Stockport:



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.

In Q4, 317/407 (78%) of all deaths were reviewed and concluded the following:

Quarter	Total	Reviewed	Avoidablity >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 avoidability	Score 1 - Definetly avoidable	Total	Reviewed	Avoidability
Q4	407	317	2	308	5	2	2	0	0	2	2	0

3.1 Potentially Preventable Deaths

There were 2 potentially preventable deaths noted:

- Problem with sliding scale insulin and death of the patient from hypoglycaemia
- Missed diagnosis in patient with femoral hernia

3.2 Themes/Learning

Themes identified during the corporate mortality review are:

- Long wait in AE for a NoFF patient resulting in delays

- People dying with COVID rather than from COVID
- Patient unable to have NIV due to capacity of NIV beds
- Failure to provide sepsis care
- Missed lung cancer on a previous admission
- Omitted drugs
- Patient with fall and late diagnosis of retroperitoneal haemorrhage
- Death of patient waiting for CABG
- Failure to identify a patient correctly for DNACPR, the patient received CPR when they were DNACPR.
- Lack of interventional radiology
- Patient spends 3 days in ED before dying in majors
- Late presentation of disease (lung cancer)
- Failure to deliver NIV
- Patient with fall and late diagnosis of retroperitoneal haemorrhage

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

4.0 External Reporting

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

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

In Q3, the Trust reported 7 deaths to LeDeR. 2 of these died in the acute Trust at WWL

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

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

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

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

The Trust had 0 Maternal Deaths in Q4 2021-2022, 1 stillbirth and 0 Neonatal death.
This was a 27 weeks 2 days gestation with a history of early onset fetal growth restriction. Plan of care was in place for monitoring fetal wellbeing. On attending for a planned appointment, the fetal death in-utero was diagnosed.
The case is being reviewed as per recommendations from MBRRACE using the Perinatal Mortality Reporting Tool. Awaiting placental histology reports from RMCH and cytogenetics. The baby's Parents' declined Post-mortem.

5.0 Community Deaths

There have been 0 community deaths reported via Datix in Q4 2021/2022 who died outside the acute Trust.

6.0 Prevention of Future Deaths Notices

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

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

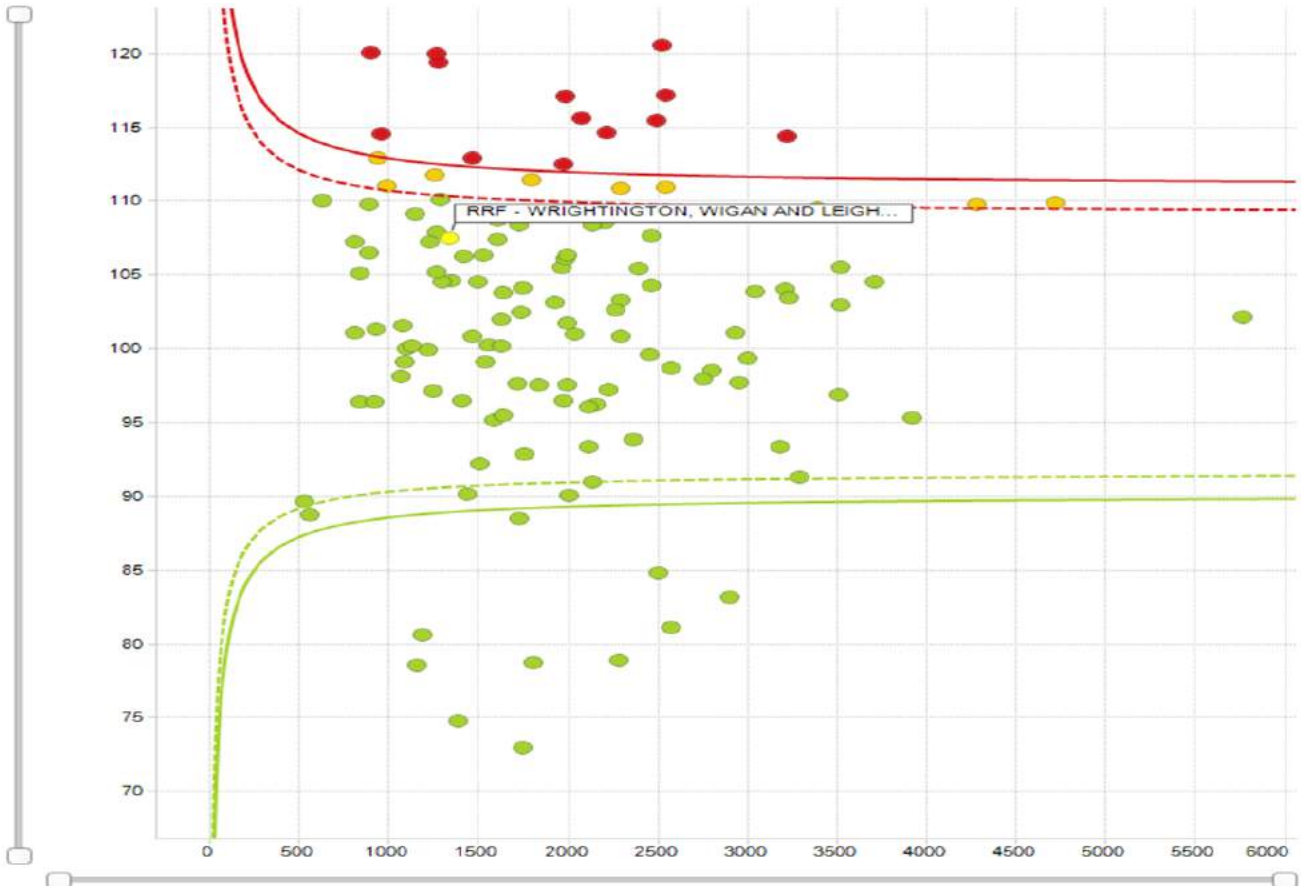
The Trust has recently moved from using Dr Foster Healthcare information software tool produced by Telsta to HED (Health Care Evaluation) Healthcare information tool which is owned and produced by Birmingham University Hospitals. This still calculates HSMR and SHMI using the same methods.

7.1 SHMI

SHMI calculated data using NHS digital SHMI / HED data rolling 12 months data is 107.47 for the time period January 2021 to December 2021. This is a slight increase from the previously reported data for the time period October 2020 to September 2021 was 104.87.

Chart 4 shows the national position of WWL when compared nationally. WWL is currently within the expected parameters.

Chart 4 SHMI



There are currently two groups with alerts on NHS Digital SHMI.
These are septicaemia and urinary tract infections.
Septicaemia; 455 cases/140 deaths / 95 expected
UTI; 820 cases/ 55 deaths / 40 expected.

Work surrounding sepsis and UTI deaths is ongoing.

7.2 HSMR

The current HSMR is for the rolling 12 month period of Jan 2021 to December 2021 using HED is 91.10 which is below the national benchmark of 100. This is slightly higher than the previous reported figure for November 2020 to October 2021 using HED of 89.3
It should be noted that patients with COVID-19 are not included in the figures.

Title of report:	University Hospital Status Update
Presented to:	Trust Board
On:	8th June 2022
Presented by:	Dr Sanjay Arya, Medical Director
Prepared by:	Madeleine Jackson, Service Development Manager
Contact details:	T: 07464652520 E: Madeleine.Jackson@wwl.nhs.uk

Executive summary

One of the Trust's key strategic priorities, as articulated in Our Strategy 2030, is to become a University Hospitals Trust.

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

Work began on developing a plan to achieve University Hospital Status in line with our Corporate Objective 2021/22. However, part way through this process the University Hospital Association changed the membership criteria for achieving University Hospital Status increasing some targets which may affect our ability and/or timescales.

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

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

This paper describes the new membership criteria, WWL's current position against each criterion and current programme of work to further assess our capability to achieve University Hospital Status.

Link to strategy

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

Risks associated with this report and proposed mitigations

None

Financial implications

None

Legal implications

None

People implications

None

Wider implications

None

Recommendation(s)

The Board is asked to:

- Note the new criteria to become a University Hospital Trust
- Note the appraisal of the Trust's current position against the criteria
- Note progress made towards WWL achieving University Hospital status in the future

Report

Introduction

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

Whilst work commenced in 2021/22 to create a plan to achieve University Hospital Status in line with our Corporate Objective, the University Hospital Association changed the membership criteria in 2021, which may significantly impact on our ability to achieve University Hospital status and/or the timescales we initially proposed in Our Strategy 2030.

The University Hospitals Group was established in December 2021 to review the new criteria and assess WWL's ability to achieve University Hospital Status in the future. The group unanimously agreed that we should continue to pursue this objective.

The Corporate Objective for 2022/23 'To make progress towards our ambitions to be a University Hospitals Trust with a continuation of the three-to-five-year timescale', reflects the Trust's continued commitment to achieving University Hospital Status.

This paper will document the new membership criteria, describe WWL's current position against each criterion and describe the programme of work to further assess capability to achieve University Hospital Status.

Changes to the Membership Criteria

The new criteria and our baseline assessment of our ability to meet each criterion can be found in Appendix 1, which details each criterion and our current "rag" rating of how close we are to achieving it.

Implications of New Membership Criteria

The Trust already meets most of the criteria to become a University Hospital. Evidence will be gathered to demonstrate that WWL meets those requirements that we have rated as green. However, there are requirements we have not yet met.

Where the University Hospital Group felt the Trust would quickly and easily be able to undertake the measures needed to meet the criteria an amber rating was given.

1a *The Trust shall have in place with the University a Memorandum of Understanding on Joint Working for Effective Research Governance; it will actively investigate joint Research Offices to foster more efficient working;*

The Research Management at both institutions will meet in the next two months with the aim of achieving consensus on joint arrangements for research governance.

1b *The Trust shall demonstrate that it is working collaboratively with the university to develop an agreed joint research strategy*

The Research Management teams are proposing a joint statement for discussion and agreement with Edgehill following comparison of the two Research Strategies. We expect progress against this criterion in the next two months.

There are two criteria that are currently red and will the most challenging to achieve. They are as follows:

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

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

When the Group meets again in Summer. HR representation will also be in attendance to explore further options for WWL to meet criterion 1c i).

1c iii) For Trusts in England, an average Research Capability Funding allocation of at least £200k average p.a. over the previous two years.

In the year 2021/22 the Trust has achieved c. £143k of Research Capability Funding. The National Institute for Health Research (NIHR) provides Research Capability Funding based on the previous financial year's NIHR grant income. WWL attracted 3 NIHR grants since January 2021 and the first grant completed part way through 2021/2022, the 3rd grant activated in 2022/23. This resulted in less grant income in 2021/22 and therefore less RCF allocation in 2022/23.

The summary below shows WWL will be very close to achieving the £200k RCF annual income criterion by 2023/24 and will achieve this criterion in 2024/25 without any further grants being awarded. The criterion is required to be met in two consecutive years, therefore further NIHR grants are needed in the next 12-24 months to achieve this.

Increased support will be provided by the Research Management team to encourage more NIHR grant applications, however, there are some already in the pipeline.

Particularly, and following the successful delivery of the HipHop feasibility study, we can confirm that the grant submission to NIHR is in discussion for the main trial. This will be submitted within the year and if successful would expect to become active within the financial year 2023/24, which would contribute an increase in RCF to the subsequent financial year 2024/25 and thereafter.

Forecast of Research Capacity Funding - according to NIHR grant payment schedules												
Financial Year		Total Award	**Start date**	**2019/2020**	**2020/2021**	**2021/2022 (actual)**	**2022/2023 (actual)**	**2023/2024 (forecast)**	**2024/2025 (forecast)**	**2025/2026 (forecast)**	**2026/2027 (forecast)**	**2027/2028 (forecast)**
RAPSODI	NIHR	2,129,041	01/03/2022				348,737	428,247	418,038	368,871	326,142	238,946
SOFFT	NIHR	1,737,362	01/10/2020	170,925	338,089	323,164	335,169	320,673	197,395			
HipHop	NIHR	286,710	01/01/2021	99,000	174,000							
Total Grant Income per year					512,089	323,164	683,906	748,920	615,433	368,871	326,142	238,946
Research Capability Funding £s					39,024	143,385	88,870	191,494	209,698	172,321	103,284	91,320

Programme of Work

A project plan will be created after the meeting in Summer. The Group will continue to meet every two months to review our progress in achieving the University Hospital Associations University Hospital Status Criteria.

Conclusion and recommendation

The Board is asked to note the new criteria to become a University Hospital Trust and WWL's current position against each criterion; also, to note the progress made towards WWL achieving University Hospital status in the future.

Appendix 1

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

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

Title of report:	Well-led action plan
Presented to:	Board of Directors
On:	8 June 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 contains 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 was approved by the Board at its last meeting and the executive team has updated each with progress to date. Updates will continue to be provided to each Board meeting until all recommendations have been fully implemented.

Link to strategy

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

Risks associated with this report and proposed mitigations

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

Financial implications

There are no financial implications associated with this report.

Legal implications

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

People implications

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

Wider implications

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

Recommendation(s)

The Board of Directors is recommended to review the updates provided and approve closure of those actions marked as completed (a blue RAG status on the attached table).

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

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
1 High	The CEO should ensure that the pending executive team development programme explicitly captures good practice in providing focused executive presentations to board and committees and addresses the need to embed collective ways of working across the executive team.	Seven executive development sessions will be held between April and December 2022. Each session will last around 3 hours and will focus on team and personal development. An additional executive development session on presenting to board and committee meetings will be delivered by 30 June 2022. Team members have agreed that attendance at all these sessions will be prioritised above all other items, including annual leave.	Chief Executive	The executive development programme has been commissioned from an external supplier and the first session took place on 8 April 2022. Part of the first session involved a diagnostic to allow team members to identify areas of focus for the remainder of the programme. Session on presenting scheduled for 9 Jun 2022.	
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.	

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
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.	
4 High	The CEO should consider including senior divisional leaders in some executive team development activities to help further build cohesion between the executive and divisional leadership levels, as well as exploring ways in which leaders can further demonstrate the values and behaviours expected within the organisation.	As part of the executive development programme referenced at recommendation 1 above, divisional leaders will be invited to participate in at least 1 session in H1 2022/23 and at least one further session in H2 2022/23.	Chief Executive	This has been shared with the programme facilitator and is being built into session plans. The first joint session is provisionally scheduled to take place during Q2 2022/23.	
5 High	The Trust should consider the development of a refreshed accountability and performance framework, in collaboration with divisional leaders, to formalise responsibilities and accountabilities for divisional and directorate leaders at different levels of the organisation.	By the end of Q2 2022/23, we will have 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	This action will be progressed via the *Our Family, Our Future, Our Focus* programme. The programme has recently focused on the development of a Civility Charter, based on feedback from staff engagement, and the development of a Responsibility Framework will be progressed in the coming months. A break between the two activities has been built in the programme to avoid seeking concurrent feedback and potentially diluting focus.	

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, the assurance committee terms of reference have been updated so that core attendees are now listed as the Committee Chair, specified board members and a governor observer. The new terms of reference address the issue of large numbers of attendees and the style (briefing vs. assurance) of the meeting. Divisional leaders and subject matter experts are invited on an agenda item basis, where they will play a key role in making the case and being accountable for the recommendations on behalf of their division or subject area. The updated terms of reference have been approved. '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 account for their position if necessary.	

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
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 is scheduled to take place on 7 June 2022. The review of Divisional Assurance Meetings has commenced.	
8 Medium	The Trust should consider further refinements to the presentation format of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) to ensure that it provides more focus that guides board and committee discussion. This could be accompanied by a board development session on best practice in the use of the BAF and CRR.	By the end of Q1 2022/23, we will introduce 'AAA' reports for committee chairs which, in conjunction with the BAF, will assist in focusing board and committee discussions. By the end of Q1 2022/23, we will have agreed a revised format for the BAF which will then be used throughout 2022/23. By the end of Q1 2022/23, we will have delivered a board development session on best practice in the use of the BAF and CRR.	Director of Corporate Affairs	AAA report template for committee reporting has been introduced. 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)

№ 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 is provisionally scheduled for 6 July 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
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. One report writing training sessions for authors was delivered on 26 May 2022 and the next is scheduled to take place on 7 Jun 2022. 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. 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.	
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. The talent programme has been prioritised for development from April 2022. This will include identification of potential, talent pathways and development programmes. The design element of the talent programme will be completed by the end of Q1 2022/23 and phased implementation for organisational tiers will commence in Q2 2022/23.	

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

Title of report:	Analysis of Patient Relations/Patient Advice and Liaison Service (PALS) data Q4
Presented to:	Trust Board
On:	8 June 2022
Presented by:	Rabina Tindale Chief Nurse
Prepared by:	Patient Relations and PALS Manager
Contact details:	T: 01942 773342

Executive summary

The report describes descriptions of the themes / trends of concerns and complaints taken over the period from 1 January 2022 to 31 March 2022 (Q4).

- Formal complaints

During this period there was 124[1] formal complaints received; the top three complaint subjects were in respect of concerns about **medical treatment or management**, **communication** (with relatives, and no information given), and concerns about **nursing care**, or care needs not adequately met.

- Recorded concerns

There was a total of 373 recorded concerns during this period, the top three complaint subjects are **communication** (with patient, and with relative), delay in **appointments** and cancellations, and concerns regarding **discharge** arrangements (poor planning), and discharged too early.

- Reopened complaints

During Q4, the Patient Relations Department received 16 second bites. The main reasons stated were to seek further clarity or to challenge the content of the answers provided in the response. Further information regarding this is found in the body of the report.

- On the spot concerns

The total number of telephone-based queries during this period was 627, in addition to approximately 1650 emails dealt with. The contacts cover a wide range of issues, such as information and advice, guidance, and appointment/admission queries to name a few.

- Compliments

[1] As of 21 April 2022 – nb: these figures can change due to complainants' decision not to take forward or take forward as a concern

During this period there was 143 recorded by the department, 40 of which were forwarded by the Medical Examiner's office, these were recorded and disseminated to the relevant staff/area involved.

- Message to my loved one

During this period there was 68 email correspondences, which the team printed off and delivered to the relevant ward/areas.

- Parliamentary Health Service Ombudsman

In this period the PHSO contacted the department regarding four cases; two proposals to investigate but not confirmed yet, and two requested entire files (still being considered by the PHSO).

- Lessons learned from complaints

During this period (Q4) there have been several lessons learned and planned improvements; within this report there are two improvements relating to Surgery, one with Medicine, and one with Specialist Services. In order to share learning PRD present to CAB, Discharge Improvement, themed sessions, ESG, patient experience, bereavement and other task and finish/improvement groups.

- Overdue complaints

The back log of complaints that had accumulated because of the pause period March to July 2020, has been resolved, however the timescale of 60 working days is still not being achieved. For this quarter, the compliance was 39%. The Chief Nurse has assigned a task and finish group led by two Deputy Divisional Director of Nurses, which is to look at how the investigations into formal complaints can be made slicker, thus improving the timescales – with a view to meeting the Trust target set at 85%. Two kick off meetings have been undertaken with a work top exercise arranged the middle the of May 2022. The Patient Relations and PALS Manager, and her Deputy have completed 'how to respond to a complaint' day training session, which had positive feedback (5/5). Further dates can be provided but this depends on the staffing within PALS.

Link to strategy

This covers all the 4 Ps of Patients, People, Performance and Partnerships.

Risks associated with this report and proposed mitigations

Achievement of the Quality Priority for 2022/23 in relation to timely responses. To be able to continue to meet our community's needs (contacts to the department), staffing within the PALS team will require review. A task and finish group has been established to address both these risks.

Financial implications

None identified.

Legal implications

None identified.

People implications

None identified.

Wider implications

None identified.

Recommendation(s)
Board is asked to:

1. Note the contents of the report
2. Note the risks associated with in this report. Agree that quarterly reports will be produced and presented to the Quality and Safety Committee, with a deeper dive in relation to complaint theme, trends and lessons learned on all subjects reported
3. An annual report will be presented to Board

Report

1. Formal Complaints

Formal complaints are received via telephone, email, or paper correspondence, and can be made or coordinated by the MP, and other organisations. In the first instance the PALS team will ascertain whether they can deal with formal complaints informally, and if not, the Patient Relations Officer will also attempt to resolve formal complaints following a full review of the complaint, preliminary investigation, and conversation with the complainant. When this is achieved the complaint is recorded as a concern. However, the divisional teams will also review the complaint to determine whether they can too resolve the complaint informally, and if this is successful the grade is re-coded to green (very low), and this is auditable. In this period 14 formal complaints were deescalated to a concern following the further input from the Patient Relations team and divisional governance teams.

In this period of the 124 formal complaints, 21 were graded high – 7 of the high rated complaints were linked to an incident relating to pressure sore, incorrect diagnosis, clinical treatment, injury sustained during treatment or operation, delay, or failure in acting on test results and patient fall.

The main subjects, the KO41 Subject code is applied to the formal complaints upon first review and preliminary investigation; what is the complaint about, what are the main areas of concern, and this is reflected in the NHS digital data collections criteria.

In this period the top three main subjects are **clinical treatment,** mainly in respect of medical treatment and management plan, followed by delay or failure to diagnose, and other subjects around delay such as delay in treatment and in acting or ordering tests. **Communication** is also a top subject with concerns relating to issues around communication with relatives, incorrect or no information given and communication with the patient. **Patient Care** featured prominently too with concerns regarding nursing care and care needs not adequately met**.** Appendix 1 shows details of the main subjects and sub subjects (clinical treatment, patient care, communications) and their frequency.
Themes arising from formal complaints will be taken through the Patient Experience and Engagement Group to enable trust wide solutions to be found.

2. Recorded Concerns

Concerns are received via email, paper correspondence, verbally, or telephone (including via other organisations) and are dealt with by the team. These figures include the formal complaints that are received and turned around successfully and satisfactorily to a concern.

Of the 373 recorded concerns received during this period 30 were forwarded from the Medical Examiner's Office demonstrating an increase on Q3, and 4 from the Care Opinion website. The **Care Opinion** website is managed by the Patient Relations Manager; this site is free text rather than a survey structure, and is for patients, relatives, and carers, to comment on their experience both positive and poor; so that these can be recorded and included in the figures for 'concerns' and 'compliments'.

The main subject during this period is in respect of the subject of **Communication**; in particular regarding the lack of information or communication with the patient, and with the patient's relatives, there is also concerns regarding unable to get through to Trust telephone (switchboard) –

and this is reflected in the 'on the spot' data where switchboard contacts are 392, there are also concerns regarding delay in giving information/results. The second most prevalent subject is **Appointments,** such as delay including the length of waiting time for an appointment, cancellations of appointments that have been arranged, availability of clinics appointments, and referral delays. **Admissions & Discharge** is also high in the reporting subject numbers, with concerns about discharge arrangements and discharge too early, with many also relating to admission arrangements and cancelled/rescheduled surgery/procedure. Details of the Subjects and the sub-subjects can be found in appendix 2.

3. Reopened complaints

During Q4, the Patient Relations received 16 second bites; of the second bites **received in Q4** the original date of receipt of the complaints when they were initially received in April 2021 2021 x2, May 2021, June 2021 x3, July 2021, August 2021, September 2021 x3, October 2021 x2, December 2021x2, and November 2019.

A key reason for complainants to come back to the department and the is dissatisfaction with the response or elements of the complaint not answered.

4. "On the Spot" concerns

The PALS team resolves a high number of contacts by patients and their loved ones on a daily basis which are resolved on the spot, and these are mainly telephone enquiries, emails, or personal callers. The contacts cover a wide range of issues, such as advice, guidance, information, and appointment/admission queries to name but a few. The on-the-spot resolution of such a high number of contacts is beneficial for patients/their loved ones and takes away the onus of a detailed investigation by divisional teams. The contacts during this period were 627, in addition to approximately 1650 emails dealt with. There are many reasons for patients, relatives, carers, other organisations, members of the public to contact the PALS team, and these are recorded as on the spot. For example time can be spent on providing advice on how to complain about a different organisation, counsel a person who requires input from Greater Manchester Mental Health Services, a patient who is a new referral for appointments and requires an explanation of the procedures, details of how to obtain health records, visiting advice, general waits for investigations, and obtaining advice from a ward if the person cannot get through/cannot continue to ring the ward telephone. This is just some of the many reasons / examples of what is received by the department. It is important to note that many of these calls do take time to resolve, and even those that are requiring a transfer to switchboard (when switchboard staff cannot keep up with demand) – and if PALS experience the same delay getting through, they will take a contacts number and seek the advice from the area on their behalf, though we still record these as switchboard contacts.

The PALs and Patient Relations team continue to visit A&E in times of busyness, to assist staff by talking to patients, those in cubicles and in the waiting room, advising them of the status of the hospital, assuring that they are being observed and seen in clinical priority order. We contact and relay messages to patient's relatives and give updates where appropriate. The team also visit the Urgent Care centre and assist when necessary. There has been a significant increase in contacts due to the covid-19 pandemic, but the team continue to work through concerns and deal with them as efficient, and in real time as much as possible. Details of the on-the-spot subject matter during this period can be found in appendix 3.

5. Compliments

The Patient Relations and PALS team only sees the tip of the iceberg of compliments received into the Trust as many are provided to the wards and areas directly. The team try to record raw numbers from ward and teams via monthly returns.

The correspondence in respect of compliments that are received directly to the department and recorded on to Datix. In this period 143 compliments (40 of which were from the Medical Examiner's office and 6 from Care Opinion) were recorded, which is an increase on Q3. The full chart of the 143 compliments by location can be found in appendix 4.

Examples of compliments:

Thank you from the bottom of my heart for the support received by the Midwifery Dept on the birth of my 2 baby girls. Everything was explained throughout, and I thoroughly enjoyed my time in hospital bonding with my babies as a result of the fabulous supportive staff and atmosphere. I will always be grateful.

The partner of this patient has nothing but gratitude for everything the hospital did in terms of caring for her partner. She said that nothing was too much trouble and the overall compassion, professionalism and treatment received from the Doctor was second to none

Family member wanted to thank Patient Relations/PALS team for their Service 'Message to my loved one'. Family states that this service made a bridge between family and patient which was greatly appreciated.

Sincere gratitude for the lovely care and support received by the District Nurses. Professional, dedicated, and outstanding expertise shown that will not be forgotten

6. Overdue complaints

The divisional response rates are measured monthly by comparing those formal complaints that are due a response that month, compared with how many have been closed on time. The Patient Relations team continue to review every formal complaint; firstly, at PALS level, then Officer level and at both stages attempt to turn the formal complaint around by resolving the concerns as much as possible. This helps with the timescales, and volume of formal complaints.

Q4 response rates by month

Month	Percentage
January 2022	**32%**
February 2022	**33%**
March 2022	**33%**

Below is the overall response rate for Q4

Complaint Responses Due	Number of Responses Due in Q4 2021/22	Total No Responded to on Time	Response Rate	Overall Response Rate for Q4

30 days	0	0	n/a	
40 days	0	0	n/a	
60 days	90	36	40%	
>60	2	0	33%	
Totals	**92**	**36**	**39%**	
Medicine	50	19	38%	39%
Surgery	21	8	38%	
Maternity & Child Health	3	1	33%	
Community	4	4	100%	
Specialist Services	13	4	31%	
E&F	1	0	n/a	
Corporate Services	0	0	0%	

The Chief Nurse has assigned a task and finish group led by two Deputy Divisional Director of Nurses, which is to look at how the investigations into formal complaints can be made slicker, thus improving the timescales – with a view to meeting the Trust target set at 85%. Two kick off meetings have been undertaken with a work top exercise arranged the middle the of May 2022.

The Patient Relations and PALS Manager, and her Deputy have completed 'how to respond to a complaint' day training session, which had positive feedback (5/5)

7. <u>My message to my loved one</u>

This email service is still running and the activity to this inbox is variable, but more recently there has been an increase in messages. Provide a link with the relative and the patient has been reported by the users as an essential and positive service. Whether the mailbox has hundreds a day or one a day means we are keeping our loved ones connected. During this period there was 68 email correspondences; and the team print off messages and deliver them to the wards/areas.

8. <u>Parliamentary Health Service Ombudsman (PHSO)</u>

The PHSO often contact the Patient Relations department to ask information regarding formal complaints cases. Information is provided, such as whether the case is still being reviewed by the Trust i.e., at the stage where local resolution is still being sought, or that the case has exhausted local resolution and that the divisional investigator has no other information that would benefit the complainant. At this stage, the PHSO will ask for copies of the hospital records, and the complaint file and any correspondence in respect of the case. This is sent to and reviewed by the PHSO – who then propose to investigate or confirm they will investigate.

In Q4 the PHSO contacted the department regarding four cases; two proposals to investigate but not confirmed as yet, and two requested entire files (still being considered by the PHSO).

9. Lessons Learned and planned improvements

Examples of the lessons learned and planned improvements to the way the Trust operate are shown below (please note these are the ones that have been closed in Q4)
Nb: **12**21 relates to **December** 2021

Surgery Division- Langtree Ward 1221-17820
Concern - 'Patient Care' – Concerns about nursing care – delay in medication

Improvement:
Explanation and apologies given for patient's experience. The incident regarding Pharmacy has been discussed at team meetings, medicines safety group, Pharmacy quality and safety group and features in the Medicines Safety Newsletter for wider learning and recognition of this potential due to the medicines sounding alike. To further prevent harm Tallman lettering has been implemented on the Pharmacy computer system, this highlights specific letters within the names making it more obvious to dispensers and checkers which drug is intended.

Surgery Division- Swinley Ward 1121-17756
Concern - 'Communication' – Conflicting information

Improvement:
The Gynae Assessment Unit now has a newly appointed lead nurse who has started developing an education package that will be completed by all staff who work on the unit, to ensure the staff have the appropriate skills to deliver the care to our patients. The lead nurse is also creating new standard operating procedures and protocols for the gynaecology services that are delivered, including the management of miscarriages and the process of histology/karyotyping following pregnancy loss, and this is being supported by the Lead Gynaecology Consultant who is keen to ensure all staff delivering care are trained to a high level. The aim of this new training programme will ensure all our patients receive compassionate care, and will also improve the patient experience, by reducing error. Reflection for individual staff members.

Medicine Division- Winstanley Ward 1121-17706
Concern – 'Clinical Treatment' – Concerns about communication of medical treatment/management – End of Life Care

Improvement
Confirmed that we now have the mobile phone within the CPAP bay to support better communication and updates. Also fed back to the Ward Manager around the healthcare assistants not wearing their PPE correctly, and this has been revisited with all staff on the ward.

Specialist Services - Admissions 1121-17702
Concern – 'Admissions & Discharge' – Cancelled/rescheduled surgery/procedure

Improvement
A transformation project in place focusing on improving the pathway and primarily patient experience. I understand that training on the revised process for staff has been implemented and all staff are now aware of the correct process.

Other learning opportunities:

Audit workshops and the Clinical Advisory Board; Patient Relations provide data and information relating to specific subject areas which may have been identified as being particularly topical. The Patient Relations Manager also attends the Clinical Advisory Board where data and complaint's themes are presented and discussed, and where necessary this information is fed back to junior doctors.

The Executive Scrutiny Group meets 3 times each month, and the data from Patient Relations and PALS for the previous week is tabled and discussed – highlighting areas of concern or themes evident from concerns. Compliments received are also provided to this group

Training provided by Patient Relations Manager, in particular 'Caring for our customers', (which includes communication) 'How to respond to a complaint in writing'. These training and awareness sessions are in the process of being a part of the Trust's 'on boarding' program.

How to respond to a complaint was commenced in April 2022, with two further dates planned in May and June 2022, and this will continue to be delivered by the Patient Relations team to meet with the demand required. Patient / relatives / staff stories; the Patient Relations team video patients or their relatives as part of lessons learned for poor experiences and getting it right for positive experiences; these videos are shared with the Chief Nurse, who in turn shares them with the Trust Board. The Patient Relations team later use these stories in the training they deliver, as it is evident that real people talking about their experience of our services and what that meant to them has a much stronger impact than statistical data.

Several quality improvement projects are underway which proactively take the learning from complaints delivering tangible change.

- <u>All other contacts for information advise</u>

Examples of these would be concerns regarding Human Resources, full information and advice from a Trust Specialty, information required from another Trust, or a listening hear to concerns that are related to another Trust. Nevertheless, these contacts take time and still requiring monitoring and recording. Appendix 5 is a chart of these contacts in this period.

Conclusion

The Trust is committed to responding to complaints within the agreed timeframes and as such we have agreed an organisational objective to achieve 85% timely response rate for 2022/23. A workshop commissioned by the Chief Nurse will identify barriers within the current process, the reduction of non-value-added steps, education, training, and support required to improve the quality of investigations and responses.

The newly established Patient Experience and Engagement Group will continue to oversee the learning arising from complaints, supporting Quality Improvement Methodology to help the organisation learn and improve, this will feed into the Aspire Accreditation programme.

Appendices

Appendix 1: top 3 subjects highlighted

Recorded Formal complaints 1 January to 31 March 2022 (Q4) = 124	
Main Subject (KO41a)	**main Sub -subject**
Admissions and discharges x 8	4 x Discharged too early 2 x Discharge arrangements inc lack of poor planning 1 x Transfer Arrangements 1 x Discharge to inappropriate setting
Appointments x 10	3 x Referral failure 2 x Cancellation 1 x Referral delay 1 x Failure to provide 1 x Appointment error 1 x Delay (incl length of wait) 1 x Other
Clinical treatment x 40	17 x Regarding medical treatment/management 4 x Delay or failure to diagnose (inc missed fracture) 2 x Lack of clinical assessment 2 x decision to issue DNACPR 3 x incorrect diagnosis 3 x delay in treatment 3 x injury sustained during treatment or operation 1 x medication error 2 x delay or failure in ordering tests 2 x delay or failure in acting on test results 1 x post-treatment complications
Communication x 17	3 x with relatives/carers 3 x incorrect/no information given 2 x with external 1 x with patient 2 x access to interpreting service 1 x Breakdown in communication- appointments 2 x breaking bad news 1 x conflicting information 1 x incorrect information within clinic letter 1 x incorrect/inaccurate interpretation

end of life care x 1	1 x statement of intent
Facilitates x 2	1 x car parking availability 1 x car parking- disability issues
Patient Care x 15	4 x care needs not adequately met 5 x concerns about nursing care 1 x inadequate support provided 1 x acquire infection not present on admission 1 x acquired pressure ulcer 1 x failure to monitor/observe 1 x inappropriate care setting 1 x risk assessment not completed
Other x 3	3 x loss of false teeth/ loss of/ damage to property/ loss of jewellery
PDW x 4	1 x patient against PPE 1 x visiting restrictions 1 x other 1 x breach of confidentiality (by non-staff)
Prescribing x 1	1 x medication prescribed known allergy
Values and Behaviours x 13	3 x Attitude of admin & clerical staff 5 x Attitude of Medical staff 4 x Attitude of nursing staff 1 x Attitude of other staff
Consent x 1	1 x insufficient information provided
Trust Admin Policies & Procedures x 6	1 x policy decisions 1 x other 1 x complaint handling 1 x accuracy of health records 1 x failure to follow procedures 1 x code of openness
Waiting times x 3	1 x wait for operation/procedure 2 x ED/MIU waiting times

Appendix 2

Recorded concerns 1 January to 31 March 2022 = 373 top 3 subjects highlighted

Access to treatment/drugs x 8
- 1 x access to services
- 1 x funding of medication
- 3 x other
- 1 x service not available
- 2 x service provision

Admissions and discharges x 45
- 6 x admission arrangements
- 7 x cancelled / rescheduled procedure
- 2 x delay in treatment
- 12 x disch arrangement incl poor planning
- 1 x discharge to inappropriate setting
- 8 x discharged too early
- 1 x discharged with incorrect TTO's
- 2 x bed not available for admission/not ready
- 1 x delay in discharge
- 1 x delay/failure in transfer
- 1 x discharge inappropriate hour
- 1 x discharge without discharge letter
- 1 x inadequate discharge planning
- 1 x other

Appointments x 63
- 4 x availability (inc urgent)
- 4 x letter not issued/received
- 8 x cancellation
- 25 x delay inc length of wait
- 3 x error
- 3 x failure to provide
- 1 x appointment time
- 1 x appointment booking system
- 1 x appointment not kept by staff
- 3 x other
- 3 x referral delay
- 3 x referral failure
- 3 x referral refusal
- 1 x referral cancelled

Commissioning x 3
- 1 x services- not available locally
- 2 x commissioning services/issues

Clinical Treatment x 45
- 1 x injury sustained during treatment/operation
- 20 x regarding medical treatment/management
- 3 x delay in treatment
- 2 x delay or failure in acting on test results
- 2 x delay or failure to diagnose (inc missed fracture)
- 1 x scanning errors
- 1 x incorrect diagnosis
- 1 x outcome was not as expected
- 3 x delay in receiving medication
- 1 x catheter accidentally pulled out
- 2 x delay in treatment due to lack of knowledge
- 1 x delay/difficulty obtaining clinical assistance
- 1 x delay/failure in observations
- 4 x delay/failure in treatment/ procedure
- 1 x delay/failure to follow up
- 1 x incorrect procedure

Communications x 77
- 1 x breaking bad news
- 2 x between medical teams
- 2 x with GP
- 2 x with other hospital
- 21 x with patient
- 18 x with relatives
- 4 x DNACPR
- 1 x conflicting information
- 4 x delay in giving information/results
- 1 x delay in reporting results
- 2 x method style of communication
- 1 x other
- 3 x patient not listened to
- 8 x unable to get through Trust phone
- 2 x breakdown in communication re appointments
- 2 x communication between medical teams
- 1 x with nursing home
- 1 x inadequate information provided
- 1 x incorrect information within clinic letter

end of life x 7
- 2 x lack of privacy for dying patients/ relatives
- 4 x Care in the last hours/days of life

PDW x 9
- 1 x Breach of confidentiality
- 3 x Other Privacy and Dignity issue
- 5 x visiting restrictions

1 x information communicated to patient/family

Facilities x 7
- 3 x car parking availability
- 1 x access issues
- 1 x Car parking - disability issues
- 1 x Maintenance of buildings/grounds
- 1 x Equipment availability

Other x 31
- 2 x Covid 19 social distancing
- 1 x Customer services
- 1 x financial procedures/finance
- 1 x loss of false teeth
- 1 x loss of hearing aids
- 6 x loss of jewellery
- 19 x loss of/damage personal property

Patient care x 12
- 1 x birth after thoughts
- 2 x care needs not adequately met
- 2 x nursing care
- 1 x failure to adopt infection control measures
- 1 x failure to monitor/observe
- 1 x failure to provide adequate fluids
- 2 x other
- 1 x slips trips and falls
- 1 x Catheter managment

Trust Admin/Policy procedures x 9
- 2 x access to health records
- 1 x availability/not available
- 3 x policy decisions
- 2 x Visiting times/arrangements
- 1 x Other

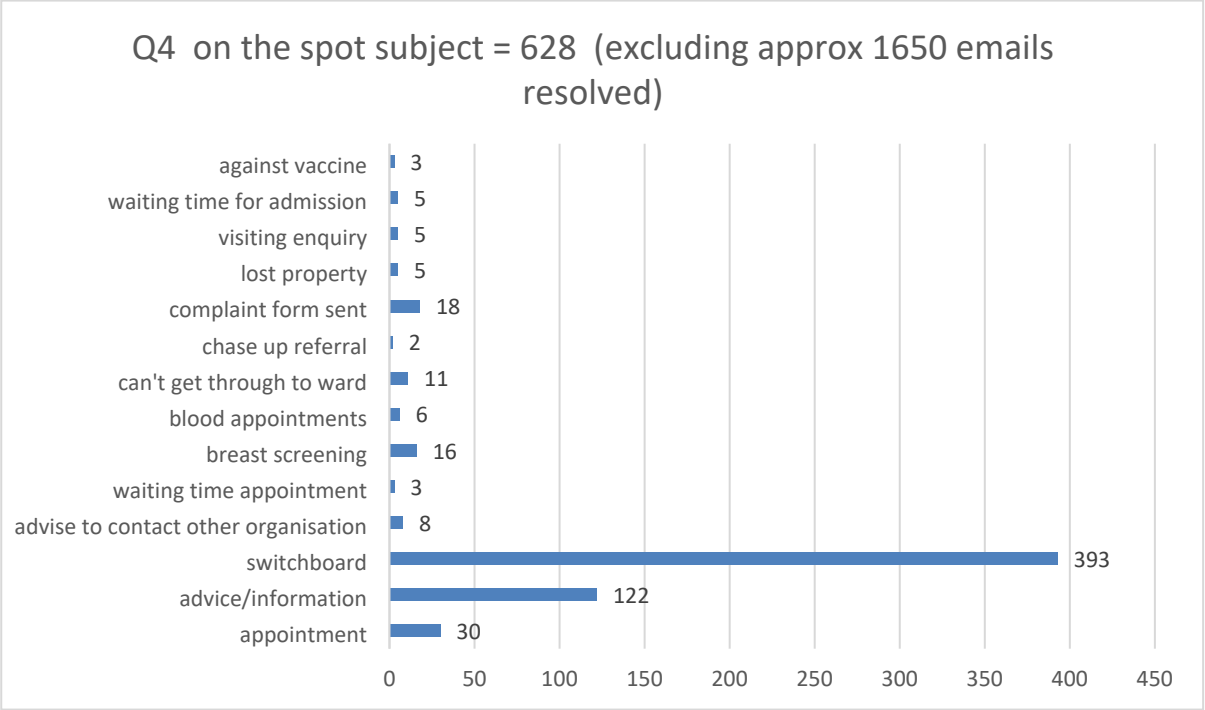
Values and Behaviours x 38
- 8 x attitude of admin staff
- 7 x attitude of medical staff
- 12 x attitude of nursing/midwifery staff
- 5 x attitude of other staff
- 2 x lack of compassion
- 1 x attitude of facilities staff
- 1 x use of media
- 1 x rudeness
- 1 x breach of confidentiality by staff

Prescribing x 1
- 1 x prescribing

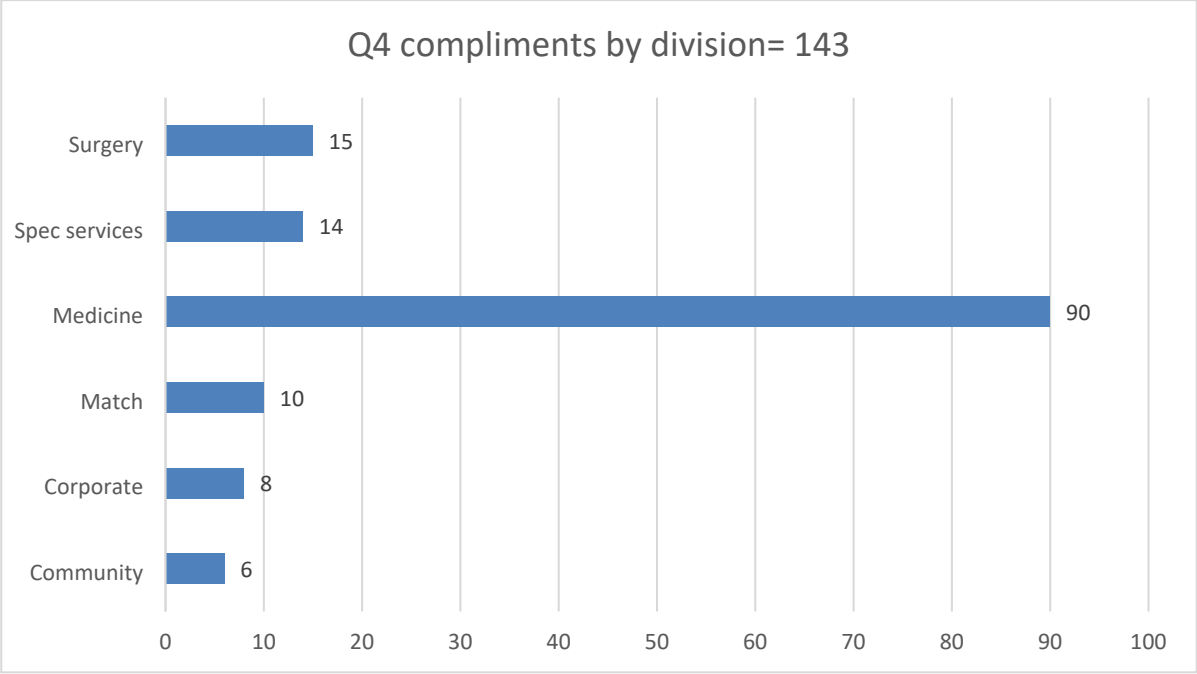
Waiting times x 15
- 6 x Wait for operation/procedure
- 2 x Waiting for appt/length of list
- 6 x emergency department
- 1 x waiting time at the appointment

Mortuary x1
- 1 x disposal or retention issues

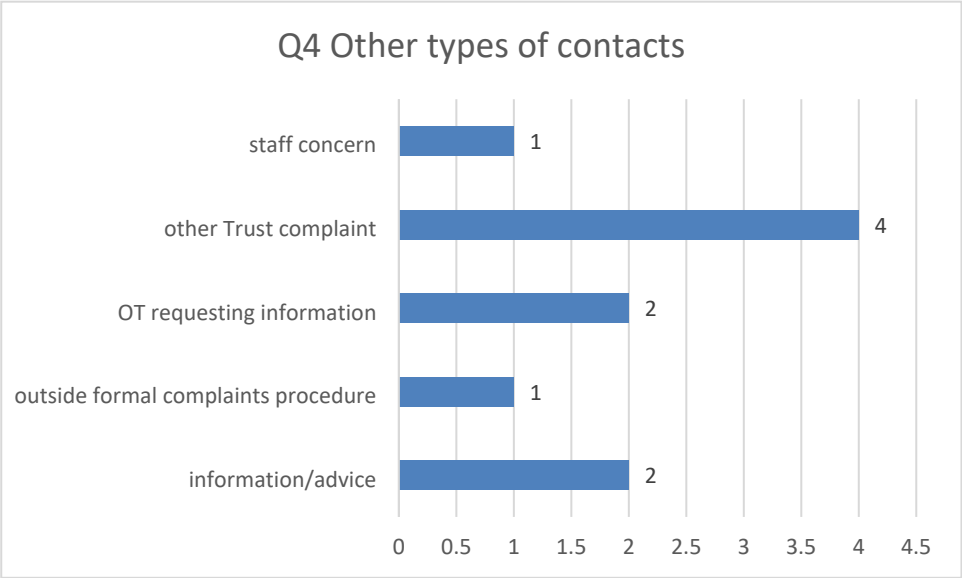
Appendix 3



Appendix 4



Appendix 5


Q4 Other types of contacts
staff concern
1
other Trust complaint
4
OT requesting information
2
outside formal complaints procedure
1
information/advice
2
0
0.5
1
1.5
2
2.5
3
3.5
4
4.5

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	IPC Board Assurance Framework update. Version 1.8
Presented to:	WWL Board of Directors
On:	08 June 2022
Presented by:	[Rabina Tindale, Chief Nurse, Director IPC]
Prepared by:	[Julie O'Malley, Deputy Director IPC]
Contact details:	T: 01942 773115 E: Julie.omalley@wwl.nhs.uk

Executive summary

Summary

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

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

- **Microbiology provision within the Trust:** Two Microbiologists left permanent posts during Q4. One locum Microbiologist is currently providing a specific/ limited remit, via virtual/ remote service arrangement in the interim period. The recruitment of permanent Microbiologist's is under consideration. Risk Assessments have been submitted.
- **The IPC Audit Programme** continued to be modified in response to the Omicron wave noted during Q4. The increase in positive COVID-19 cases within the Trust continued demand on bed capacity and impacted the response required by the IPC Team and capacity to deliver a full IPC audit programme. There is an expectation to resume the audit programme during Q1 2022/2023.

The WWL Way

- **The demand on the IPC workforce** has increased on the background of depleted team capacity, the continuing COVID-19 Pandemic, and the impact of the Omicron variant. A full Business case being developed during Q4 with an aim to secure resource and investment for the IPC Service within the Trust. Risk assessment have been submitted for review. The vacant Band 7 IPC Nurse has been successfully recruited in May 2022.
- **The current unknown impact and uncertainty of the path the COVID-19 Pandemic** required services to prepare for additional impact on capacity and demand of rising COVID-19 cases. IPC measures, and management resources, guidance and SOPs remain in place to support staff and patient care.
- Due to the number of patients with COVID 19 during the Omicron wave, the Trust was not always able to separate pathways. Amber site status continued to be adopted during the Omicron wave in response to capacity and demand and local application of pathways in line with UKHSA/ NHSE Guidance.
- During May 2022, the requirement for in-patient COVID-19 Contacts to isolate was removed. All identified COVID-19 positive in-patients continue to be transferred to designated COVID-19 positive areas.
- **Within the Trust there is limited side room capacity** to consistently enable isolation as required, for patients with confirmed or suspected infections, including COVID-19. A risk assessment on the lack of side rooms has been completed. The IPC Team attend daily bed meetings and support bed managers with decision making on a 24/7 basis. A Datix is completed if unable to isolate a patient and mitigating IPC actions and measures are implemented to maintain safety whilst bed management colleagues continuing to secure isolation capacity.
- **Limited capacity to segregate patients within ED without adaption of the environment.** Rapid PCR and Point of care testing available within ED.
- **The Trust has a heavy reliance on natural ventilation**, particularly at the RAEI site. Most areas have been identified as being adequately mechanically ventilated, or natural ventilation has been improved. Some limited small areas may still have poor ventilation.
- **Lateral Flow Device (LFD) testing:** New NHSE and UKHSA Guidance published during February, March, April, and May 2022 introduced a new phase of managing operational activity within the Trust. New and updated arrangements for Pre-attendance LFD testing of Elective patients and continued twice weekly LFD testing for staff.
- **LFD testing for asymptomatic in-patients has been proposed by NHSE** but due to lack of a reporting system to record the results, this has been delayed. PCR testing of asymptomatic routine in-patient PCR testing has reduced to admission (day 1), day 4, day 6. No further routine swabbing of patients unless symptoms present, or a planned discharge to a Care Home. Meetings/ discussions with the HIS Team to consider of a system to enable LFD Test recording.
- **Compliance with the staff LFD reporting process.** Clinical staff only are now completing twice weekly asymptomatic LFD testing with own responsibility for ordering LFD test kit supplies and reporting results via the .gov portal. All staff to perform LFD test if COVID-19 symptoms present.
- **Face fit testing** continues but the central register of staff tested indicates that not all staff are tested to a model that is currently in stock. Fit test sessions continue to be advertised and encouraged. Divisions have been provided with a list of compliant staff to review.
- **Fit testing training records** are not fully complete for staff who wear air purifying respirators (PAPR) (mechanical respirators with hood). Health and Safety are working with Divisions to identify staff who rely on or choose to wear PAPR to ensure they have all been fully trained.
- **Specific options and arrangements for mask exempt staff** are being investigated and reviewed in collaboration with Occupational Health, Human Resources and Infection Prevention and Control Services to secured working arrangement for mask exempt staff to return to workplace whilst maintaining the safety of the individual, patients, staff colleagues and visitors.
- **The use of face masks in non-clinical area offices, meeting rooms and education centre** is not required. All staff within clinical areas are required to wear face masks in line with current UKHSA Guidance. The guidance remains unchanged and was last updated on 15.3.2022
- **Currently the Trust are 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.

- **A reduction in compliance with the Mandatory IPC and COVID-19 e-learning modules** was noted to in Quarter 4. Compliance with Mandatory training raised at the March 2022 IPC Committee with each Division requested to provide a timeline and action plan to address and improve compliance.
- **Hand hygiene and PPE compliance** is below expected standard in ward areas. A refocus on IPC Compliance with "Back to Basics" approach will be adopted to support improved compliance and ownership. The reintroduction of the full audit programme will focus on standard IPC.
- **Inpatient visiting** was modified during Q4 and currently allows two visitors per patient with the duration increased to one hour. The visiting arrangements are being reviewed with consideration to returning to pre-COVID-19 arrangements.

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

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

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

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

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

Wider implications:
IPC is fundamental to the way all staff work and requires a Trust-wide approach.

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

Appendix 1: Infection Prevention and Control (IPC) Board Assurance Framework (BAF). Last updated 26 May 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.	▪ Pandemic Plan in place. ▪ POCT in Emergency Care Centre (ECC). ▪ All patients attending ECC are screened for COVID-19 on registration with a risk assessment completed. Symptomatic and asymptomatic patients are segregated at this point. ▪ All patients requiring admission undergo a LAMP test as well as PCR. ▪ Patients who are admitted straight to wards are tested on admission. ▪ Triaging to COVID-19 status: Positive/ Negative. ▪ **March 2022:** Local application of care pathways in line with UKHSA COVID-19 Guidance: *Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022*. Updated 15.3.2022. ▪ Amber site status in operation during Omicron wave in response to capacity and demand. ▪ Segregation of patients enabled through care pathways: Blue: Positive. Amber status, Contact and Post 14 days isolation/ COVID-19 recovered. ▪ Flowchart for respiratory pathways ▪ **January 2022:** Additional bed capacity created during January 2022 at Leigh site:	None	N/A

	Jean Heyes, Community Assessment Unit (ECC pressures/ flow), Wrightington Ward A, and Designated setting: Alexandra Court/ Intermediate care. ▪ **January 2022:** Alexandra Court SOP developed and updated as care pathways changed in response to demand. Collaboration between CCG, Trust, and Local Authority colleagues. ▪ Collaboration: IPC Team supports Bed Managers at Bed Meetings. ▪ Regular communications three per day ▪ Discussions re patient placement: IPC/ Microbiology/ Operations Team ▪ Outbreak Meetings attended by: IPC/ Microbiology, Ward Sisters/ Matrons/ Nursing staff/ Domestic Services/ Bed/ Ops Managers. ▪ **February 2022:** UKHSA Guidance: *Management of staff and exposed patients or residents in health and social care settings.* ▪ **February 2022: Flowchart and checklist** developed and enabled ending isolation early for COVID-19 positive patients remaining in hospital. ▪ **15 March 2022: UKHSA updated:** *COVID-19 Guidance: Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022.* ▪ **30 March 2022:** *NHSE and NHSI: Updated UKHSA Guidance – Testing update* published. The guidance set out the approach to delivering staff and patient		

	testing including, on admission, in-patients, planned elective admission and Maternity. Work commenced to implement the changes as published. ▪ **March 2022.** *In-patient Visiting SOP*. Modified Visiting resumed within the Trust during Q4, with continued unaffected visiting for end of life, children, and maternity patients. **March 2022:** UKHSA Guidance: Testing Update **March 2022**: LAMP testing ended on 31.3.2022. All patients requiring admission undergo a PCR, Rapid PCR or POCT (Abbott). **May 2022:** In-patient COVID-19 Contacts no longer required to isolate **May 2022:** All COVID-19 positive in-patients transferred to designated COVID-19 positive areas **May 2022:** Visiting SOP updated. Two visitors per patient with duration increased to one hour		
Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	▪ Estates and Facilities support secure workplace requirements, room capacity limits with signage. This continues and remains in place, supported by the IPC Team. ▪ The IPC Audit programme includes COVID-19 safe measures as a standard/ criterion. ▪ Home working arrangements continue within the Trust as aligned with agreed working arrangements. ▪ **4 May 2022:** Physical distancing restrictions removed across all healthcare settings	**January 2022:** The IPC Audit Programme was modified in response to the Omicron wave which resulted in increasing demand on capacity of the IPC Team in response to increasing COVID-19 cases within a background of staffing vacancies within the Team.	Resource and investment within the Trust IPC Service. A full Business case is being developed with an aim to secure resource and investment for the IPC Service. **May 2022:** Approval being sought for Business case **March 2022:**

	▪ **18 May 2022:** Wearing of Face masks removed in Non-clinical area offices, meeting rooms and education centre. ▪ **Face mask wearing continues in Clinical settings:** Hospital site, Community and Primary Care	**March 2022:** The currently presenting increase in positive COVID-19 cases within the Trust suggests a return to increasing demand on bed capacity and will impact the response required by the IPC Team. The audit programme may require a further pause.	Recruitment to Band 7 IPC Lead Nurse: Post advertised. Band 8a Acting-up role continues, until funding secured to full time, permanent arrangement. CCG Seconded role continues. **May 2022:** Recruitment to Band 7 IPC Junior Matron: Successful and post offered. **May 2022:** Band 4 IPC Nursing Associate leaving post. Band 4 Secondment IPC Support Practitioner recruitment in progress
Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: ▪ based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area. ▪ applied in order and include elimination; substitution, engineering, administration and PPE/RPE. ▪ communicated to staff.	▪ Risk manager has reviewed and advised on risk assessments with respect of IPC risks. ▪ Risks are reviewed at Trust Risk Management Group. ▪ **December 21:** Estates have completed a review of ventilation at all sites with the exception of a small area at the Leigh site. The report has highlighted there is a heavy reliance on natural ventilation particularly at the RAEI site. ▪ **December 21:** Window opening capacity has been increased at the Wigan site within safety limitations.	Secured working arrangement for mask exempt staff to return to workplace whilst maintaining the safety of the individual, patients, staff colleagues and visitors.	**March 2022:** Specific options and arrangements for mask exempt staff are being investigated and reviewed in collaboration with OH, HR and IPC. **May 2022:** Restrictions lifted in Non-clinical areas for Mask exempt staff

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

	▪ Changes are communicated through the IPC team, newsletters and Divisional leads and meetings. ▪ **January to March 2022:** Gold and Silver Command meetings ▪ **March 2022:** Meetings/ discussion with OH, HR and IPC are reviewing specific options and arrangements for mask exempt staff to return to workplace whilst maintaining the safety of the individual, patients, staff colleagues and visitors. ▪ Review of current National guidance, surveillance and audit activity by the Trust IPC Team including Microbiologist in respect of infection prevalence and new variants of concern. ▪ Regular communications to staff. ▪ Reporting to the Trust Board, ETM and Chief Nurse. ▪ Input to and collaboration with operational flow and bed capacity with joint working between IPC, Bed Management and Operations Teams. ▪ Regular global communications shared with all staff. ▪ **4 May 2022:** Physical distancing restrictions removed across all healthcare settings ▪ **18 May 2022:** Wearing of Face masks removed in Non-clinical area offices, meeting rooms and education centre. ▪ **May 2022:** Mask fitting encouraged with non-compliant wards.		
Safe systems of working; including managing the risk associated with infectious agents through the	▪ Trust Risk Assessment tools approved through Trust Governance process	None	N/A

completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	▪ Risk assessments completed by Ward Leaders/ Managers and Recruitment Team with support available from OH Team. ▪ Process for repeat/ update of risk assessments in line with UKHSA Guidance. ▪ Risk assessments are completed for all staff including Bank, Agency and Locum staff across the Trust and all organisations within the Borough. ▪ Input to process from OH, IPC, HR Teams, and Ward Managers/ Leaders. ▪ DIPC presents to the Board through the performance report or specific agenda items. ▪ IPC Committee and Quality and Safety committee review quarterly IPC reports. ▪ **May 2022:** No change		
If the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems.	▪ **December 2022:** Amber status approach adopted by the Organisation from 29.12.2021 continues to date. ▪ **January 2022:** UKHSA Guidance: *Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022.* The removal of the 3 COVID-19 specific care pathways (high, medium, and low) in response to stakeholder feedback to facilitated local application of the guidance by organisations/employers. Care pathways defined locally: Amber status. ▪ **January 2022:** GM NHSE/ NHSI Guidance (v3 1.2022): *Decision making support tool for managing COVID-19 contacts and*	None	N/A

	closed wards/ bays during times of extreme bed pressure. ▪ **March 2022:** Trust process continues with specific pathways from point of entry segregation and testing: On identification of positive result, patients transferred to a positive ward. ▪ Contact patients are identified, and isolation period maintained in line with current UKHSA guidance. ▪ Outbreaks are identified and declared in line with guidance definition and managed in line with national guidance, Trust Policies and SOPs. ▪ Bay closures in operation with criteria as above for positive and contact patients. ▪ Routine swabbing to identify COVID-19 status and support appropriate patient management. ▪ **April 2022:** Routine Asymptomatic PCR testing adapted to day 4 and day 6 only. No testing post day 6. ▪ **April 2022:** Plan to adopt LFD testing when reporting system established. ▪ **12 May 2022:** Meeting: HIS/ IPC Testing. ▪ **16 March 2022:** System Meeting (WWLFT, CCG and LA): Care Homes/ IPC/ Pathways/ capacity		
Risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents.	▪ Trust Risk Assessment tools approved through Trust Governance process. ▪ Risk assessments completed by Ward Leaders/ Managers. ▪ Support available: IPC Team, Health and Safety, Occupational Health, Risk	None	N/A

	Managers, Governance Team, Senior Team.		
If an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	▪ FFP3 face masks worn in COVID-19 Positive areas, High risk areas, areas experiencing Outbreaks and where AGP procedures are undertaken. ▪ Programme of FFP3 mask fit training in operation within the Trust. **May 2022:** Report titled Mask Fit Compliance: Occupational Health/ Health and Safety **May 2022:** Targeted Mask Fit testing	None	N/A
Ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.	▪ This is adopted whenever possible and practicable in conjunction with IPC, Bed Management and Operations Teams. ▪ Microbiology results are obtained and documented in HIS before patients are moved to designated COVID negative or positive wards. ▪ The process to limit movement of the patient contacts of a positive case, during the isolation period continues to operate. ▪ An IPC Team member attends the daily bed meetings to support appropriate patient placement.	None	N/A
The Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases	▪ The IPC Team review and validate data for all reported hospital onset COVID-19 infections (HOCI) cases in collaboration with Business Intelligence and electronic systems: HIS. Data is received by Senior Team/ DIPC/CN/ MD. ▪ **March 2022:** Case of Influenza A reported to Senior Team/ Medical Team. ▪ **May 2022:** Data validation continues as above.	None	N/A

There are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.	▪ **February and March 2022:** Ward and Service area visits, Walk Abouts and ASPIRE accreditation visits, completed by the Senior Leadership Team, including DIPC and DDIPC, Senior Nurses and Governance to provide challenge and learning opportunities to support staff, compliance, and patient safety. ▪ The visits extend to include multiple areas of care, leadership, management, learning, staff wellbeing and development. ▪ IPC Team provide supportive visits to clinical/ practice areas in both hospital and community settings. ▪ **May 2022:** Aspire Accreditation visits attended by Chief Nurse/ DIPC and DDIIP	None	N/A
Resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	▪ IPC Audit Programme for all aspects of IPC Practice, standard IPC precautions, COVID-19 safe measures. ▪ Audit visits include all staff working within area at time of audit. inclusive of permanent, agency and external contractors. ▪ **January 2022:** The IPC Team targeted audit activity due to the impact of the Omicron variant and the presenting outbreaks and bay closures. ▪ Action plans are developed, and supportive learning opportunities provided in collaboration with the ward leaders and the IPC Team. ▪ **March 2022:** Routine COVID-19 Swabbing audit undertaken by all ward areas with reported Outbreaks and Bay closures.	The demand on the IPC workforce has increased on the background of depleted team capacity and the continuing COVID-19 Pandemic, and the impact of the emerging Omicron variant.	Resource and investment within the Trust IPC Service **May 2022:** Business case submitted for approval. **May 2022:** Recruitment to Band 7 IPC Junior Matron: Successful and post offered. **May 2022:** Band 4 IPC Nursing Associate leaving post. Band 4 Secondment IPC Support Practitioner recruitment in progress

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

	▪ Quarterly Quality and Safety reports are submitted with opportunity for review at Executive meetings. ▪ Outbreak updates, email cascades include Trust Board members/ Senior Leadership Team. ▪ IPC activity reports through IPC Committee up to Quality and Safety and monthly Performance reporting to the Trust Board. ▪ Action plans and IPC Committee documentation are available for review and included in reports.		
The Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	▪ Face fit testing sessions continue with a plan in progress to achieve fit test to three models in high-risk areas and two models in all other areas. ▪ **May 2022:** Report by Health and Safety: Mask Fit Compliance to the Occupational Health/ Health and Safety Group ▪ **May 2022:** Targeted Mask Fit testing	None	N/A
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: ▪ The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness (NSHC) and this plan is monitored at board level.	The Trust has implemented the NSHC this is evidenced by the appropriate auditing of the clinical areas.	None	N/A
The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	All clinical rooms have been designated as meeting the revised changes to the standards of Health care cleanliness. The Bed Management Team communicate and identify functionality of areas and priority of the cleanliness in patient rooms.	None	N/A

Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	Cleaning standards and frequencies are monitored in all clinical areas.	Currently the Trust are not monitoring non-clinical areas **May 2022:** Currently the Trust are only cleaning prioritised areas within the non-clinical areas	The Trust board has approved a 2nd wave of recruitment to undertake the cleaning and monitoring of non-clinical areas in 2022/23 **May 2022:** 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
Increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.	All clinical areas have been revised within the cleaning frequencies incorporating the increased standard of cleanliness **May 2022:** All clinical areas have been revised within the cleaning frequencies incorporating the increased standard of cleanliness staffing hours have been increased to accommodate these changes	None	N/A
Where patients with respiratory infections are cared for: cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance.	All clinical areas are cleaned with 1000 ppm chlorine-based product (SoChlor), this is in line with current UKHSA/ NHSE guidance. **May 2022:** NHSE Guidance update in April 2022, noted step down to cleaning in low-risk areas (in comparison to disinfection as above). This is currently subject to discussion with Estates and Facilities	None	N/A
If an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.	Whilst there is no deviation from cleaning with chlorine the domestic service and IPC have a strong partnership and work together with the implementation of new products and chemicals through the cleaning services	None	N/A

	forum.		
Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	The Trust follows manufactures guidance and contact time for all cleaning and disinfectant cleaning solutions.	None	N/A
A minimum of twice daily cleaning of: ▪ Patient isolation rooms ▪ Cohort areas ▪ Donning & doffing areas ▪ 'Frequently touched' surfaces (FTS) e.g., door/toilet handles, patient call bells, over bed tables and bed rails ▪ Where there may be higher environmental contamination rates, including, toilets/ commodes particularly if patients have diarrhoea.	The Trust has a 2nd clean process for all wards and clinical areas incorporating Frequently Touched Surfaces (FTS) and toilets in addition to the standard daily clean. **May 2022:** Enhanced cleaning enabled during outbreak management only.	None	N/A
A terminal/deep clean of inpatient rooms is carried out: ▪ Following resolutions of symptoms and removal of precautions. ▪ When vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens). ▪ Following an AGP if room vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).	▪ The Domestic Response Team are responsible for the Terminal Infected Cleaning regime for all areas vacated by infectious patient areas. ▪ Disposable curtains where applicable are replaced as part of this process. ▪ Hydrogen Peroxide Vapour (HPV) Decontamination Cleaning (Bioquell) process is also undertaken when applicable. **May 2022:** No change. Remains in place.	None	N/A
Reusable non-invasive care equipment is decontaminated: ▪ between each use. ▪ after blood and/or body fluid contamination ▪ at regular predefined intervals as part of an equipment cleaning protocol ▪ before inspection, servicing, or repair equipment.	All patient equipment is cleaned by nursing staff and follow Trust processes and SOP. **May 2022:** No change. Remains in place	None	N/A

Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	The Trust has designated auditors who monitor the standard of cleanliness of the clinical environment in line with the NSHC: FR1 – Weekly. FR2 – Monthly. FR3/FR4 – Monthly. **May 2022:** No change. Remains in place	None	N/A
As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult inpatient facilities	▪ The NHS does not routinely undertake any annual verification exercises on general ventilation systems. ▪ The HTM 03-01 DH refers to the requirement for annual verification for specialised ventilation systems such as Operating Theatres etc only. ▪ However, Estates and Facilities at WWL have evaluated ventilation across the Trust and especially RAEI. **May 2022:** No change. Remains in place	As previously identified, large parts of RAEI clinical areas are not mechanically ventilated. This includes the following patient ward areas; Astley, Standish, Swinley, and Langtree and Maternity area. Additionally, parts of Orrell and Winstanley are NOT mechanically ventilated.	Across most of the patient areas at RAEI, the window openings have been increased from 100mm to 200mm in order to increase natural ventilation. *NHS mandatory window opening restriction is 100mm – this rule restricts natural ventilation in buildings that are designed to be naturally ventilated?
The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer.	▪ **December 21:** Estates and Facilities Team completed a review of ventilation at all sites, with the exception of, a small area at the Leigh site. ▪ A report, written by the Head of Operational Estates highlighted a heavy reliance on natural ventilation, particularly at the RAEI site. ▪ **March 2022:** The report has been submitted to the Ventilation and Water Group (VWG) and the IPC Committee. **May 2022:** No change	Most areas have been identified as being adequately mechanically ventilated, or natural ventilation has been improved. Some limited small areas may still have poor ventilation.	N/A

A systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	▪ Respiratory care area pathways are usually via the Emergency Floor into COVID-19 wards, escalating to Winstanley/ Ince with further escalation to ICU/ HDU. Some patient areas including parts of Winstanley Ward (Respiratory - CPAP/ BiPAP) are NOT mechanically ventilated. **May 2022:** No change	The VWG is not aware of any ventilation consideration when determining respiratory pathways.	The VWG could be asked to provide as assessment of ventilation when determining patient pathways.
Where possible air is diluted by natural ventilation by opening windows and doors where appropriate	▪ Across the majority of the patient areas at RAEI (both mechanically ventilated and naturally ventilated), the window openings have been increased from 100mm to 200mm in order to increase natural ventilation. ▪ December 21: Window opening capacity was increased at the Wigan site within safety limitations. ▪ Where mechanical ventilation is not available, managers have been advised to encourage the dilution of air by opening windows. **May 2022:** Natural ventilation continues to be encouraged **May 2022:** Global communications to all staff continue	Some limited small areas may still have poor ventilation.	Window open capacity has been increased at the Wigan site within safety limitations.
Where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.	RAEI and Leigh Endoscopy utilise Filtex AC-1500 HEPA and UV filtration “air scrubbers”. SunWeb S-400 smaller “air scrubbers” were trialled on Winstanley Ward but the trial was stopped at the request of local staff. **May 2022:** No change	Widely recognised standards have not been developed. A variety of products are available. CIBSE recommend either HEPA or UV but not both.	N/A
When considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams,	Estates within Estates and Facilities manages requests for partitions, with the majority of	None	N/A

to ensure that air flow is not affected, and cleaning schedules are in place.	screens/ partitions erected much earlier in the Pandemic. Once installed the Estates and Facilities Domestic Teams clean the screens in line with current cleaning schedules in line with NSHC. **May 2022:** No change		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: ▪ Arrangements for antimicrobial stewardship are maintained	▪ Remote antimicrobial ward rounds were performed by the Clinical Pharmacist from January 2022. ▪ Antimicrobial ward rounds performed within Critical Care by Clinical Pharmacist from January 2022. ▪ Data collected on each intervention and feedback given. ▪ Antimicrobial Pharmacist continues to review prescribing and new guidance as appropriate. ▪ Antimicrobial audit programme. ▪ Antibiotic audits completed on wards following each reported CDT case in line with Saving lives guidance and repeated if <95% scored. ▪ **January 2022:** Microbiologist/ IPC Doctor has left the Trust ▪ **March 2022:** Second Microbiologist has left the Trust ▪ **March 2022:** Two Locum Microbiologists recruited, providing remote/ virtual support 5 days per week with a specific/ limited remit. ▪ **May 2022:** Second Microbiologist left the Trust: Not replaced at time of reporting. The IPC Nursing Service does	**January 2022:** Microbiologist/ IPC Doctor left the Trust and not permanently replaced at time of reporting. **March 2022:** Second Microbiologist has left the Trust and not permanently replaced at time of reporting. **May 2022:** No Microbiology: Infection Control Doctor in post to support the IPC Nursing Service	**May 2022:** One locum Microbiologist currently providing a specific/ limited remit, via virtual/ remote service arrangement in the interim period. Recruitment of new/ Microbiologist discussed at Senior Meeting (Risk Management Group). **April 2022:** Organisational Risk Assessment: Microbiology Service reviewed by Risk Management Group **May 2022:** Two IPC Risk Assessments currently in place: Lack of Microbiology support to IPC Nursing Service and IPC Service unable to deliver service due to lack of specialist staff.

	not have the capacity to support the Antimicrobial Pharmacist with Antibiotic reviews		Both awaiting risk Review at Corporate Risk Group and Risk Management Group
Previous antimicrobial history is considered	▪ Data available via HIS ▪ Clinical Pharmacist in post to support reviews	**May 2022:** Limited assurance of support to Clinical Pharmacist from Microbiologist	**May 2022:** Only one locum Microbiologist providing a specific/ limited remit, via virtual/ remote service arrangement in the interim period.
The use of antimicrobials is managed and monitored: ▪ To reduce inappropriate prescribing. ▪ To ensure patients with infections are treated promptly with correct antibiotic.	▪ Data available via HIS ▪ Clinical Pharmacist and two locum Microbiologist's in post to support review ▪ **March 2022:** Two Locum Microbiologists recruited, providing remote/ virtual support 5 days per week with a specific/ limited remit. May 2022: Programme of Antibiotic Point Prevalence Audits by Medicines Management Team continues	**January 2022:** Microbiologist/ IPC Doctor left the Trust and not permanently replaced at time of reporting. **March 2022:** Second Microbiologist has left the Trust and not permanently replaced at time of reporting. **May 2022:** Only one locum Microbiologist providing a specific/ limited remit, via virtual/ remote service arrangement in the interim period.	**May 2022:** One locum Microbiologist currently providing a specific/ limited remit, via virtual/ remote service arrangement in the interim period. Recruitment of new/ Microbiologist discussed at Senior Meeting (Risk Management Group) **May 2022:** Additional Risk Assessment: Microbiology support to IPC Nursing Team awaiting review at Corporate Risk Group and Risk Management Group
Mandatory reporting requirements are adhered to, and boards continue to maintain oversight	▪ Mandatory reporting through the Board performance report.	None	N/A

	▪ Mandatory reporting through the quarterly IPC paper to Quality and Safety Committee. ▪ Monthly reporting through Divisional Quality Assurance Groups.		
Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	▪ Microbiology support risk assessments until left the Trust. Limited support available at time of report: March 2022. ▪ Clinical Pharmacist in post to support reviews **May 2022:** Only limited support available at time of report	**January 2022:** Microbiologist/ IPC Doctor has left the Trust and not replaced at time of reporting. **March 2022:** Second Microbiologist has left the Trust and not replaced at time of reporting. **May 2022:** No change, only one Microbiologist. No Infection Control Doctor	**April 2022:** Recruitment of new/ Microbiologist discussed at Senior Meeting (Risk Management Group) **May 2022:** Only one locum Microbiologist currently providing a specific/ limited remit, via virtual/ remote service arrangement in the interim period.
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
▪ **Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: ▪ Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff, and visitors	▪ Visiting suspended during December 2021. ▪ Specific visiting continued during the visiting pause and included: End of Life, Paediatrics and Maternity. ▪ Visiting recommenced in **February 2022**, enabling one visitor. ▪ Trust Visiting SOP and information leaflet. ▪ **March 2022:** Review of NHS Guidance: *Visiting healthcare inpatient settings while COVID-19 is in general circulation: principles.* ***8 March 2022****. Version 4.*	None	N/A

	▪ Communications of process to staff, patients, and visitors. **May 2022:** Visiting reviewed. Two visitors can now visit per patient. Duration increased to one hour. **May 2022:** Visiting SOP and Patient information leaflet reviewed and updated in line with changes to visiting		
National guidance on visiting patients in a care setting is implemented.	▪ Visiting in operation: **February 2022**. ▪ Trust Visiting SOP and information leaflet. **May 2022:** Visiting reviewed. Two visitors can now visit per patient. Duration increased to one hour. **May 2022:** Visiting SOP and Patient information leaflet reviewed and updated in line with changes to visiting	None	N/A
Restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	▪ Visiting is suspended during a declared outbreak and/ or bay closure, with exceptions of End of Life, Paediatrics and Maternity. ▪ Risk assessment may enable consideration to other visiting arrangements in specific/ individual circumstances. ▪ Visiting suspended during December 2021. ▪ Visiting recommenced in **February 2022** enabling one visitor. **May 2022:** Two visitors can now visit per patient. Duration increased to one hour	None	N/A
There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing.	▪ Information and signage present and visible throughout Trust site areas. ▪ Trust Visiting SOP and Visitor information leaflet available. **May 2022:** Visiting SOP and Patient information leaflet reviewed and updated in line with changes to visiting	None	N/A

If visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.	▪ Local Trust SOP/ Policy aligned with National UKHSA/ NHSE guidance. ▪ All changes communicated through Divisional Teams and via COVID-19 communications. ▪ Visitor disclaimer, Decision tree and IPC requirements available within SOP. ▪ December 21: Patient visiting was suspended for 14 days due to Outbreak and Bay closures. Reviewed and the decision taken to pause visiting with the exception of End of Life, Paediatrics and Maternity. ▪ Visitor information provided by ward and clinical staff. ▪ Visiting recommenced in **February 2022** enabling one visitor. **May 2022:** Two visitors can now visit per patient. Duration increased to one hour	None	N/A
Visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.	▪ Processes in place adopting UKHSA/ NHSE Guidance. Mitigation includes pre-booked visits. Triage questions/ safe measures, excluding symptomatic visitors. ▪ Trust Visiting SOP and information leaflet aligned with the current UKHSA/ NHSE guidance. ▪ Entry to wards is via swipe which restricts unauthorised access. ▪ Visible signage at entry points. ▪ Individual consideration and risk assessment by care area staff/ clinician **May 2022:** No change	None	N/A
Visitors are not present during AGPs on infectious patients unless they are considered essential	▪ Process in place with presence only following individual risk assessment on a specific patient basis: carer, child,	None	N/A

following a risk assessment e.g., carer/ parent/ guardian.	guardian. **May 2022:** No change		
Implementation of the Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been considered C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	▪ Review of all resources by IPC and Comms. ▪ Several items have been used in internal and external comms. ▪ Toolkit also shared with HR staff.	None	N/A
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: ▪ Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	▪ Dedicated COVID-19 tab on landing page of Trust Intranet with divided sections including PPE and IPC. ▪ External website has clear information and advice. ▪ Signage is available at all entry points. ▪ Triage on entry. ▪ Entry to wards is via swipe which restricts unauthorised access. ▪ Entry signage in place for all wards, departments. ▪ Signage includes key instructions, e.g., PPE required, hand hygiene and physical distancing. ▪ Information is displayed at each entrance to prompt patients, visitors, and staff to comply with hands, face, space. ▪ Alcohol hand gel/ mask stations are available at entrances. ▪ Patient leaflets includes information on masks, hand hygiene and physical distancing. ▪ Clear signage in EEC indicating triage on entry. **May 2022:** No change	None	N/A

Infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred.	▪ Infection status is communicated verbally before the patient is transferred and then in writing via a transfer form when the patient is moved. ▪ Discharge to assess process works to rapidly discharge patients to the most appropriate setting with a philosophy of home wherever possible reducing contact with others. ▪ Patients are swabbed 48 hours before discharge to nursing or care home. **May 2022:** No change	None	N/A
Staff are aware of agreed template for screening questions to ask.	▪ Screening questions are available for ward, service, and division staff in line with current UKHSA/ NHSE guidance. ▪ Screening questions in line with UKHSA/ NHSE guidance are included within Visitor SOP and Information leaflet. ▪ HIS core assessment questions are included in the COVID-19 checklist. ▪ Staff encouraged to adopt proactive approach to self-screen/ triage before attending for duty. **May 2022:** No change	None	N/A
Screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment.	▪ Pre attendance screening for elective pathways/ Maternity pathways. ▪ Dedicated COVID-19 tab on landing page of Trust Intranet with divided sections including PPE and IPC. ▪ External website has clear information and advice. ▪ Telephone screening is in place for all elective patients; they are swabbed 3 days prior to admission and asked to self-isolate prior to coming in.	None	**April and May 2022:** Discussions in progress. Awaiting notification of swabbing process/ LFD supply arrangement from National Team. **May 2022:** Pathways in place

	▪ SOPs are in place to support guidance. ▪ **March 2022:** Review of updated guidance in progress: *NHSE/ NHSI: UK infection prevention and control (IPC) guidance for elective services.* 11 February 2022. **May 2022:** Elective Pathways: Pre-admission LFD testing and reporting by patients **May 2022:** Elective Pathways: Pre-admission PCR testing for predicted critical care post-surgery and High-risk patients **May 2022:** Cancellation Pathway to enable optimal capacity in place		
Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance.	▪ All patients attending EEC (and other entry sites i.e., Walk-in-Centre) are screened for COVID-19 symptoms on entry. ▪ Patients are assessed at triage (EEC) and COVID-19 tested and subsequently segregated appropriate to pathway and designated ward area. ▪ Fluid Resistant Surgical Masks (FRSM) are available in all clinical areas and at all entrances; staff and visitors continue to be requested to wear masks as they enter the hospital setting. ▪ **December 2021:** Patient flow pathways developed by the Microbiologist and shared within Divisions/ Clinical colleagues, remain in place. ▪ **March 2022:** Updated UKHSA/ NHSE Guidance: *Infection Prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for Winter 2021 to 2022'.* Reviewed and Trust guidance updated. **May 2022:** *Infection Prevention and control*	**May 2022:** Limited capacity to segregate patients within ED without adaption of the environment. **May 2022:** Rapid PCR and Point of care testing available within ED	N/A

	for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for Winter 2021 to 2022' remains in place. Update to guidance expected imminently		
Triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	▪ Staff within EEC have received specific training in relation to COVID-19 clinical case definition. ▪ Triage questions and COVID-19 checklist assessment within HIS further supports staff in clinical care definition and patient allocation. ▪ Pathways of care are defined within the Trust Policy/ SOP. ▪ **March 2022:** Updated UKHSA/ NHSE Guidance: *Infection Prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for Winter 2021 to 2022'.* Reviewed and Trust guidance updated. ▪ Patient flow pathways developed by the Microbiologist and shared within Divisions/ Clinical colleagues. **May 2022:** No change	None	N/A
There is evidence of compliance with routine patient testing protocols in line with Trust approved hierarchies of control risk assessment and approved.	▪ Patients are swabbed on day of admission (day 1) (PCR and LAMP tests), day 4, day 6 and then weekly thereafter. ▪ Reminders on HIS tracking board to alert staff when swabs are due. ▪ Appropriate management and action is taken on receipt of results. ▪ Surveillance of results by IPC Team. ▪ An App is available to report compliance with swabbing and the data reported to IPCC and included in quarterly IPC reports. ▪ **March 2022:** Routine COVID-19 Swabbing	**May 2022:** National guidance requires LFD testing on day 4 and day 6. Unable to comply as no system to record results onto electronic system (HIS). **May 2020:** Meetings/ discussions with HIS Team to consider	**May 2022:** Regional meetings in plan to discuss and agree consistent approach across the regional Hospitals. The DDIPC attends the Regional Meetings

	audit undertaken by all ward areas with reported Outbreaks and Bay closures. Audits completed by ward staff. Plan to extend swabbing audit to all ward areas. **May 2022:** Asymptomatic routine in-patient PCR testing reduced to admission (day 1), day 4, day 6. No further routine swabbing unless symptoms present or discharge to Care Home **May 2022:** LFD supplies ordered and delivered to the Trust. Will be stored securely until reporting system enabled	system to enable LFD Test recording	
Patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated.	▪ Patients are asked to wear a mask unless clinically impossible or medically exempt. ▪ Patient mask wearing is encouraged with all patients. ▪ Patients requested to wear a face mask during transportation around the hospital site. ▪ Patient mask wearing is reinforced if increased incidence/ during outbreak or bay closures. ▪ Department and ward staff advise and encourage patients, unless medically exempt. ▪ There is an information leaflet for patients on masks wearing approved at the IPC Committee. ▪ Compliance was audited in 2021. **May 2022:** Patients supported with the same approach	No recent data of in-patient compliance of wearing masks.	**May 2022:** Ward and Department staff continue to encourage in-patient mask wearing. Unless medically exempt. **May 2022:** Plan to re audit Mask wearing by patients.
Patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result.	▪ Patients are assessed at triage and segregated appropriate to pathway and designated ward area.	**May 2022: See Criteria 7.** Lack of isolation capacity is a challenge	**May 2022:** See Criteria 7: Provide Secure adequate isolation facilities

	▪ Patients are asked to wear a mask unless clinically impossible or medically exempt. ▪ There is an information leaflet for patients on masks approved at IPC Committee.	within the Trust with competing priorities for isolation.	
Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing.	▪ Identified high risk/ symptomatic patients are prioritised for side rooms. ▪ Included in SOP with mitigation. ▪ Datix reporting for lack of isolation capacity. ▪ An IPC Lead nurse attends daily bed meetings and are available 24/7 (including on-call) to support patient placement decisions. **May 2022:** No change	**May 2022: See Criteria 7.** Lack of isolation capacity is a challenge within the Trust with competing priorities for isolation.	
Patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered.	▪ High risk patients are prioritised for side rooms. ▪ Included in SOP with mitigation if no capacity. ▪ Datix reporting for lack of isolation capacity. ▪ An IPC Lead nurse attends daily bed meetings and are available 24/7 (including on-call) to support patient placement decisions. **May 2022:** No change	**May 2022:** See Criteria 7. Lack of isolation capacity is a challenge within the Trust with competing priorities for isolation.	
Where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	▪ Clinical assessment to inform decision making. ▪ Virtual consultation option to be considered. **May 2022:** No change	None	N/A
Face masks/coverings are worn by staff and patients in all health and care facilities.	▪ **March 2022:** FRSM are required by all staff, to be worn Universally within all Trust settings in line with current UKHSA guidance. ▪ RPE/ FFP3 masks are required in high-risk	No recent data of in-patient compliance of wearing masks.	**May 2022:** Ward and Department staff continue to encourage in-patient mask wearing.

	areas/ whilst undertaking AGPs and if indicated during COVID-19 outbreaks/ bay closures. ▪ Audit of compliance, reported to and monitored by IPCC. ▪ FRSMs are available in all clinical areas and at all entrances. ▪ Visitors are requested to wear masks as they enter hospital. ▪ Outpatients and visitors are requested to wear at all times, unless exempt. ▪ IPC SOPs includes information on mask wearing. **May 2022:** IPC precautions: Remain same for Clinical areas **May 2022:** Mask wearing not required in non-clinical offices, meeting rooms and education venues **May 2022:** Trust Global Communication to staff		Unless medically exempt. Plan to re audit Mask wearing by patients.
Where infectious respiratory patients are cared for physical distancing remains at 2 metres distance.	▪ Physical distancing has been maintained at 2 metres within the Trust in all settings, with the exception of direct care. ▪ March 2022: Trust SOPs in line with current UKHSA/ NHSE guidance **May 2022:** Physical distancing removed in all Trust areas with continued compliance with HTM Guidance: 01-04/ Bed spacing	None	N/A
Patients, visitors, and staff can maintain 1 metre or greater social and physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g., to protect reception staff.	▪ Physical distancing has been maintained at 2 metres within the Trust in all settings, with the exception, of direct care. ▪ Seating rearranged or areas blocked off to ensure segregation. ▪ Floor markings where required. ▪ Trust SOP in line with current UKHSA/	None	N/A

	NHSE guidance. ▪ Staff are not utilising patient entrances in order to reduce footfall. ▪ Screens are in-situ within reception areas. ▪ **March 2022:** Consideration to reducing to 1 metre distancing in low-risk areas/ specific situations i.e., elective programme under consideration in line with NHS/ DH guidance. **May 2022:** Physical distancing removed with continued compliance with HTM Guidance: 01-04/ Bed spacing		
Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly.	▪ Symptomatic patients are re-swabbed and transferred to a symptomatic ward (or isolated dependent upon capacity/ side room availability), whilst awaiting swab result and are transferred depending on results. ▪ Review of contacts are completed. ▪ Patient incident forms completed for all HOCI >8days that includes test and trace requirements. ▪ IPC Team undertake daily tracking to monitor patient transfers and bed moves. ▪ IPC Lead Nurse attends the bed manager meetings every day. ▪ Bay closure spreadsheet is maintained by the IPC Team. ▪ **March 2022:** COVID-19 Routine swabbing audits in progress on wards and actively requested in Outbreak/ Bay closure areas. **May 2022:** Identified COVID-19 positive patients are transferred to positive ward areas. **May 2022:** Contacts no longer require	None	N/A

	isolation: Implemented across the Trust		
Isolation, testing, and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative.	▪ Symptomatic patients are re-swabbed and transferred to a symptomatic ward (or isolated dependent upon capacity/ side room availability), whilst awaiting swab result and are transferred depending on results. ▪ Review of contact are completed. ▪ Patient incident forms completed for all HOCI >8days that includes test and trace requirements. ▪ IPC Team undertake daily tracking to monitor patient transfers and bed moves. ▪ IPC Lead Nurse attends the bed manager meetings every day. ▪ Bay closure spreadsheet is maintained by the IPC Team. **May 2022:** Contacts no longer require isolation: Implemented across the Trust **May 2022:** Positive patients transferred to positive ward areas	None	N/A
Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	▪ Patients are managed in line with UKHSA guidance for symptomatic individuals, swabbed and advised to isolate at home and follow UKHSA guidance until result received. To follow UKHSA guidance in line with result. ▪ Clinical review in line with presenting symptoms/ differential diagnosis. ▪ In line with departmental SOPs, a risk assessment must be undertaken if a symptomatic patient attends a routine appointment. ▪ All COVID departmental SOPs are signed off by IPC.	None	N/A

	May 2022: No change		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: ▪ Appropriate infection prevention education is provided for staff, patients, and visitors.	▪ Mandatory e-learning for all staff. ▪ Environmental risk assessments have been completed at ward and department level. ▪ Where concerns are raised additional bespoke training is undertaken by the relevant individual to ensure staff comply. ▪ COVID-19 safe information available in all clinical areas and at all entrances. ▪ Patients are supported with IPC measures during hospital attendance/ admission, i.e., hand hygiene, face masks and distancing. ▪ Information leaflet for patients on COVID-19 Safe measures masks approved at IPC Committee.	**January 2022:** A reduction in compliance with Mandatory IPC/ COVID-19 e-learning modules was noted to in Quarter 3. **May 2022:** A reduction in compliance with Mandatory IPC/ COVID-19 e-learning modules was noted to in Quarter 4.	**January 2022:** Compliance with Mandatory training was reported at the January 2022 IPC Committee with a request for each Division to provide a timeline and action plan to address and improve compliance at the next meeting in March 2022. **March 2022:** Timeline and action plans discussed at IPCC.
Training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely.	▪ Mandatory e-learning for all staff. ▪ All mandatory training is recorded through personal passports and electronically through the Trust mandatory training system. ▪ Environmental risk assessments have been completed at ward and department level. ▪ Where concerns are raised additional bespoke training is undertaken by the relevant individual to ensure staff comply. ▪ Mask fit training available for Trust staff as applicable to working environment and risk assessment. ▪ FFP3 mask fit training is organised and	**January 2022:** A reduction in compliance with Mandatory IPC/ COVID-19 e-learning modules was noted to in Quarter 3. **May 2022:** A reduction in compliance with Mandatory IPC/ COVID-19 e-learning modules was noted to in Quarter 4. **May 2022:** Mask fit	**January 2022:** Compliance with Mandatory training was reported at the January 2022 IPC Committee with a request for each Division to provide a timeline and action plan to address and improve compliance at the next meeting in **March 2022**. **May 2022:** Timeline and action plans discussed at IPCC.

	managed by the Health and Safety Team. Records held centrally and shared with Divisions. ▪ Information provided to all staff at time of Mask fit test advising fit check on each episode of wearing an FFP3 mask and correct donning and doffing procedure applicable to mask type. ▪ Audit of compliance with PPE practice by ward and IPC Team.	training continues and encouraged. **May 2022:** Health and Safety Report to ETM: Mask Fitting	
All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it.	▪ Don and doff posters are displayed in all wards and departments. ▪ IPC check posters are present on ward visits. ▪ IPC advice is available 24/7. ▪ The Professional Practice Team support IPC to carry out classroom training on donning and doffing. ▪ Don and doff guidance is included in the PPE e-learning module. ▪ Specific Mask fit testing and training for individual staff members dependent upon role, work environment and risk assessment. **May 2022:** No change	None	N/A
Adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	▪ Compliance with correct technique reviewed, observed, and audited by the IPC Team during ward visits. ▪ Spot audits are undertaken by IPC Team and ward leaders. ▪ Responsive audits are undertaken during episodes of Outbreaks, Bay closures and episodes of C.*difficile* infection. ▪ All key wards PPE compliance is audited at least every 2 months. Results feedback to	PPE compliance is below expected standard in ward areas. **May 2022:** Compliance with Mask wearing has significantly improved	A refocus on IPC Compliance with "Back to Basics" approach will be adopted to support improved compliance and ownership. **May 2022:** Audit programme continues

	ward leaders and staff members. ▪ PPE audit results are reported to IPCC, reviewed with action plans as indicated. ▪ Audit results are included within quarterly report to Quality and Safety Committee. ▪ **January 2022:** The compliance with PPE was reiterated to the IPCC group. members for cascade within all Divisions. ▪ Ownership of PPE compliance reinforced and encouraged through IPC Committee and ward level IPC support. ▪ **March 2022:** PPE Compliance reported through IPC Committee. ▪ **March 2022:** Compliance reviewed during Senior Leader Ward visits/ Accreditation visits. **May 2022:** PPE Compliance audited and reported in Q4.		
Gloves are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	▪ Compliance with correct glove use is reviewed, observed, and audited during IPC Team ward visits. ▪ Spot audits are undertaken by IPC Team and ward leaders. ▪ Responsive audits are undertaken during episodes of Outbreaks, Bay closures and episodes of C.*difficile* infection episodes. ▪ IPC support with doffing and donning technique. ▪ Education included within Mandatory e-learning. ▪ **March 2022:** Compliance reviewed during Senior Leader Ward visits/ Accreditation visits. **May 2022:** Actions continue as above	May 2022:	May 2022:

The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per **national** guidance	▪ There are no hand dryers in any clinical areas at WWL. Where hand dryers were available for the public these have been deactivated and replaced with paper towels. ▪ Hand hygiene training is mandatory. ▪ Monthly hand hygiene audits are completed in all clinical areas and the results are monitored by IPCC. ▪ There is an annual programme of CQC Spot audits for clinical areas monitoring the environment and practice. **May 2022:** Actions continue as above	May 2022:	**May 2022:** A refocus on IPC Compliance with "Back to Basics" approach will be adopted to support improved compliance and ownership.
Staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	▪ Physical distancing has been maintained at 2 metres within the Trust in all settings, with the exception, of direct care in line with current UKHSA guidance. ▪ **March 2022:** Compliance reviewed during Senior Leader Ward visits/ Accreditation visits. **May 2022:** Physical distancing removed in all areas	None	N/A
Staff understand the requirements for uniform laundering where this is not provided for onsite.	▪ Trust Uniform Policy in line with National guidance ▪ **January 2022:** Global communication: Compliance with Uniform Policy reinforced. **May 2022:** No change	None	N/A
All staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance	▪ Regular Trust communications reinforcing UKHSA guidance and Trust Policy/ SOP. ▪ Testing drive through facility for staff testing at Leigh and Wrightington. ▪ Flowchart: Early isolation early following COVID-19 positive result. ▪ Flowchart: Exemption from isolation	**March 2022:** Awaiting National guidance regarding staff LFD swabbing/ testing arrangement and the process for provision and availability of LFD	**May and March 2022:** Trust colleagues are linking with Regional/ GM colleagues and groups to source further information.

	following COVID-19 Contact. ▪ Staff responsibility for own supply of lateral flow kits for twice weekly testing. ▪ IPC advice and support is available 24/7. ▪ **February 2022:** UKHSA guidance updated: *COVID-19 Management of staff and exposed patients or residents in health and social care settings.* ▪ **March 2022:** Updated UKHSA/ NHSE Guidance: *Infection Prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for Winter 2021 to 2022'.* Reviewed and Trust guidance updated. ▪ **March 2022:** UKHSA guidance: *Living with COVID-19* **March and April 2022:** NHSE Guidance: Testing for In-patients, symptomatic and asymptomatic staff **May 2022:** Clinical staff: Twice weekly LFD testing. **May 2022:** Clinical staff responsible for ordering LFD test kit supplies and reporting results via .gov portal **May 2022:** All staff to perform LFD test if COVID-19 symptoms present	swab supplies (No response as at: 21 March 2022. To note: From **1 April 2022** the government will no longer provide free universal testing for the general public.	**May and March 2022:** Internal Trust discussions regarding LFD swab/ process/ supplies arrangements.
To monitor compliance and reporting for asymptomatic staff testing	▪ Organisational process for twice weekly LFD Testing and local system reporting. ▪ Track and Trace reviews by dedicated COVID-19 Test and Trace Team, risk assessments completed and shared with IPC Team. ▪ IPC Team and Test and Trace Team worked collaboratively to support the system	**January 2022:** Reduced capacity to undertake all Test and Trace assessments with volume of positive results and capacity of Team.	**March 2022:** To consider sources of support for Test and Trace Team.

	▪ Regular communications encouraging. staff engagement. ▪ **January 2022:** All staff are advised and encouraged to LFD testing twice weekly in line with current guidance during Omicron wave. ▪ **March 2022:** Noted small increase in staff COVID-19 positive results. ▪ **March 2022:** Noted decrease in the number of completed Test and Trace assessments for COVID-19 positive staff. **May 2022:** Clinical staff responsible for ordering LFD test kit supplies and reporting results via .gov portal. **May 2022:** Staff test and trace discontinued **May 2022:** Non-clinical staff not required to complete asymptomatic LFD testing	**March 2022:** Awaiting National guidance regarding staff LFD swabbing/ testing arrangement and the process for provision and availability of LFD swab supplies (No response as at: 21 March 2022. **To note: From 1 April 2022 the government will no longer provide free universal testing for the general public.** **March 2022:** Noted small increase in staff reported COVID-19 Positive staff results with no Test and Trace risk assessment completed. **March 2022:** The capacity of Test and Trace provision within the Trust is limited and currently unable to meet the current demand. Compliance with the LFD staff reporting process. The data is not accurate for the	**March 2022:** Trust colleagues are linking with Regional/ GM colleagues and groups to source further information. **March 2022:** Internal Trust discussions regarding LFD swab/ process/ supplies arrangements. **May 2022:** Global communications to encourage staff compliance with reporting LFD test results to .gov portal and sickness reporting to line manager.

		number of staff carrying out twice weekly lateral flow tests. **May 2022:** Clinical staff report LFD test results directly to .gov portal	
There is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	▪ The IPC Team undertake daily surveillance of all reported results, including COVID-19 results from local and PHE/ UKHSA reporting systems. ▪ An electronic laboratory reporting process (Queue) provides the IPCT with timely COVID results. ▪ Surveillance data for patients and staff. ▪ Hospital onset COVID-19 cases (HOCI) are reported via the daily nosocomial sitrep. ▪ Active surveillance for any increased incidence to specific areas/ staff/ patient groups. ▪ An in-house COVID-19 App has been developed that supports the collation, evaluation, and summary of COVID cases. ▪ Wards/ Departments/ Bed Managers and Operations Team to be vigilant for increased patient or staff incidence and encouraged to report staff positive result notifications. ▪ Local UKHSA information on population transmission is circulated to IPC. **May 2022:** Clinical staff responsible for ordering LFD test kit supplies and reporting results via .gov portal. **May 2022:** Staff test and trace discontinued	None	N/A

Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	▪ Active surveillance by the IPC Team. ▪ Active surveillance for any increased incidence to specific areas/ staff/ patient groups. ▪ Patient investigation templates are completed for patients who test positive for COVID-19 from 8 or more days after admission. ▪ Wards/ Departments/ Bed Managers and Operations Team to be vigilant for increased patient or staff incidence and encouraged to report staff positive result notifications. ▪ Local outbreak email cascades sharing information. ▪ If the Outbreak criteria is met, an outbreak is declared and management in line with Trust Policy and SOPs and current UKHSA guidance. ▪ Outbreaks are reported in line with Trust/ Regional Policy, SOPs and process and reported to DIPC and NHSE/ NHSI via App. ▪ Bay closures are reported internally and managed in line with Trust Policies and SOPs. ▪ Daily outbreak meetings are held when necessary and minutes recorded. ▪ StEIS Concise Investigations completed for all reported Outbreaks. ▪ StEIS Concise Investigation reports are reviewed through Trust Governance and Safety Systems with additional external scrutiny. **May 2022:** All actions above continue	None	N/A

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: ▪ That clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	▪ Advice and guidance is provided to in-patients within the Trust with mask wearing, providing they can be tolerated and not detrimental to their (physical or mental) care needs. ▪ IPC measures to continue within all Trust health and care settings including face masks/ coverings for all patients/visitors, Physical distancing, and increased ventilation. ▪ National UKHSA guidance followed. ▪ Trust COVID-19 SOP aligned with National UKHSA guidance. **May 2022:** All actions continue	No current audit data available for patient mask wearing compliance.	**May 2022:** Staff monitor compliance at ward level
Separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients.	▪ Patient pathways according to risk stratification have been defined and included within the Trust COVID-19 SOP which has been disseminated to all clinical teams. ▪ Environmental risk assessments have been completed by wards and departments to establish safe flow of patients and staff. ▪ **December 21:** UKHSA/ NHSE Guidance: Infection Prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for Winter 2021 to 2022'. Reviewed and Trust guidance updated. ▪ Patient flow pathways developed by the Microbiologist and shared within Divisions/ Clinical colleagues. **May 2022:** Physical distancing removed	None	N/A

	Planned scheduling continues. Segregation of positive patients continues to positive ward areas. **May 2022:** Isolation of asymptomatic contacts is no longer required		
Patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.	▪ **December 21:** Updated UKHSA/ NHSE Guidance: Infection Prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for Winter 2021 to 2022'. Reviewed and Trust guidance updated. ▪ Patient flow pathways developed by the Microbiologist and shared within Divisions/ Clinical colleagues.	None	N/A
Patients are appropriately placed i.e., infectious patients in isolation or cohorts.	▪ Patient flow pathways were developed by the Microbiologist and shared within Divisions/ Clinical colleagues. ▪ Patients continue to be appropriately placed if confirmed COVID-19 positive, transferred to COVID-19 ward. If a confirmed Contact, isolated in side-room or bay closure. ▪ Outbreak confirmed and management if meet definition. ▪ Collaboration between IPC Team, Operations Team, Bed Managers, and ward staff to inform patient placement. ▪ Patients tracked through the Bed management team, the number of transfers and outbreak occurrences to minimise risk. This is monitored and supported by IPC ▪ Designated side room capacity is utilised as available for incidence of infections, informed by risk assessment. This applies	Due to the number of patients with COVID 19 during the Omicron wave, the Trust was not always able to separate pathways. **May 2022:** Within the Trust there is limited side room capacity to consistently enable isolation as required.	Amber site status adopted during Omicron wave in response to capacity and demand. Local application of pathways in line with UKHSA/ NHSE Guidance. There is a risk assessment on lack of side rooms. **May 2022:** IPC attend bed meetings and support bed managers with decision making. **May 2022:** A Datix is completed if unable to isolate a patient and mitigating IPC actions and measures are

	to clinical need, irrespective of infection as capacity allows and in collaboration with IPC and Bed management Teams. **May 2022:** Positive patients are transferred to designated positive ward areas **May 2022:** Isolation of contacts is no longer required		implemented to maintain safety. **May 2022:** Action to secure isolation continues by Bed management colleagues.
Ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).	▪ All bed spaces have been reviewed by Estates and Facilities. ▪ Physical distancing continues within Office spaces to ensure distancing in line with National guidance for healthcare services is maintained. ▪ Home working arrangements continue within services. ▪ Additional review of areas as additional capacity brought on-line within the Trust estate. ▪ All community premises have been reviewed for social distancing and a number of work areas have been designated as no longer in use. ▪ Areas will be reviewed in line with any change to National guidance. ▪ Ward staff are requested to use privacy curtains between beds to minimise close contact where safe to do so. ▪ IPC guidance is available on all ward areas, supported by the IPC Team and reinforced through staff global communications, newsletter, and meetings. ▪ IPC advice continues to support national guidance within healthcare services, Wards, include minimum numbers at staff handovers and meetings, safe break	Due to the number of patients with COVID 19 during the Omicron wave, the Trust was not always able to separate pathways.	Amber site status adopted during Omicron wave in response to capacity and demand. **May 2022:** Physical distancing removed in all areas Positive patients are transferred to designated positive areas

	arrangements, advice re car sharing. ▪ Amber site status adopted during Omicron wave in response to capacity and demand. ▪ Collaboration between IPC Team, Operations Team, Bed Managers, and ward staff to inform patient placement. ▪ IPC Lead Nurse attends Bed Management meetings to support decision making. ▪ Outbreak meetings arranged and held during Outbreaks and Bay closures. ▪ IPC environmental checklists completed with every confirmed outbreak. **May 2022:** Actions continue as above. Physical distancing has been removed. Bed spacing continues in line with HTM 01-04		
Standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result	▪ SICP and COVID-19 safe measures are adopted across the Trust in line with current National UKHSA/ NHSE guidance and aligned with Trust Policy and SOPs. **May 2022:** Continues as above	None	N/A
The principles of SICPs and TBPs continued to be applied when caring for the deceased	▪ National UKHSA guidance followed. ▪ Trust SOP aligned with National UKHSA guidance.	None	N/A
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: ▪ Testing is undertaken by competent and trained individuals;	▪ The Laboratories used are UKAS accredited. **May 2022:** No change	None	N/A
Patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance;	▪ Testing is performed in line with national guidance. It is provided by Northern Care Alliance; monitoring of compliance is through contractual discussions (PAWS). ▪ Trust guidance is in line with national guidance on testing for suspected COVID-	Current unknown impact and uncertainty of the path the COVID-19 Pandemic will take.	Services to prepare for additional impact on capacity and demand of rising COVID-19 cases.

	19 cases and for other infections. ▪ The HIS tracking board highlights when patients need re-swabbing in line with National guidance. ▪ System established for antibody testing in line with UKHSA Guidance: *Coronavirus (COVID-19): antibody testing. Last updated 4 November 2021* ▪ System established for carrying out additional testing on vaccinated patients and for identifying patients who may have new variants. ▪ December 21: Identification of the new variant of concern Omicron notified via Regional UKHSA. ▪ **February 2022:** UKHSA guidance updated: *COVID-19 Management of staff and exposed patients or residents in health and social care settings.* ▪ **March 2022:** Current increase in COVID-19 cases noted impacting on services and capacity. ▪ **23 February 2022:** UKHSA guidance: *Living with COVID-19* ▪ **15 March 2022:** Updated UKHSA/ NHSE Guidance: *Infection Prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for Winter 2021 to 2022'*. Reviewed and Trust guidance updated. **May 2022:** No change		IPC measures, and management resources, guidance and SOPs remain in place to support staff and patient care.
Staff testing protocols are in place	▪ Local testing systems in place, including rapid testing where indicated. ▪ Testing via National systems also in operation via UKHSA/ gov portal.	None	N/A

	May 2022: Clinical staff responsible for ordering LFD test kit supplies and reporting results via .gov portal. **May 2022:** Staff test and trace discontinued		
There is regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available;	▪ App shows turnaround times. ▪ HIS alert if time interval is greater than 24 hours. **May 2022:** No change	None	N/A
There is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data);	▪ National policy is followed. ▪ Patient incident reviews are carried out on all probable and definite hospital onset COVID-19 patients. **May 2022:** No change	None	N/A
Screening for other potential infections takes place;	▪ National policy is followed. ▪ Alert organisms are reported as required on national database and at IPCC and investigated according to National guidance. **May 2022:** No change	None	N/A
That all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission;	▪ All patients tested on admission via LAMP and PCR. **May 2022:** LAMP testing discontinued 31.3.2022. **May 2022:** All patients are offered a PCR test/ Rapid PCR or Point of care test on emergency admission in line with current NHSE testing guidance	None	N/A
That those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise;	▪ Management in line with Trust COVID-19 SOP. ▪ Patients re-swabbed if symptoms present in line with National guidance and moved to a symptomatic ward and to positive ward on confirmation of positive result. **May 2022:** All positive patients are transferred to designated positive ward area	None	N/A

That emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission	▪ National policy is followed. ▪ An App is in place to monitor compliance. ▪ There are electronic reminders on the HIS tracking board to highlight when swabs are due. ▪ Q3 Audit demonstrated compliance with inpatient COVID-19 swabbing at 89%. ▪ **March 2022:** Routine COVID-19 Swabbing audit undertaken by all ward areas with reported Outbreaks and Bay closures. Audits completed by ward staff. Plan to extend swabbing audit to all ward areas. **May 2022:** Asymptomatic routine in-patient PCR testing reduced to admission (day 1), day 4, day 6. No further swabbing unless symptoms present or discharge to Care Home	**May 2022:** National guidance requires LFD testing on day 4 and day 6. Unable to comply as no system to record results onto electronic system (HIS). **May 2020:** Meetings/ discussions with HIS Team to consider system to enable LFD Test recording	**May 2022:** Regional meetings in plan to discuss and agree consistent approach across the regional Hospitals. The DDIPC attends the Regional Meetings
That sites with high nosocomial rates should consider testing COVID negative patients daily;	▪ IPC Team consider and review if nosocomial rates high. Swabbing of all patients 3 times per week in an outbreak. ▪ There will be a discussion with Microbiology for any deviation from guidance. **May 2022:** Not applicable at current time	None	N/A
That those being discharged to a care home are tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge;	▪ National UKHSA guidance followed. ▪ Trust COVID-19 SOP aligned with National UKHSA guidance. ▪ **January and February 2022:** Trust DDIPC provided assistance to WBCCG and Wigan Council to develop and review an SOP for use by local Designated care setting in line with UKHSA guidance. **May 2022:** Action continues: PCR testing 48hrs prior to transfer to a Care Home	None	May 2022: System wide collaboration continues: WWLFT, WBCCG and Wigan Council. Last meetings: 17.5.2022 and 24.5.2022

That patients being discharged to a care facility within their 14 day isolation period are discharged to a designated care setting, where they should complete their remaining isolation; as per national guidance	▪ National UKHSA guidance followed. ▪ Trust COVID-19 SOP aligned with National UKHSA guidance. ▪ **January and February 2022:** Trust DDIPC provided assistance to WBCCG and Wigan Council to develop and review an SOP for use by local Designated care setting in line with UKHSA guidance. ▪ **February 2022:** UKHSA guidance updated: *COVID-19 Management of staff and residents in health and social care settings* **May 2022:** Transfer continues to Care Homes, and Intermediate Care Centre. Guidance for ending isolation early implemented	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.	▪ National UKHSA guidance followed. ▪ Trust SOPs aligned with National UKHSA guidance. ▪ **March 2022:** Arrangements for elective programme currently under review in line with UKHSA guidance. **May 2022:** Elective programme pathways and screening implemented in line with current NHSE guidance **May 2022:** Elective Pathways: Pre-admission LFD testing and reporting by patients **May 2022:** Elective Pathways: Pre-admission PCR testing for predicted critical care post-surgery and High-risk patients **May 2022:** Cancellation Pathway to enable optimal capacity in place	None	N/A
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that:	▪ IPC Policies and SOPs are approved at IPCC and are available via the Trust Intranet.	**January 2022:** Noted decrease in	**January 2022:** This was raised as an Agenda item

▪ The application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	▪ A review process is in operation for the review, update and ratification/ approval of all Policies and SOPs ▪ IPC and microbiology advice is available 24/7 for all Trust staff. ▪ IPC level 1 and 2 e-learning is mandatory in line with national guidance with engagement and completion monitored. ▪ **March 2022:** Review of Policies and SOPs is currently limited due to gap in Microbiology/ IPC Doctor role to support. This applies to all the points below in criteria/ section 9. **May 2022:** Review of Policies and SOPs is currently limited due to gap in Microbiology/ IPC Doctor role to support. This applies to all the points below in criteria/ section 9.	compliance with COVID-19 and IPC level 2 training during Quarter 3 with the modules scores below the Trust target of 95% during Quarter 3. **May and January 2022:** Microbiologist/ IPC Doctor left the Trust and not permanently replaced at time of reporting. **March 2022:** Second Microbiologist has left the Trust and not permanently replaced at time of reporting. **May and March 2022:** Microbiology input required to review Policies and SOPs robustly, specifically with reference to treatment and clinical management of infections.	at the IPC Committee in Jan 2022, with a request for all Divisions to provide a trajectory with a timescale to improve compliance at the next IPCC in March 2022. One locum Microbiologist is currently providing a specific/ limited remit, via virtual/ remote service arrangement in the interim period. Recruitment of new/ Microbiologist discussed at Senior Meeting (Risk Management Group) **May 2022:** Additional Risk Assessment: Microbiology support to IPC Nursing Team awaiting review at Corporate Risk Group and Risk Management Group
Staff are supported in adhering to all IPC policies, including those for other alert organisms.	▪ IPC Policies and SOPs are approved at IPCC and are available via the Trust Intranet. ▪ A review process is in operation for the review, update and ratification/ approval of all Policies and SOPs. ▪ IPC and microbiology advice is available	Operational pressures and increased COVID-19 staff absence/ sickness relating to the Omicron variant have impacted upon	**May 2022:** This was raised as an Agenda item at the IPC Committee in March and Jan 2022, with a request for all Divisions to provide a

	24/7 for all Trust staff. ▪ IPC level 1 and 2, COVID-19 Module e-learning is mandatory in line with national guidance and engagement/ completion monitored.	compliance with COVID-19 and IPC level 2 training during Quarter 3 with the modules scores below the Trust target of 95% during Quarter 3. **May 2022:** E-learning module compliance below Trust target during Q4.	trajectory with a timescale to improve compliance.
Safe spaces for staff break areas/changing facilities are provided.	▪ Areas are provided within ward and Service areas. ▪ IPC audits monitor compliance. ▪ Educational messages and organisational communications are cascaded to staff. **May 2022:** Physical distancing restrictions no longer required	None	N/A
Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	▪ Trust policies and SOPs are available via the intranet. ▪ Surveillance by IPC Team identifies positive results, increased incidence, and identification of outbreaks in line with the recognised definition. ▪ Outbreaks are managed by the IPC Team in collaboration with Microbiology, ward staff teams, Operations, bed managers. ▪ Robust documentation of outbreaks is completed and informs reporting of outbreaks as incidents and completion of StEIS investigation. Theses are reviewed through Trust review and CCG systems/ National reporting systems. **May 2022:** Systems remain in place	None	N/A

All clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored, and managed in accordance with current national guidance.	▪ Trust adheres to national guidance and Waste Legislation. This is evidenced within the Trust's Waste Management Policy and Procedures under Category waste. Community staff also follow the Trust's Policies including the national guidance regarding the disposal of COVID-19 PPE within a patient's home environment. ▪ The Clinical Waste Management Module is mandatory for all staff. **May 2022:** Systems remain in place in line with current NHSE and UKHSA guidance	None	N/A
PPE stock is appropriately stored and accessible to staff who require it.	▪ PPE is distributed to the wards on a daily basis. The main PPE store is on the RAEI site and is accessible 24/7. Opening times are highlighted in Trust communications. ▪ PPE stores also at Leigh and Wrightington. ▪ In Community settings, PPE store is well stocked and accessible to all teams. ▪ **February 2022:** Transparent Face masks now available to order by the Trust. Communications shared to encourage wards/ services to provide supplies. ▪ **March 2022:** No issues with PPE supplies across the Trust. **May 2022:** No issues with PPE supplies across the Trust. Systems remain in place.	None	N/A
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: ▪ Staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.	▪ Service level agreements (SLA) in place with external organisations and the Trust to provide an Occupational Health (OH) service and advice for staff. Occupational Health Policies as per organisation.	None	N/A

	▪ Dedicated OH email/ inbox for staff to contact OH Services. ▪ A system of access and response available to all staff, operated by the OH staff team. ▪ 24 hours access to IPC and Microbiology advice and support available to all staff. ▪ A system of access and response available to all staff, operated by the IPC staff team. ▪ Dedicated email/ inbox for staff to contact the IPC Team. ▪ Comprehensive SOPs and Policies available for staff. ▪ Pre-employment/ Recruitment on-boarding available for the lifetime of employment within the Trust. ▪ Trust local Induction provides information of access routes to OH Services and services available, available to all staff inclusive of nursing, medical, ancillary, estates/ facilities, bank, agency, and locum staff. ▪ Staff Handbooks available to all staff; Matrons and Ward Leaders handbooks. **May 2022:** Systems remain in place		
Bank, agency, and locum staff follow the same deployment advice as permanent staff.	▪ The systems and processes as above at point 1 are available to all Bank, Agency, and Locum staff. **May 2022:** Systems remain in place	None	N/A
Staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance)	▪ **Flowchart: *Ending Isolation Early for COVID-19 Contacts*** available to support staff identified as a COVID-19 Contact to enable ending isolation early to return to work. All local/ internal guidance in line	None	N/A

	with current UKHSA Guidance. The guidance reviewed and updated in line with any new or update guidance. ▪ Regular internal communications are emailed to all staff (minimum weekly, with increased frequency if indicated). ▪ Support available from IPC and OH Teams. ▪ UKHSA Guidance, Flowcharts, SOPs Policies available via Trust intranet. ▪ Process of review for SOPs and Policies in place within the Trust, updated by IPC Team, Microbiologist's, and IPC Committee. **May 2022:** Vaccination continues to be encouraged to all staff but not a requirement to return to work **May 2022:** Return to work is enabled for all staff in line with current UKHSA guidance Trust Flowcharts to support staff Regular global communications to support staff		
Staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.	▪ COVID-19 Mandatory training via e-learning, ▪ Education programme delivered by IPC Team, face to face sessions. ▪ Practical education session in donning and doffing PPE (with the exception of RPE/ FFP3) is delivered by the Professional Practice Team. ▪ Opportunistic learning and training during ward/ service area visits ▪ Formal mask fit training programme for Mask fit trainers/ assessors. ▪ Mask fit testing programme in place across the Trust site.	None	N/A

	▪ Audit of practice and compliance **May 2022:** Systems remain in place		
A fit testing programme is in place for those who may need to wear respiratory protection.	▪ Fit testing programme is established and operational. **May 2022:** Systems remain in place and staff encouraged and supported to continue and maintain fit testing	None	N/A
Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: ▪ Lead on the implementation of systems to monitor for illness and absence. ▪ Facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce ▪ Lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 ▪ Encourage staff vaccine uptake.	▪ COVID-19 Test and Trace (T+T): National and Local process. Local dedicated T+T Team, with support from IPC and OH Teams. ▪ Staff sickness/ COVID-19 absence monitoring within the Trust, Ward Leaders, Human Resources (HR). Data reported through Trust systems/ E-roster. Results via T+T Teams, IPC Systems and GM reporting systems. ▪ Data systems: Diagnostic codes, statistics, and analysis support reporting (HR and Business intelligence). ▪ Staff sickness/ absence data and impact reported via Silver and Gold Command/ Trust Senior Teams. Outbreak reporting/ IPC Teams. ▪ Access to antiviral treatment via general medical services/ routes (in-patients and Community). Signposting by OH Team. ▪ Staff self-refer to OH Service and access is available to support. ▪ Managers/ Ward Leaders refer staff to OH Services. ▪ Pre-employment/ Recruitment on-boarding available for the lifetime of employment within the Trust. ▪ Trust local Induction provides information	None	N/A

	of access routes to OH Services and services available, available to all staff inclusive of nursing, medical, ancillary, estates/ facilities, bank, agency, and locum staff. ▪ Staff Handbooks available to all staff; Matrons and Ward Leaders handbooks. ▪ Dedicated Trust Vaccination Team provides vaccination for all Trust staff including: COVID-19 and Influenza. ▪ Vaccination available to all staff across the Trust, Including, Agency and Bank. ▪ Opportunistic vaccination by OH Team. ▪ Vaccination uptake rates monitored within the Trust: Human Resources (HR) and reported via IPCC/ Board and IPC BAF, quarterly Q+S reporting and Regional reporting. ▪ OH, Doctor provides dedicated input to vaccination across the Trust. ▪ Mutual support by OH Team to support COVID-19 vaccination across the Borough ▪ Regular internal/ global communications are emailed to all staff (minimum weekly, with increased frequency if indicated). ▪ Additional: Blogs, radio, Chief Exec Briefs and Blogs, Posters and constant reinforcement encouraging vaccination. **May 2022:** Staff Test and Trace no longer in operation		
Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.	▪ Trust SOP'S and Policies. ▪ Audit and monitoring of IPC Measures in line with national guidance. ▪ Ward leaders support compliance with IPC Measures, SOP's, and Policies.	None	N/A

	▪ Support available from IPC and OH Teams. ▪ National information provided at vaccination. **May 2022:** Systems remain in place		
A risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19. ▪ A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups, ▪ That advice is available to all health and social care staff, including specific advice to those at risk from complications. ▪ Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. ▪ A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	▪ Risk assessments completed by Ward Leaders/ Managers and Recruitment Team with support available from OH Team. ▪ Process for repeat/ update of risk assessments in line with UKHSA Guidance. ▪ Risk assessments are completed for all staff including Bank, Agency and Locum staff across the Trust and all organisations within the Borough. ▪ Input to process from OH, IPC, HR Teams, and Ward Managers/ Leaders. ▪ Records of the outcomes from the self-declaration forms are logged and maintained within HR. **May 2022:** Systems remain in place	None	NA
Vaccination and testing policies are in place as advised by occupational health/public health.	▪ Trust Vaccination Policy in line with national guidance. Available to all Trust staff. ▪ Dedicated Trust Vaccination Team. ▪ Dedicated T+T Policy in line with national guidance. Available to all Trust staff. ▪ Dedicated T+T Team. ▪ OH, and IPC Teams had greater input with Vaccination and T+T in earlier stages of the Pandemic but as progressed dedicated Vaccination and T+T Teams were developed and continue to date. **May 2022:** Access to COVID-19 vaccination remain in place	None	N/A

Staff required to wear FFP3 reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally/ ESR records;	▪ Face fit testing is available across all acute sites and in the community and is co-ordinated by the Health and Safety (H+S) Team. ▪ All mask fit testers have been trained in line with National legislation. ▪ An RPE SOP has been developed and shared with all Testers. ▪ For staff who cannot wear a close fitting FFP3 mask e.g., due to facial hair. A limited number of air powered hoods are available and issued to Wards and Departments with instructions for use. ▪ **March 2022:** A list of registered users of Powered air purifying respirators (PARP) is being developed and made available to Divisions for regular review so new starters can be captured. ▪ **March 2022:** Divisions have been provided with a list of compliant staff to review. ▪ **March 2022:** Some Divisions have also undertaken Fit testing of staff to improve local compliance. **May 2022:** Systems remain in place	**March 2022:** Fit testing training records are not fully complete for staff who wear air purifying respirators (PAPR) (mechanical respirators with hood).	**March 2022:** Health and Safety are working with Divisions to identify staff who rely on or choose to wear PAPR to ensure they have all been fully trained.
Staff who carry out fit test training are trained and competent to do so;	▪ Fit test training is managed by the Trust Health and Safety (H+S) Team and conducted by staff who have been trained in line with National legislation and are competent to do so. ▪ **March 22:** External contractor provides accredited Fit to Fit tester training to the Trust Face fit testers who then fit test WWLFT employees. ▪ **March 22:** Database of Face Fit Testers maintained by H+S Team.	None	N/A

	▪ **March 22:** Refresher training required every 2 years. ▪ **21 March 22:** There are currently **90** trained local mask Fit Testers in key clinical areas across the Trust. 10 of the Fit Testers will require re-training by the end of April 2022. **May 2022:** Systems remain in place		
All staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used;	▪ **March 2022:** Face fit testing sessions continue with a plan in progress to achieve fit test to three models in high-risk areas and two models in all other areas for staff. **May 2022:** Face fit testing sessions continue	Face fit testing continues but the Central Register of staff tested indicates that not all staff are tested to a model that is currently in stock.	Fit test sessions continue to be advertised. Divisions have been provided with a list of compliant staff to review
A record of the fit test and result is given to and kept by the trainee and centrally within the organisation;	▪ A record of the fit test and the result is given to the staff member and mask fit trainer records on a central database managed by the Health and Safety Team and uploaded onto ESR.	None	N/A
Those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods;	▪ Process in place: Individuals have two attempts on six models. If all failed, the individual is trained in the use of a powered hood. ▪ For staff who cannot wear a close fitting FFP3 mask e.g., due to facial hair. A limited number of air powered hoods are available and issued to Wards and Departments with instructions for use.	None	N/A
That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions.	▪ **March 2022:** A decontamination process in line with manufacturer's instructions is in place for all powered hoods.	None	N/A

Members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm;	▪ Included within the Respiratory Protective Equipment Policy - Training Guidance SOP. ▪ Line Managers are advised of all staff members/ individuals who fail a fit test to six models. A discussion is completed on available options including powered hoods. ▪ If an individual was unable to be provided with alternative respirators and hoods, opportunity for discussion provided with Occupational Health and HR Teams/ colleagues with regards to redeployment. ▪ The Trust has a designated Redeployment team who oversee staff skill mix, knowledge, and experience.	None	NA
A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health;	▪ Documented records of discussions with staff member, Line manager, Occupational Health and HR are held centrally in line with Trust policies.	None	NA
Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board;	▪ Trust Respiratory Protective Equipment Policy in place. ▪ A centrally held mask fit database is maintained by the Health and Safety Team and is available. ▪ **March 2022:** A quarterly compliance report is produced for the Occupational Safety and Health Group, chaired by a member of the Trust Board. **May 2022:** Quarterly compliance report: Mask Fit Compliance to the Occupational Safety and Health Group, chaired by a member of the Trust Board	None	N/A
Consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care	▪ Healthroster system used for nurses which includes Staff risk status. ▪ Medical rotas for medical staff.	Head of Estates and Facilities has reviewed non-clinical staff	Some staff do have to move between different areas on a daily basis.

pathways and urgent/emergency care pathways as per national guidance;	▪ Where safe and practicable staff are allocated to segregated areas in response to acuity and dependency of patients and COVID-19 status. ▪ Where safe and practicable staff are allocated to segregated areas during outbreaks of infection/ bay closures. ▪ Staff have been redeployed during the Pandemic in response to care/ service requirements/ to need for escalation of services. ▪ **March 22:** Consideration and planning for the return to the elective programme of care, enabling safe changes to services, in line with a local assessment of risk. **May 2022:** Elective programme resuming within the Trust	allocation, but it was not possible to achieve everywhere.	This includes circulating staff such as porters and phlebotomists.
Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone;	▪ Space planning exercise undertaken at the start of the pandemic. ▪ Maximum staff allowance per room assessments completed and supportive guidance provided to Departmental managers remain in place. ▪ Environmental risk assessments completed. ▪ Compliance in own areas continues to be reinforced and supported by IPC. ▪ **March 22:** National guidance: Living with COVID-19 was published on 23 February 2022 and the UKHSA COVID-19 Guidance updated on 24 February 2022 reinforcing the measures for healthcare services remains unchanged due to the higher risk nature of health care settings. ▪ **March 2022:** Consideration is being given	None	NA

	to the return to operational activity balanced against the uncertainty about the path of the Pandemic. **May 2022:** Physical distancing restrictions removed **May 2022:** Face masks not required in Non-clinical area offices, meeting rooms and education centre		
Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing.	▪ Staff absence is recorded for payroll purposes through e-roster. ▪ Staff are required to report sickness absence to Line managers. ▪ Staff are requested to undertake LFD testing twice weekly and report the results via the Trust reporting system. ▪ Staff continue to have access to COVID-19 swab tests via a Trust drive through facility and home testing. ▪ Expectation that staff source their own supplies of LFD testing kit supplies via the National government portal. **See note**. ▪ COVID-19 Flowcharts are available via the Trust intranet and are frequently communicated to staff. ▪ **Flowcharts:** Ending Isolation early for COVID-19 Positive staff and Ending Isolation early for COVID-19 Contacts are available via the intranet and IPC Team. ▪ Well-being offers remain available to staff members, with pro-active holistic well-being provision through our Steps 4 Wellness and occupational health services. Psychological support programmes remain in place including access to well-being apps, EAP, SOS rooms with trained	**March 2022:** Awaiting National guidance regarding staff LFD swabbing/ testing arrangement and the process for provision and availability of LFD swab supplies (No response as at: 21 March 2022. To note: From 1 April 2022 the government will no longer provide free universal testing for the general public. **March 2022:** Noted increase in staff reported COVID-19 Positive staff results with no Test and Trace risk assessment completed. **March 2022:** The capacity of Test and Trace provision within the Trust is limited	**March 2022:** Trust colleagues are linking with Regional/ GM colleagues and groups to source further information. **March 2022:** Internal Trust discussions regarding LFD swab/ process/ supplies arrangements. **May 2022:** Clinical staff continue twice weekly LFD testing with responsibility for ordering test kits and reporting results directly to .gov portal. **May 2022:** Test and Trace assessments discontinued

	facilitators, critical incident debriefing and departmental support programmes. ▪ The Trust continues to actively manage and support staff through attendance management procedures. The Strategic HR lead completes a monthly review of all long-term sickness absence cases with HR Business Partners. ▪ The Central Unplanned Absence Team continues to contact staff on first day of absence and support managers through the attendance management process.	and currently unable to meet the current demand. **May 2022:** Clinical staff continue twice weekly LFD testing with responsibility for ordering test kits and reporting results directly to .gov portal. **May 2022:** Test and Trace assessments discontinued **May 2022:** Staff report sickness absence to Line Manager	
Staff who test positive have adequate information and support to aid their recovery and return to work.	▪ Flow charts based on national guidance outline the processes and time periods to follow and are on intranet. Staff are supported via managers during absence in accordance with all sickness absence. ▪ **Flowcharts:** Ending Isolation early for COVID-19 Positive staff and Ending Isolation early for COVID-19 Contacts are available via the intranet and IPC Team. ▪ HR advisors are available to staff and managers to seek advice and support where any individuals are concerned or have questions around returning to work or being absent due to COVID-19. **May 2022: Flowchart:** Ending Isolation early for COVID-19 Positive staff remains in place. **May 2022: Flowchar**t: Clinical Staff Contacts	**March 2022:** Ending isolation early for COVID-19 positive and contact staff will require availability of LFD testing kit supplies. The confirmation of government arrangements from 1 April 2022 are awaited: **See above**. **May 2022:** Engagement from staff required	Staff will have supplies as in place to 31.3.2022. Regional and local discussions taking place, whilst decision awaited. **May and April 2022:** Global Communications to all Trust staff

	can return to work if asymptomatic with twice weekly LFD testing. **May and April 2022:** Global Communications to all Trust staff **May 2022:** Clinical staff continue twice weekly LFD testing with responsibility for ordering test kits and reporting results directly to .gov portal.		

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	WWL M11 Balanced Scorecard
Presented to:	Board of Directors
On:	8 June 2022
Presented by:	Director of Strategy & Planning
Prepared by:	Data, Analytics and Assurance
Contact details:	BI.Performance.Report@wwl.nhs.uk

Executive summary

This paper is an interim report as 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 first Scorecard Development Project Board scheduled for 7 June 2022.

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: M1 WWL Balanced Scorecard: April 2022

QUALITY & SAFETY

	Month	ON/OFF Track	Why?
Patient Safety (Safe)			
Never Events	*M11*	*Off Track*	*0 in month, 2 YTD Target 0*
Number of Serious Incidents	*M11*	*Off Track*	*8 in month, 78 YTD*
Sepsis - Screening and Antibiotic Treatment (Grouped)	*M11*	*Under Development*	
Serious Pressure Ulcers (Lapses in Care)	*M11*	*Off Track*	*1 Incident in month, 21 YTD (Community & Hospital Acquired)*
Serious Falls	*M11*	*Off Track*	*0 in month, 5 YTD*
Infection Prevention and Control (Grouped)	*M11*	*Off Track*	*4 / 6 in month, 5 / 6 YTD; Metrics Off Track*
Patient Experience (Caring)			
Complaints Responses	*M11*	*Off Track*	*40.6% M11, 33.3% 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%	M1	Off Track	8% M01, Target 2%
Ambulance Handovers (Grouped)	M1	Off Track	3 / 3 in month Metrics Off Track
Cancer Referral Rates	M1	Off Track	1445 M01, Target 1310
Cancer - Waits Longer Than 62 Days	M1	On Track	
Virtual Outpatient Consultations	M1	On Track	28% M01, Target 25%
Outpatient DNA Rates	M1	Off Track	9.6% M01, Target 7%
Outpatient Utilisation		Under Development	
Total Patients Waiting Over 104+ weeks	M1	On Track	
RTT Clock Stops	M1	Off Track	7036 M01, Target 8510
Elective Theatre Utilisation	M1	Off Track	76% w/e 1/5/22, Target 85%
G&A Bed Occupancy - Adults	M1	Off Track	
Elective Recovery Plan	M1	Off Track	

PEOPLE

	Month	ON/OFF Track	Why?
Output			
Your Voice Score (YVS) - engagement score	Q1	Off Track	3.94 Q1, 3.91 Q3, 3.90 Q2 Target 4
% turnover rate	M1	On Track	10.08% M1, 9.98% M12 Target 10%
Sickness - % time lost	M12	Off Track	6.96% M12, 7.02% M11 Target 4%
Culture			
FTSU contacts	M1	TBC	3 M1, 5 M12, 4 M11
Your Voice Score (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)	M1	On Track	162 M1, 133 M12 Target 110
Usefulness of Trust wide comms - % of participants stating they found the ASTB session useful	M1	On Track	82% M1 Target 70%
Number of outputs per month (LF, ASTB, Executive Vlogs, CEO Vlog/Blog)	M1	On Track	7 M1, 6 M12 Target 6
Well-being			
Empactis coverage (% of staff)	M1	TBC	11.4% M1, 7.1% M12, 5.84% M11
Your Voice Score (YVS) - well-being score	Q1	Off Track	3.35 Q1, 3.22 Q3, Target 4
Leadership & Teams			
Vacancy rate	M1	Off Track	10.83% M1, 10.14% M12 Target 5.0%
Roster timeliness	M1	Off Track	39% M1, 20% M12 Target 90%
Rate card adherence (medical)	M1	Off Track	50% M1, 62% M12 Target 85%
Personal development			
Mandatory training compliance	M1	Off Track	88.2% M1, 88.4% M12 Target 95%
Appraisal	M1	Off Track	75.1% M1, 73.9% M12 Target 90% NB. Excludes M & D Staff

FINANCE

Financial Position (£000s)	Month	Year to Date
	Variance against plan	
Surplus / Deficit	(1,110)	(1,110)
Capital Spend (CDEL)	(380)	(380)
Cash	1,357	1,357
CIP	(1,911)	(1,911)
Agency Spend	(684)	(684)
BPCC target 95%		
NHS	91.3%	
Non-NHS	91.4%	

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

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

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.

ACTIVITY & EFFECTIVENESS

Summary:

Planned care

Several assumptions to support the Trust's 22/23 elective recovery plan is not met in Month 1, Urgent care demand, cancer referral rates and General & Acute bed occupancy rates remain high. Despite these on-going pressures, the Trust is on track to deliver the first of the National milestones treating all patients waiting over 104 weeks by the end of June, except for those who choose to wait, including patient transfers as part of our mutual offer to support other organisations across the Northwest.

WWL is currently achieving its plan to reduce the number of long waits for patients on a cancer referral pathway, however additional resource is required to achieve the new Faster Diagnosis Standards. Detailed recovery plans with targeted interventions and clear escalation protocols are in place to increase elective activity which is behind plan.

Unscheduled Care

Good progress continues on the National Hospital Only Discharge programme aimed at reducing ambulance handover times as well as the number of people waiting 12 hours in A&E which fell from 11% in March to 8% in April. Ambulance handover times have slightly improvement in April despite a significant rise in A&E attendances. A second successful national visit took place in April resulting in the Trust rated 'Green' against its recovery plan. A third visit is scheduled in June focusing on a system wide approach to address on-going pressures.

PEOPLE

Culture

Exit interview pilot in conjunction with the Guardian Service to launch 1st July

Developing a range of financial support measures to ease the cost of living burdon 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

Positive YV survey trends - 11 out of 16 enablers improved significantly since last survey, overall engagement and well-being scores continue to improve

Focus on hard to reach groups - work around integrating teams and ward leaders pivotal in enabling this and in supporting E&F managers. Listening sessions being set up.

Poll on the usefulness of all staff team brief was conducted in April; 29% extremely useful 53% very useful (82% overall)

Wellbeing

Wellness at Work Lounge - June launch

IAPTUS system launching soon for managing Psych Support referrals.

Leadership & Teams

Increase in vacancy rate mitigated through GM recruitment campaign and Wrightington recruitment event

Reducing the number of recruits - including FT to perm, renewal of FT contracts and expansion of the transfer protocol.

Strategic retention group established and divisional task forces being set up

FINANCE

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

The national NHS financial plan has yet to be approved and the Trust's plan is still in draft.
The Trust will receive less funding in 2022/23 versus last year which places extra emphasis on efficiencies and cost reductions. In April expenditure was £2.8m more than income resulting in an adverse variance to plan of £1.1m.

The three factors behind the April financial position are 1) £0.1m less expenditure on Covid related costs, 2) £0.7m more agency spend than planned and 3) underachievement against the CIP plan of £1.9m.

To support the achievement of the finance plan a new financial scrutiny regime has been introduced underpinned by RAPID meetings (recovery, action, planning, implementation and delivery).

Please see the monthly finance report for further commentary.

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

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Monthly Trust Financial Report – Month 1 (April 2022)
Presented to:	Board of Directors
On:	08 June 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	37,744	37,121	624	37,744	37,121	624
Expenditure	(38,794)	(37,042)	(1,752)	(38,794)	(37,042)	(1,752)
Financial Performance	(2,768)	(1,657)	(1,111)	(2,768)	(1,657)	(1,111)
Cash Balance	48,161	46,804	1,357	48,161	46,804	1,357
Capital Spend	530	300	(230)	530	300	(230)

Key Messages:

- The Trust has reported an actual deficit of £2.8m for April 2022 (month 1), which is £1.1m adverse to the planned deficit of £1.7m.
- The plan reflects the final submission to NHSEI made on 28th April 2022 which has a full year planned deficit of £19.8m.
- 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).

The WWL Way

- In month 1, £0.1m was transacted against the target of £2.0m. The slow start to CIP delivery in 2022/23 is driving the variance to plan in month 1. A refresh and relaunch of the CIP approach for 2022/23 is being supported across the Trust.

- Cash is £48.2m at the end of Month 1.

- Capital spend is £0.5m in month.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Guardian of Safe Working Hours Quarterly Report, Qtr 3 2021-2022
Presented to:	Board of Directors
On:	08 June 2022
Presented by:	Shams Khan
Prepared by:	Guardian of Safe Working Hours 4 Feb 2022
Contact details:	T: 8667 E: [shams.khan@wwl.nhs.uk]

Executive summary

Out of a total of 60 Hours and Rest Exception Reports, 37 were medical and 12 Surgical. I note that inability to take breaks were a recurrent theme and I note that trainees are covering more than one role. Documented feedback from educational supervisor to trainees shows good advice and supervision in these scenarios however the covering of 2 roles by a trainee is a significant safety issue.

The key take-home messages are: trainees are covering multiple bleeps, staff absences are increasing out of hours workload and lack of breaks are emerging as an issue.

Link to strategy

Educational Supervisors are giving good, documented feedback to trainees – this can be raised in TMEC to mitigate staff absences and ensure trainees are fully supported. Locum rates have been raised at JDF and the BMA IRO has suggested that starting rates are raised and can take this forward. Educational Supervisors, Clinical Supervisors and Clinical Leads should consider ways of ensuring juniors are able to take breaks – can be discussed at TMEC and JDF.

Solutions to the staffing crisis are difficult but I note that individual managers are going to great lengths to understand this issue and its effect on staff. I was pleased to see attendance and great engagement of the Deputy Directorate Manager of Performance at JDF. Some ideas out forward were to increase the starting locum rates for absent shifts and to identify consultants as points of contact for rota co-ordinators.

Risks associated with this report and proposed mitigations

Absence of staff – this is going to make breaks difficult and a doctor trying to do the work of two is a serious patient safety risk and should be directly addressed by clinical leads. Absence of breaks will lead to burnout and increases the risk of staff shortage due to sickness. Suggested solutions that have been made are: to increase the starting rate of pay for absent shifts and also for acknowledgement of absences at handover. Those leading handover could advise staff on shift how to manage with lower staffing and how breaks should be covered. Debriefing following a shift would be useful to learn how a trainee has been affected and to inform clinical leads of the risks and how they should be mitigated. Specific solutions should be identified by clinical leads of specialities. I would recommend that Foundation Programme Directors and Training Programme Directors are kept up to date with this.

Financial implications

Payment from extra hours worked through exception reporting from understaffing, risk of clinical error and litigation will rise whilst understaffed

Legal implications

Staffing is not at safe levels – there may be legal risks from this alone, litigation as risk of serious untoward events will rise with this level of understaffing. Breeches of 2016 TCS leading to exception reports and payments are a risk and the risk of a breech incurring a fine will rise.

People implications

Burnout of junior doctors, junior doctors having to both step up and step down leading to increased workloads, consultants also stepping into resident roles

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

Recommendation(s)

A full acknowledgement of understaffing issues. Clear guidelines to clinical leads on ways to mitigate this and feedback / debriefing to junior staff and also to look at what rest can be given after such shifts and what resources are available overnight to ensure doctors overnight can have a break?

Report

Guardian Quarterly Report Qtr 3
24 Jan 2022

Count of Type	Column Labels					
Row Labels	Educational	Hours	Pattern	Service Support	(blank)	Grand Total
Accident and emergency	**5**	**1**				**6**
FY2	3	1				4
ST2	2					2
Cardiology	**1**	**2**				**3**
FY1	1	2				3
General medicine	**4**	**37**	**1**	**5**		**47**
CT1	1					1
FY1	1	28	1	3		33
FY2	2	9		2		13
General surgery	**8**	**12**				**20**
FY1	8	9				17
FY2		3				3
Geriatric medicine		**1**				**1**
FY1		1				1
Paediatrics	**4**	**5**	**2**	**3**		**14**
FY2	4	5	2	3		14
Trauma & Orthopaedic Surgery		**2**				**2**
FY1		2				2
(blank)						
(blank)						
Grand Total	**22**	**60**	**3**	**8**		**93**

The above is a tabulated summary of Exception Reports from Qtr 3. This report will comment only on Hours and Rest ERs (Hours on the above table)
From a purely numbers perspective, Surgical Exceptions appear to have decreased , with Medicine relatively consistent. As expressed previously however, it is not the numbers that are important but the content.
Missed breaks feature in at least 6 exceptions throughout all specialities. I suspect this is very under reported. I have overheard trainees mention to consultants that they have not had lunch – the time being quite late in the afternoon. Great credit to the consultant reacting with horror and sending the trainees for a break. The climate of significantly decreased staffing due to isolation rules and sickness is taking a toll.
Another more disturbing feature is the holding of two bleeps. Whilst I understand that the Trust is discussing increased pay for this responsibility, the serious safety issues of one individual doing the work of two is not mitigated by this. Nor is the risk of stress and burnout to the affected clinicians. I have read the Educational Supervisors responses to these issues and I give great credit to the ES – they have been a huge support to their trainees. Exception Reporting will not capture the full extent of this matter. This has been raised in JDF as an issue in paediatrics and I suspect every rota is affected.

At the Regional Meeting of Guardians on the 19 Jan 2022, the Associate Dean of Health Education England made it clear that from an HEE perspective that this is a serious safety matter.
I recognise that the Trust and all specialities are going to great lengths to ensure shifts are covered – this was clear from a face to face meeting with the clinical director of paediatrics. However, the amount of absentees due to isolation rules and sickness coupled together with levels of stress and burnout mean that trainees are unable to fill these gaps.
I call upon clinical leads to address this in the best possible manner. Examples would include acknowledging the risk, briefing affected trainees before and debriefing after and ensuring any concerns about specific cases are addressed as early as possible. Junior trainees must know how to access senior help rapidly and when to escalate concerns during a shift and who to escalate too. One ER highlighted that one individual carried 2 pagers that are part of the cardiac arrest team. I do not believe that cardiac arrest cover was in anyway compromised but it would be prudent for the Trust to know and be aware of these gaps and to ensure senior clinicians working on shifts know their skill mix of staff and understand the gaps and how they are to be addressed on the night.
The issue of rota gaps was the only topic discussed at JDF on the 14 Jan 2022. This JDF was well attended by rota co-ordinators and by Sam Duff, Deputy Director Manager of Acute Medicine. Some solutions that were discussed were the identification of consultants to assist rota managers in moving staff from one ward to another area to mitigate clinical risk and also to start a higher rate of locum pay when advertising vacancies. The use of the patient flow control centre as a hub to identify sickness centrally so that senior clinical leads are aware of gaps early was also discussed.

Training Vacancies					Trust Grade Vacancies			
	Grade							
Speciality:	FY1	FY2	St1/2	St3+	FY1	FY2	St1/2	St3+
A & E			1			1	1	
Anaesthetics								
Medicine	1		1	2				1
O & G			1	1				
Paediatrics			2	1				
Rheumatology								
Surgery	1							
T & O				1				

Vacancies are reported above. I note 4 in Medicine and I note several ERs outlining an FY1 doctor having to cover an SHO pager

Summary

The most significant feature of this quarter's exceptions are that trainees are covering more than one role, giving rise to potential safety issues. Missed breaks and lunches are being reported and the toll of isolation and sickness is a key theme throughout.

Exception Reasons

Unable to leave on time due to outstanding EPR shift work (urologyy + EPR jobs)
Attended Grand round - late register
Unable to attend Grand Round. Less juniors than normal on shift that day meant none of the F1s were able to leave to attend grand round.
Unable to attend Grand Round due to clinical demand
Only FY1 available to do ward jobs in afternoon for general surgery, no SHO available. Unable to complete urgent jobs before 5. Additionally pt wanted to discuss with a doctor her scan results and the plan as was very distressed and wanted to make complaint - unfortunately jobs such as these cannot be prioritised during work hours so have to be done afterwards.
Unable to attend grand round in person - attended online
Weekend ward round. Ward round completed at approx 2pm. 30 patients to see all in. No weekend phlebos. Around 8 patients required bloods. Another needed discussion with Manchester. Finished slightly before end of time, but could not hand over directly as F1 busy on wards
On call shift. Tried to start preparing list at 7pm. SpR then wanted to post take patients. Finished post take at 7.20. Started preparing list. Got called to ?torsion. Not appropriate to leave patient until after handover at 8.30. Patient reviewed and then needed to discuss with consultant and book patient for theatre. Then needed to prepare and update list for handover as only patient names had been shared, with no clinical information
Due to acutely unwell patients and high volume of jobs, I was required to stay after hand over ad night FY1 had received a large number of tasks from seniors at handover and would not have been feasible to provide my handover. There was also much confusion regarding the responsible cons for each patient as, due to sickness, 3 consultants had covered one take. To ensure reasonable efficiency of Monday morning ward round, it took me a long period of time to prepare an accurate list for each consultant for the next day. This couldn't be done before handover due to a ?anastomotic leak for which i only had an SHO's support for a reasonable length of time.
Was phoned yesterday at 6pm and asked to rescind my annual leave for today due to short staffing. I was therefore rota'd to a 'normal day' (8-5), however i was required to stay until 6:30. I did not have time to take a lunch break. I very rarely get to take a lunch break, however can usually eat-on-the-go however there was not time for this today. I also was not able to attend grand rounds.
Unable to leave ward due to high volume of jobs. Given that i had given up annual leave to work today due to short staffing, it would have been irresponsible to then be away from the ward.
Unable to attend grand round due to staffing on ward
Missed Grand Round due to patients being missed on ward round as they we were not informed they had been admitted from on call team/handover. One patient needed to be urgently reviewed as they needed emergency surgery and needed to be seen prior to the start of the afternoon surgical list. Grand Round was missed to ensure their care.
Needed to stay after hand over to ensure urgent jobs complete. Number of urgent procedures for the next day that needed to be arranged that could not be organised until bleep had been handed over to night FY1.
Multiple unwell patients and complex handovers. Had to stay after hand over to complete urgent jobs.
Stayed one hour late. Urology team were not aware of 4 patients in the hospital under urology care and therefore missed on ward round. They were not realised until 30minutes prior to my mandatory teaching and I had to review them with the registrar during my lunch break (lunch also missed in addition to staying 1 hour late). This created an unexpected work load to be done after the teaching for which I had not time managed for. There was no other foundation doctor on urology to help with this workload and the on call team were too busy to offer help during my bleep free teaching. This meant I had to stay late to write discharge letters and prescribe regular medications etc. One patient had not have regular meds including diabetic medication for almost 24 hours
Unable to take break during 12 and a half honour on call shift. Rota-ed for first on call, however there was a rota gap for second on call so covering doing both on call roles. Had to stay after evening hand over to complete some urgent jobs.
Unable to attend mandatory grand rounds due to volume of work
WR began approx 45-1hr late as waiting for cons to arrive. In addition - generated very long list of jobs. Cons not at work in afternoon and only one reg on on Friday, so difficult and slow to discuss concerns with a senior.

Resubmission I was on half day from 08:00 - 13:00 on 08/08 but I was the only F2 on ward rounds and the others were F1s. I had to stay back to help with the jobs and to support my juniors.

Worked one hour overtime due to work pressures on the ward
Required to stay late to complete tasks not suitable to be handed over to the on-call team at the start of the weekend. And then to make sure everything was in order ahead of the weekend including making a list of medical requirements for our patients to give to the nursing team, in addition to making OOH requests on HIS.
This was at the end of my final SHO clerking night shift. It was an incredibly busy set of nights. I was being handed over 8-10 patients before I'd even started getting my own referrals from A&E. I was required to stay late to finish the documentation for my final clerking (which took longer than usual due to fatigue) and also to make sure all of my patients would get their post-take review in the morning - the patients were all over the place, including being transferred to surgical wards before they'd even been clerked.
Required to stay for an extra two hours after handover to complete documentation and outstanding tasks not suitable to be given to the night team.
Required to stay for an extra hour after handover to complete documentation and outstanding tasks not suitable to be given to the night team.
Required to stay for an extra hour after handover to complete documentation and outstanding tasks not suitable to be given to the night team.
Again, was the only junior working on the ward in the afternoon, when there were multiple sick patients and one incident which required DATIX. I needed to stay overtime to finish jobs, attend to sick patients, and gather the necessary facts to report the DATIX
The only one working on CCU, needing to return to ward after teaching, and then due to ward pressures and unwell patients staying until 19:00
Due to inadequate ward staffing on Standish ward, I was unable to attend any outpatient clinics for the last 4 weeks of my placement in diabetes and endocrinology, although my attendance at clinics is required for a satisfactory ARCP outcome
Worked until 18:00 on this day. A blood transfusion needed to be arranged for a patient, however it required OOH discussion due to the complex history. Due to a mixture of the blood test results arriving later in the day, we could not address this before 17:00.
Unable to take 3 hours of SDT - scheduled FY2 cancelled at this time, however advised to use this as SDT instead - TOIL preferred in this instance to use SDT at a later date
Unable to take 4 hours of SDT due to work pressures on the ward - TOIL preferred in this instance so as to take this SDT at a later date.
There was no FY1 night ward cover all night. I was covering the SHO and FY1 night ward cover bleep/crash bleep from 20:30 on 5/12/21 to 08:45 on 6/12/21 by myself - same as 2 nights prior. It was a very busy and hectic weekend.
There was no FY1 night ward cover all night. I was covering the SHO and FY1 ward cover bleep/crash bleep by myself. It was a very busy and hectic weekend.
2hrs 15 minutes
I was not able to get self development time.
No ward cover SHO again scheduled for the night. This was escalated to multiple consultants and bed managers who did not manage to find cover, after escalated rates of £75 per hour for night ward cover SHO 6653 Was advised by bed managers I would be compensated thoroughly for covering the SHO bleep 6653 ward cover alongside 6651 FY1 over the entire weekend nights. Both 6651 & 6653 are crash team bleeps. Answered all bleeps and responded appropriately. Very disheartening to see the SHO shift overnight be advertised for £75 per hr, only to not get filled and for myself to be carrying this bleep without any certainty of recognition and pay and undertaking 2 people's responsibilities over a busy weekend set of nights.
Supposed to be clerking FY1 from 5-9pm. Asked to carry ward cover SHO bleep as no SHO present.
Night FY1 Ward Cover - No SHO allocated or present for ward cover - I am carrying the bleep for SHO Ward Cover night 6652 alongside my bleep 6651 for the weekend.
8hrs. Portfolio work and e-learning done on own time
On one of my night shifts, there was no clerking SHO. The ward cover SHO had to step in as the clerking SHO, leaving me as the only junior on ward cover. Not only that, I was asked to cover the SHO bleep, on top

of my own FY1 bleep, resulting in me carrying 2 bleeps for the whole night shifts. Since it was a busy night, I essentially had to do jobs for 2 people.
Stayed overtime to complete jobs as having to spend a lot of time dealing with a patient during the day. Nil break as trying to complete as many jobs as possible before afternoon rounds. some jobs left after PM rounds to complete.
Overtime from 17:00 to 19:00
Late for 5 minutes to grand round - exception report needed as evidence for lateness
30minutes - had no lunch break due to ward pressures
Only 2 juniors on Lowton ward and had to stay additional 1.25 hours to complete jobs and there was also a board round in the afternoon which started at 2pm, meaning more new jobs were created in the afternoon.
meant to cover A&E/CDW with my colleague. Due to ward pressure, colleague was asked to cover other ward, leaving me with all the patients in these areas. Due to number and nature of jobs, unable to take self development time and finished late.
My ward round was late to commence and was asked a question about patient care by a nurse as I was leaving for grand round, as a result I was 1 minute late to grand round. Unfortunately, the register was removed promptly at 12:30 so I was registered as late. I saw the entirety of the presentation as it had not yet began and in fact was started at 12:37.
Stayed over time from 17:00 to 18:30 to manage a patient who was having a new onset stroke on CCU. There was only myself on CCU that afternoon as the SHO went for teaching in the PM.
30 min break was not able to be taken due to ward pressures - subsequently no lunch before teaching. Dr Quinn is aware of this and has asked me to submit an exception report as a method so that the relevant people at the education centre are aware that ward pressures may be a reason as to why lunch breaks etc. havent been taken in full prior to teaching.
Had to stay from 17:00 to 18:00 for a long discussion with patient. At 17:00 was called to speak to a patient on CCU who was clueless about the results of his angiogram that was done earlier in the day. He was roughly told the results of the angiogram but consultant who did the angiogram did not advise in detail what the plan going forward is. This is a very anxious 60+ year old man with two previous MIs and a previous stroke, and previous quadruple bypass. I told him the plan was that stents had been put in, medical management for now for the remaining blockages, and MDT discussion and further tests to discuss options for revascularisation. Follow up was in 3 months. This patient was very anxious and said that anything could happen in the 3 months. Attempted to reassure but given extensive prior history he remained very worried. Given patient still unhappy with explanation I tried to find a consultant to speak to him. This patient was not deliberately being difficult but just very anxious and worried that no senior doctor has spoken to him, wanted to know the plan in detail/as much information as possible, and said that his GP could not manage his heart condition in the community and felt very unsafe being discharged (plan was discharge following day).
Unfortunately I was not able to take my two hours of agreed personal development time on Friday due to work pressure.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Self-certification in respect of provider licence condition FT4
Presented to:	Board of Directors
On:	8 June 2022
Presented by:	Director of Corporate Affairs
Prepared by:	Director of Corporate Affairs
Contact details:	E: paul.howard@wwl.nhs.uk

Executive summary

Each year, NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence and specifically conditions G6, CoS7 and FT4. The deadline for self-certification of conditions G6 and CoS7 was 31 May 2022 and the board has previously confirmed compliance with these two conditions in advance of this date. The deadline for self- certification of condition FT4 is 30 June 2022 and the board is now invited to consider its self-certification.

Whilst an excel document is provided by NHS England and NHS Improvement to facilitate this self-certification, the format does not lend itself well to review by the board. The content has therefore been duplicated in this report and it is proposed that, following approval by the board, the content will be inserted into the NHS Improvement template and the relevant signatures applied.

There is no requirement to submit the self-certifications to NHS England and NHS Improvement. Rather, NHS England and NHS Improvement will undertake an audit of a sample of FTs to confirm that they have self-certified.

Link to strategy

There is no direct link to the organisational strategy, however compliance with the NHS Provider Licence underpins the organisation's ability to provide services.

Risks associated with this report and proposed mitigations

Self-certification is a mandatory requirement and this report mitigates the risk of non-compliance.

Financial implications

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

Legal implications

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

People implications

There are no people implications to highlight.

Wider implications

There are no wider implications to highlight.

Recommendation(s)

The Board of Directors is recommended to approve the self-declaration outlined in the attached report.

FOUNDATION TRUST CONDITION 4

The board is required to respond to a number of statements in order to self-certify against condition FT4, as well as providing detail of the risks and mitigating actions. The statements, and the proposed responses are provided below:

Statement	Response and detail of risks and mitigating actions
1. The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	**Confirmed** ▪ Compliance with NHS Foundation Trust Code of Governance is regularly assessed and reported, both to the Audit Committee and within the annual report. ▪ The Trust's Standing Orders require that a register of director's and governors' interest is in place and kept up to date (held by the Company Secretary who has accountability for its maintenance). ▪ There are no material conflicts of interest in the Board. ▪ All governors' elections and by-elections are held in accordance with election rules. ▪ Systems and controls assurances are obtained via the Audit Committee. ▪ An independent review of leadership and governance using the well-led framework was completed during the year with no material concerns having been highlighted. An action plan was developed to ensure that good practice and other recommendations are implemented and embedded within the organisation ▪ The most recent CQC inspection report (published February 2020) rates the foundation trust as "good" in all areas, including well-led ▪ The most recent Use of Resources inspection undertaken by NHS Improvement rated the foundation trust as "good" ▪ More complete explanations about systems of corporate governance are set out in the annual governance statement and the foundation trust's annual report. ▪ The Company Secretary maintains an overview of corporate governance developments within the NHS and across wider sectors, and good practice is shared through established regional and national Company Secretaries Networks ▪ The Audit Committee receives regular updates on good practice from the internal and external auditors.

2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	**Confirmed** ▪ Compliance with NHS Foundation Trust Code of Governance is assessed each year as part of the annual reporting process. ▪ Any guidance requirements are routinely assessed and implemented as necessary - overview of guidance provided by auditors in updates received at each Audit Committee meeting. Assurance and advice is provided as required by the Audit Committee.
3. The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation."	**Confirmed** ▪ Board committees established with clear lines of reporting, and recently reviewed ▪ Terms of reference in place for Board and all other committees and groups within the Trust which are regularly reviewed and updated where necessary. These set out the remit of each type of meeting, membership, attendance by others, quorum requirements and reporting responsibilities. ▪ Chairs report to the board to report assurance and escalate concerns in line with reporting structure. ▪ Clear delegation of actions to committees. ▪ Annual Governance Statement in place which identifies areas of potential risk and mitigating actions. ▪ Scheme of Delegation and robust Standing Financial Instructions in place
4. The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the CQC, the NHS Commissioning Board and statutory regulators of health care professions;	**Confirmed** ▪ Risk Management Strategy in place and recently reviewed ▪ Board Assurance Framework used extensively at each committee and board meeting ▪ Datix risk management system in place ▪ Use of internal and external audit services to investigate any areas of concern ▪ Royal College reviews undertaken where appropriate or necessary.

(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	▪ Contracts for services agreed with clinical commissioning groups. ▪ Finance and Performance Committee considers detailed financial performance report at each meeting ▪ Performance report considered at each Board meeting. Detailed performance discussed at quarterly divisional performance reviews. ▪ Comprehensive agendas for Board meetings circulated to directors in advance of each meeting ▪ Cost Improvement Plans in place which are risk assessed for quality ▪ Standing Financial Instructions and Standing Orders in place ▪ Counter Fraud specialist reports to the Audit Committee ▪ In relation to point (f) and (g), the Trust's annual report and operational plan have set out a number of high-level risks facing the Trust and ways in which these are being mitigated. ▪ Points as set out in 1), 2) and 3) above apply.
5. The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care;	**Confirmed** ▪ The Medical Director and the Chief Nurse are both appropriately professionally qualified and accountable to their professional body (in addition to the Trust). ▪ NEDs individually bring extensive experience and expertise from many different areas of private and public sector activity including finance, commerce and governance ▪ Collectively, the NED component of the Board is suitably qualified to discharge its functions. ▪ Quarterly Safe, Effective Care (SEC) report presented to Quality & Safety Committee and commissioners and shared with the Board. ▪ Quality and Safety Committee – chaired by a NED – terms of reference include reporting from Divisional Quality Executive Groups, Safeguarding Groups and IPC.

(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	▪ Clinical Audits – the Trust participates in national audits and also local audits. Audit reports are submitted to relevant committees or groups. ▪ Learning from national reports with comparative reports undertaken and action plans devised and implemented. ▪ National reports and benchmarking e.g. NICE guidelines and patient safety alerts. ▪ Monthly leadership safety walk rounds undertaken by Executive directors, Non- Executive Directors and Governors. ▪ Processes in place to escalate and resolve issues - Risk and Environmental Management Group (REMG) ▪ The executive team is supported by a cadre of appropriately-qualified and capable deputies and recruitment to vacant posts is currently underway
6. The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed** ▪ The Medical Director, Chief Nurse and Chief Finance Officer are all appropriately professionally qualified and accountable to their professional body (in addition to the Trust). ▪ All Executive Directors' performance and competencies are reviewed through annual appraisals. ▪ Collective & individual skill-sets reviewed as part of board development ▪ Chair receives an annual performance appraisal from the Senior Independent Director ▪ NEDs receive an annual performance appraisal from the Chairman who advises the governors ▪ NEDs have been appointed by the Council of Governors as advised by the governors' Nominations and Remunerations Committee ▪ NEDs individually bring extensive experience and expertise from many different areas of

	private and public sector activity including finance, commerce, governance, and, OD. . Collectively, the NED component of the Board is suitably qualified to discharge its functions. ▪ Once in post, each NED undergoes an internal induction to facilitate an understanding of the Trust, its operations and strategic direction. ▪ Thereafter, on-going training to develop existing and new skills relevant to the NED role is undertaken by attendance at external conferences and workshops as required. ▪ NED progress is monitored by the Chair via one to one meetings including a formal annual appraisal session at which achievements against objectives for the preceding year are evaluated and new goals for the forthcoming year and a personal development plan are established. ▪ This is supplemented by a number of Board away days throughout the year to discuss strategy and policy as well as developing the knowledge and skills of the Board on specific issues. ▪ Divisions are led by experienced and capable teams consisting of a Divisional Director of Operations, Divisional Medical Director and Head of Nursing. ▪ Safer staffing levels on wards are reported to Board at each meeting and are monitored and are included on the wards' quality board.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

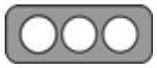
Cyber Security

Maintain standards for safe care, by protecting digital technologies from cyber threats

Board of Directors Update
Presented by Chief Information Officer

June 2022
Version 1.0

TLP:WHITE



The WWL Way

1. Introduction

This report is a follow on from the Cyber Security Briefing, discussed at the last Trust Board away day where nothing has changed. It will focus on the NHSX What does good look like framework and the controls in place at the Trust and provide an update on the latest threat intelligence.

2. NHSX – What does good look like framework

Under the NHSX (now part of the NHS Transformation Directorate) What Does Good Look like framework [*1], success criteria 3 - Safe Practice, refers to organisations maintain standards for safe care. ***'They routinely review digital and data systems to ensure they are safe, robust, secure, sustainable, and resilient. Digitally enabled outcome-driven transformation is at the heart of safe care.'***

From a cyber security perspective, the organisation would:

- comply with the requirements in the Data Security and Protection Toolkit [*2] which incorporates the Cyber Essentials Framework[*3]
- fully use National cyber services [*4] provided by NHS Digital
- have a secure and well-tested back-up, a plan to get off and stay off unsupported systems, and a rapid turn-around of High Severity Alerts
- establish a process for managing cyber risk with a cyber improvement strategy, investment and progress regularly reviewed at board level
- have an adequately resourced cyber security function, including a senior information risk owner and data protection officer (DPO)
- have an adequately resourced clinical safety function, including a named Clinical Safety Officer, to oversee Trust-wide digital and data development and deployment
- ensure ICS-wide clinical systems meet clinical safety standards as set out by DTAC and DCB0129 and DCB0160

a. Data Security and Protection Toolkit & Cyber Essentials

The Data Security and Protection Toolkit is an online self-assessment tool that allows organisations that process health and care data to measure their performance against the National Data Guardian's 10 Data Security Standards and to demonstrate that they are practising good cyber security.

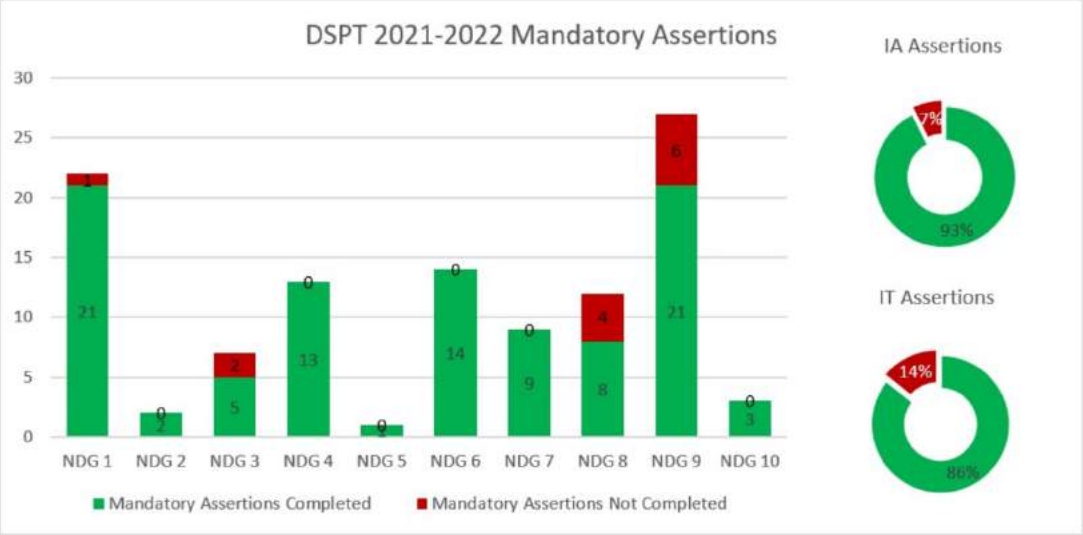
Cyber Essentials is an effective, Government backed scheme that helps protect the Trust against an entire range of the most common cyber-attacks. Cyber-attacks come in many shapes and sizes, but the vast majority are considerably basic in nature, carried out by relatively unskilled individuals. Cyber Essentials ensures the Trust has protection against a wide variety of the most common cyber-attacks.

The Trust's status for the DSPT return is classified as **Standards Met** [*5] – the highest level of conformance

ODS	Organisation name	Latest status	Published
RRF	Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust	20/21 Standards Met	18/06/2021

Work is progressing to complete the Trust's submission for the Year 2021/22 with a view to achieving the same rating, by the end of June 2022. Each year NHSX increase the number of mandatory assertions which has seen a significant increase in the number relating to IT infrastructure. All assertions are on track which is testament to the challenging work completed by the IM&T and DAA teams and the main risk presently is to ensure all staff have completed their mandatory Information Governance training. The return is also subject to external validation by the Trust's auditors.

Current DSPT Figures



b. Malware protection

Malware, or malicious software, are programs or codes that are harmful to digital systems. There are various kinds of malware, such as viruses, worms, spyware, ransomware, trojans, and botnets, all destructive in different ways: some can steal or delete your data, some spy on your computer activity without your permission, while others can disable your systems or lock down files, making them inaccessible.

IT Services has multiple controls to protect against this risk which include: -

- Secure network devices and firewalls
- Office 365 Advanced Threat Protection (ATP)
- Anti-virus and anti-ransomware protection
- Device and application patching
- Threat intelligence
- Managed Cyber Security Operation Centre
- Cyber Incident Response plan, and disaster recovery and business continuity plans
- Annual audits and penetration tests
- Mandatory staff training and regular cyber communications

c. Migration away from unsupported systems

Over the past 12 months, IT Services has been upgrading the desktop and server estate to the latest operating systems. Approx. 6000 end user computers and over 100 servers have been upgraded to the latest versions of Windows 10 and Server.

d. Patching of systems

All Trust systems and networking devices have patches applied at least monthly or sooner if a specific high severity vulnerability is identified. The team in IT Services work extremely hard applying over 76,000 software changes per year with minimal impact to staff.

e. System and data backups

IT Services perform over 800 backups per day and perform regular restores of data are carried out. This equates to 300,000 data copies per annum and 4.47 Petabytes of written data. One Petabyte would consume 1.5 million CD ROMs.

f. Cyber risk management

Cyber risk is managed via the Trust's Risk Management policy and there are 5 risks being managed at a corporate level by senior management and executive directors.

g. Managed Cyber Security service

Demand for cyber security professionals is at a record high and unfortunately the Trust is not able to offer competitive salaries for dedicated staff to manage this critical aspect. However, in addition to providing training for the current team, we have, innovatively, awarded a contract for a managed, 24/7 cyber security operational service. This service provides: -

- Next generation Security Event Incident Management solution using the Cloud and Artificial Intelligence (AI)
    - **Collect** data at cloud scale—across all users, devices, applications, and infrastructure, both on-premises and in multiple clouds
    - **Detect** previously uncovered threats and minimise false positives using analytics and unparalleled threat intelligence from Microsoft
    - **Investigate** threats with AI and hunt suspicious activities at scale
    - **Respond** to incidents rapidly with built-in orchestration and automation of common tasks
- Proactive action to manage all cyber related incidents
- A cyber helpdesk, available to all staff 24/7 where staff can call for advice and guidance to handle all their cyber related queries.

h. Clinical Safety

WWL have a Clinical Informatics Team who are all trained in Clinical Safety Assessments with the Chief Nurse Informatics Officer also undertaking the role of Clinical Safety Officer (CSO). Clinical Safety Assessments are carried out on all new internal developments following solution design and again prior to end user acceptance testing to ensure solutions are safe and fit for purpose. Clinical Safety risks are reported to the project board and to the Digital Quality Executive Group. This supports compliance with **DCB0160**.

For new solutions procurement and implementation, it is expected that the Supplier provides their clinical safety assessment to comply with DCB0129 which is reviewed by the CSO to support compliance with DCB0160.

i. Governance

Regular Cyber Updates are provided to the following meetings: -

- Senior IT Meeting, weekly
- IM&T Assurance meeting, monthly
- Senior Information Risk Owner, monthly
- Caldicott Committee, quarterly

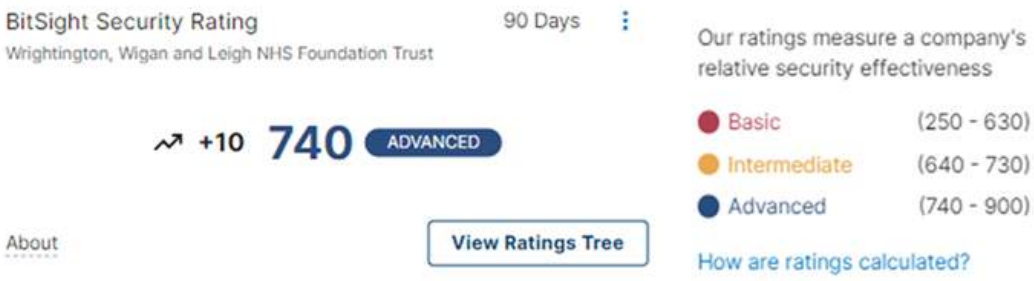
Regular IT audits are completed and monitored at the Audit Sub Committee, which includes the yearly DSPT return.

In addition, regular network penetration tests take place and business continuity exercises take place in conjunction with the Emergency Preparedness Resilience Response Group.

Security Performance Management – Bitsight cyber security performance rating.

This NHS Digital provided platform uses externally observable events, data sinkholes and third-party data to continuously assess cyber security ratings against Trust systems.

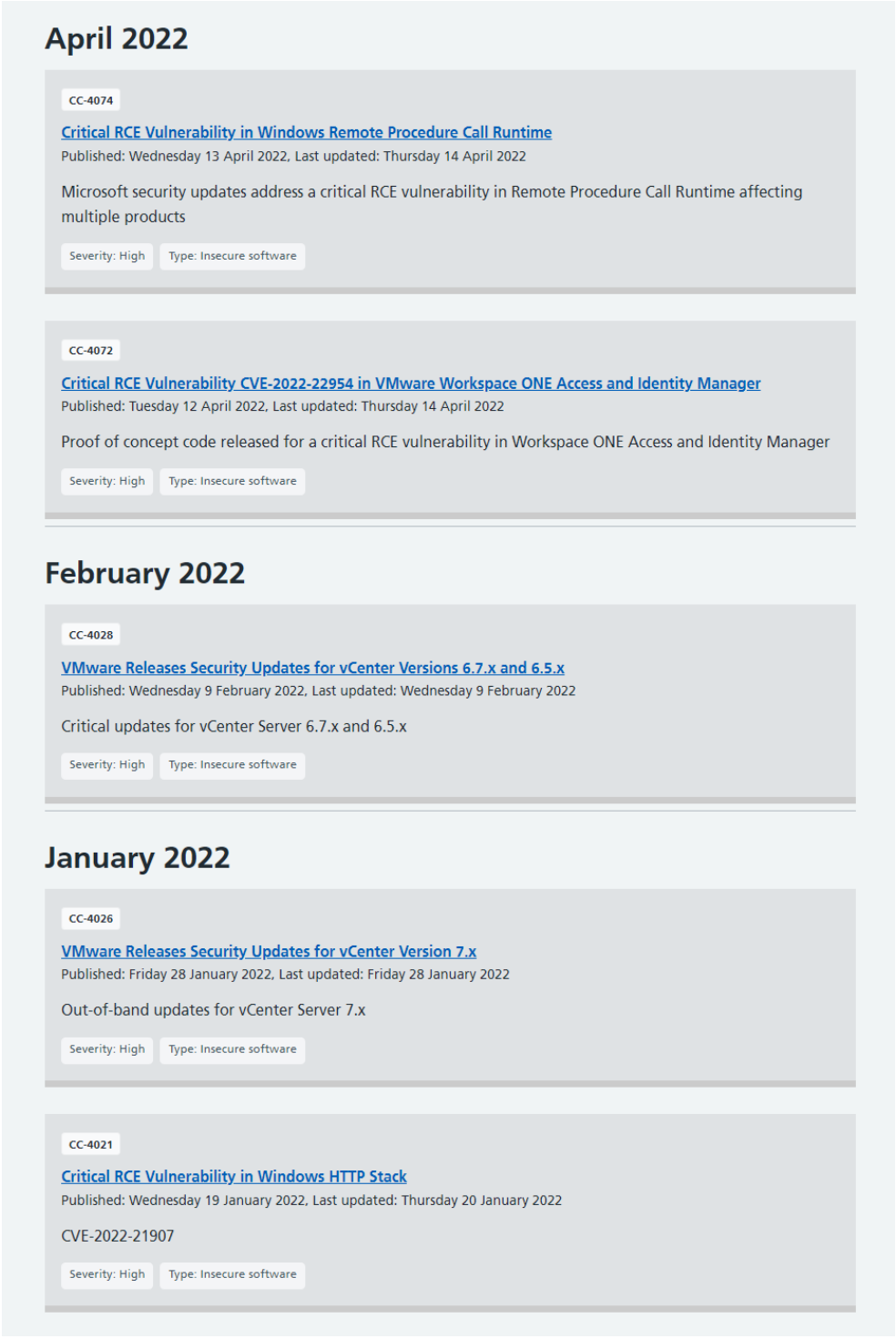
The Trust is rated as **Advanced**, the highest level achievable: -



3. Latest Threat Intelligence

a. NHS Digital Cyber Alerts

NHS Digital issue cyber security alert notifications [*6] to health and care organisations, ranging from weekly threat bulletins to high-severity alerts. So far this year a total of 91 alerts have been issued, 5 of which were rated as High. All alerts have been actioned and resolved within the agreed response and closure times. One of the High severity alerts involved immediate updating of all 6000 Trust end user devices, which was achieved with minimal impact to staff.



April 2022

CC-4074

Critical RCE Vulnerability in Windows Remote Procedure Call Runtime

Published: Wednesday 13 April 2022, Last updated: Thursday 14 April 2022

Microsoft security updates address a critical RCE vulnerability in Remote Procedure Call Runtime affecting multiple products

Severity: High | Type: Insecure software

CC-4072

Critical RCE Vulnerability CVE-2022-22954 in VMware Workspace ONE Access and Identity Manager

Published: Tuesday 12 April 2022, Last updated: Thursday 14 April 2022

Proof of concept code released for a critical RCE vulnerability in Workspace ONE Access and Identity Manager

Severity: High | Type: Insecure software

February 2022

CC-4028

VMware Releases Security Updates for vCenter Versions 6.7.x and 6.5.x

Published: Wednesday 9 February 2022, Last updated: Wednesday 9 February 2022

Critical updates for vCenter Server 6.7.x and 6.5.x

Severity: High | Type: Insecure software

January 2022

CC-4026

VMware Releases Security Updates for vCenter Version 7.x

Published: Friday 28 January 2022, Last updated: Friday 28 January 2022

Out-of-band updates for vCenter Server 7.x

Severity: High | Type: Insecure software

CC-4021

Critical RCE Vulnerability in Windows HTTP Stack

Published: Wednesday 19 January 2022, Last updated: Thursday 20 January 2022

CVE-2022-21907

Severity: High | Type: Insecure software

b. Managed Cyber Security Partner

The latest threat update received references 'Patch Tuesday,' the colloquial term for Microsoft's Update Tuesday that falls on second Tuesday of every month. This is when Microsoft rolls out patch updates to improve security of Microsoft applications.

These threat bulletins are technical in nature and provide details about the risk and mitigations to be taken to protect patient care. The Trust has robust processes in place to patch systems immediately, if deemed necessary.

The latest advice received was relating to Microsoft's Patch Tuesday updates: -

Tuesday 10 May was Microsoft's May 2022 Patch Tuesday and updates have been published to fix a total of 75 flaws, 8 of which are rated critical and if exploited could allow Remote Code Execution.

Vulnerabilities fixed by the patch include:

- 21x Elevation of Privilege Vulnerabilities
- 4x Security Feature Bypass Vulnerabilities
- 26x Remote Code Execution Vulnerabilities
- 17x Information Disclosure Vulnerabilities
- 6x Denial of Service Vulnerabilities
- 1x Spoofing Vulnerability

The patches include fixes for 3 Zero-Day vulnerabilities, with one being actively exploited in the wild. The other two are disclosed, meaning exploits will not be far behind.

Trust Comment

The patches referenced above have been applied to Trust devices and address the vulnerabilities referenced above.

c. National Cyber Security Centre (NCSC)

The National Cyber Security Centre aim is to help make the UK the safest place to live and work online [*7] Specially : -

- understands cyber security, and distil this knowledge into practical guidance that we make available to all
- responds to cyber security incidents to reduce the harm they cause to organisations and the wider UK
- uses industry and academic expertise to nurture the UK's cyber security capability
- reduces risks to the UK by securing public and private sector networks

The latest intelligence updates, relevant to the Trust, are as follows

i. Communications relating to the Russian invasion of Ukraine

Current cyber threat to UK organisations & citizens

The NCSC is not aware of any specific, targeted cyber threats to UK organisations or citizens as result of the Russian invasion of Ukraine. We encourage organisations & citizens to remain vigilant as this could change at short notice. We have produced actions to take when the cyber threat is heightened and the steps to take to improve your cyber security.

Trust Comment

The recommendations referenced are continually under review and the team will continue to monitor the developing situation with the Russian invasion.

ii. Latest Threat Reports

Report emphasises continuing cyber threat to health and education sectors *8

The health and education sectors continue to face serious cyber security threats based on the number of reported incidents to the Information Commissioner's Office (ICO).

A report from cyber security firm CybSafe has highlighted that 34% of incidents reported last year were experienced by these sectors, an increase on 2020's figures from the ICO. The report also reveals a 19% increase of ransomware attacks affecting the education sector. The report discusses data which pinpoints phishing as the most common form of cyber-attack, with ransomware becoming an increasing trend impacting all sectors.

Trust Comment

The Trust has highly sophisticated controls to protect against these types of threats and proactively block access to all known websites hosting malware. However, staff must remain vigilant to not click on links of unknown origin, which may contain malicious content. Cyber education is communicated via the WWL Staff Communication process.

iii. Active Cyber Defence – The fifth year: Summary of Key Findings *9

The aim of Active Cyber Defence (ACD) is to "Protect the majority of people in the UK from the majority of the harm caused by the majority of the cyber-attacks the majority of the time." The ACD programme is one of the NCSC's most successful ways to help bring about a real-world, positive impact against threats.

The report describes the success it has had with its Take Down service which finds malicious sites and sends notifications to the host or owner to get them removed from the internet before significant harm can be done. It also references Government themed scams and states '*In 2021, we took down 11,001 phishing campaigns, a total of 49,228 URLs with a median availability of 14 hours.*' This is the time the malware was available on the internet to users clicking on the links. The NHS appeared 3rd on the list of government phished brands.

Table 2 Top 10 UK government-phished brands

Government brand	Number of attack URLs	Number of attack groups (campaigns)	Median availability (hours)
Generic 'gov.uk'	18,037	5,257	15
HMRC	12,516	2,592	11
NHS	5,513	1,405	8
TV Licensing	4,412	1,089	154
DVLA	6,418	1,013	17
Office for National Statistics (Census theme)	572	354	1
Government Gateway	1,334	267	21
BBC	103	51	20
Council Tax	94	39	3
Generic 'HMG'	29	27	30
All UK government-themed phishing attacks	**49,228**	**11,001**	**14.3**

The first campaigns to use the NHS vaccine lure were noted in late December 2020 and were delivered in email and SMS campaigns with over seventy throughout January 2021. These attacks tailed off in numbers until summer when vaccine certification became a popular topic for lures.

Figure 1 Fake NHS COVID-19 Vaccine Booking (January 2021)

Figure 2 Fake NHS Digital Vaccine Passport Phishing (June 2021)

These campaigns were designed to harvest personal and financial information from victims. The phishing sites falsely offered vaccine booking appointments in return for a small 'fee' but as is common with other phishing campaigns, personal and financial information posted into these phishing forms was subsequently used by phishers to enable further fraud, often contacting victims directly purporting to be from UK banks.

By summer 2021, criminals modified the campaign to offer fake vaccine passports, which falsely claimed to support international travel requirements. Some even provided a QR code which looks authentic but when scanned simply redirected the victim to a free QR code generation site.

Trust Comment

The Trust acknowledges the additional protection provided by the Active Cyber Defence service and provides information to help support the take down of malicious sites on the internet. The team also monitor the digital infrastructure 24/7, looking for threats associated with Phishing campaigns, where robust procedures are in place to respond accordingly.

References

Reference	Title	Accessed on Friday 20th May 2020 at
*1	What Good Looks Like - The framework	What Good Looks Like framework
*2	Data security and protection (DSPT) for health and care organisations	Data Security and Protection Toolkit
*3	Cyber Essentials helps you to guard your organisation against cyber-attack.	About Cyber Essentials
*4	National NHS cyber services	Cyber and data security - NHS Digital
*5	DSPT Status for the Trust	Organisation Search
*6	NHS Digital Cyber alerts	Cyber alerts
*7	National Cyber Security Centre (NCSC)	NCSC - What we do
*8	Weekly Threat Report (NCSC)	Weekly Threat Report 6th May 2022
*9	Active Cyber Defence Key Findings Summary	The Fifth Year: Summary of Key Findings

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Review of risk appetite statement 2022/23
Presented to:	Board of Directors
On:	8 June 2022
Presented by:	Director of Corporate Affairs
Prepared by:	John Harrop, Head of Risk
Contact details:	E: john.harrop@wwl.nhs.uk

Executive summary

This report sets out the proposed risk appetite statement for 2022/23, which has been endorsed by both Executive and Non-Executive Directors following detailed review.

This year a matrix has been devised, rather than being presented as a series of statements. The matrix provides guidance on the level of risk that the trust is both aiming to and willing to operate with in order to achieve its objectives, which will support staff across the organisation in their decision-making.

Link to strategy

The risks identified within this report relate to the achievement of the trust's strategic principal objectives.

Risks associated with this report and proposed mitigations

This report presents a range of risk appetite statements which may influence the amount of risk which the trust is willing to pursue and tolerate when considering the trust's key strategic risks.

Financial implications

There are no financial implications associated with this report.

Legal implications

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

People implications

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

Wider implications

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

Recommendation(s)

The board is recommended to approve the risk appetite matrix as presented, for implementation from 1 July 2022.

1. Background

1.1. NHS well-led guidance (2017) requires the foundation trust to have clear and effective processes for managing risks, issues and performance, including a clear understanding of the board's risk appetite and tolerance which is reviewed regularly (at least annually) and appropriately communicated to staff.

1.2. In addition, we are required to describe the key elements of our risk management strategy as part of the annual report, including a narrative on how risk appetites are determined.

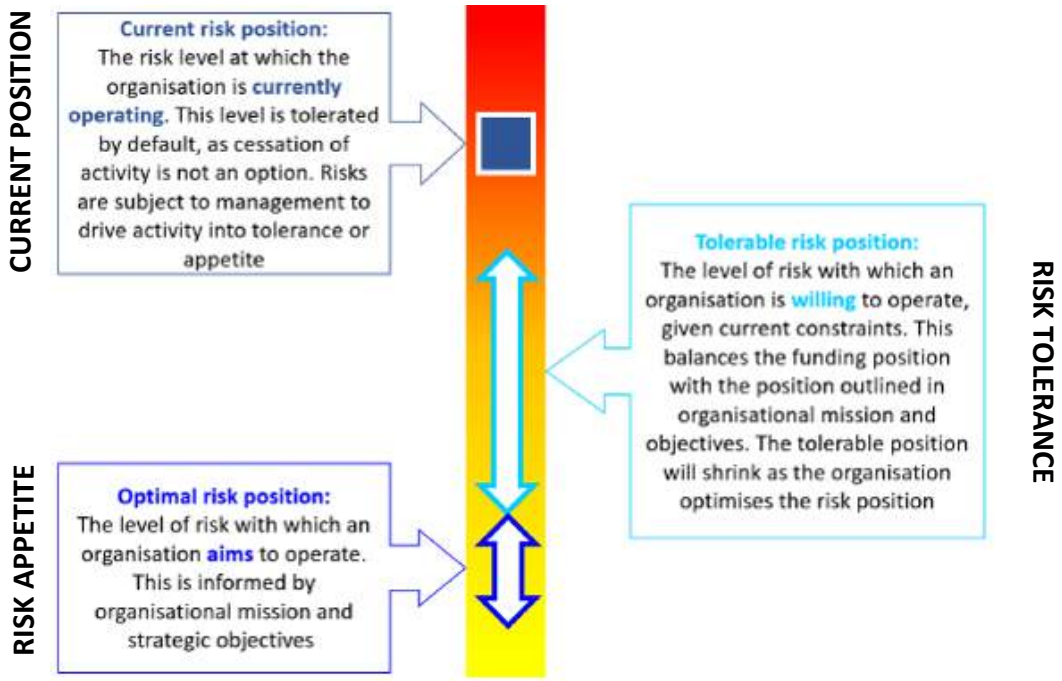
2. Definitions

2.1. 'Risk appetite' as a concept is often referenced without clearly defining what it is. Similarly, the terms 'risk appetite' and 'risk tolerance' are often incorrectly used interchangeably.

2.2. The current risk appetite statement defines risk appetite as 'the level of risk that an organisation is willing to accept'. Since this was published, however, the definition of risk appetite has been updated in line with best practice in our revised Risk Management Framework, and the new risk appetite statements have been prepared on this basis.

> **Risk Appetite:** the level of risk with which an organisation **aims** to operate (the optimal risk position).
>
> **Risk Tolerance:** the level of risk with which an organisation is **willing** to operate (the tolerable risk position).

2.3. The diagram below, adapted from the Government's *Orange Book: Management of Risk, Principles and Concepts* (2020) and *Risk Appetite Guidance Note* (2021), explains this visually:



3. Current arrangements

3.1. The **Board Assurance Framework** is the primary document supporting the board to manage uncertainty around achieving its strategic objectives.

3.2. The **Corporate Risk Register** contains risks which may impact on the achievement of corporate objectives at a divisional and trust wide level.

3.3. The current risk appetite statement, shown below, defines our risk appetite by way of very broad statements of approach:

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

3.4. This approach was based on a matrix developed for NHS organisations by the Good Governance Institute in 2012, but provides little guidance to end-users as to what each of these statements mean in practice and they are therefore open to interpretation.

3.5. The recommended risk appetite matrix for 2022/23 is shown at appendix 1 and builds on the good work already undertaken across WWL. It introduces a more precise approach to defining risk appetite by encouraging the use of defined risk categories, identification of opportunities and threats and aggregated risk appetite scoring to both guide where a risk score is acceptable and to prioritise where further action is required.

4. Risk categories

4.1. The Government's *Orange Book* recommends that risks should be organised by taxonomies or categories of risk because grouping them in this way supports the development of an integrated and holistic view of risk. A benchmarking exercise focusing on NHS providers' board assurance frameworks was undertaken by Mersey Internal Audit Agency in FY2020/21 which groups risks into broad categories which have been adapted for WWL overleaf.

4.2. Whilst it is recognised that individual risk categories could impact on any of the four principal objectives, each risk category has been aligned to its most appropriate principal objective to assist with the development of the risk appetite statement.

Risk Categories

5. Risk scoring and review

5.1. In line with the current methodology, the level of risk is determined using the following 5x5 grid:

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Probability Will the risk event happen or not?	May only occur in exceptional circumstances	The event could happen sometime	The event might occur at sometime	The event is likely to occur in most circumstances	The event is expected to occur in most circumstances

Impact score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Minimal**	**Low**	**Moderate**	**High**	**Critical**
Impact What impact will the risk event have on achieving objectives?	A risk event that, if it occurs, will have little or no impact on achieving objectives.	A risk event that, if it occurs, will have a minor impact on achieving desired results, to the extent that one or more stated objectives will fall below goals, but well above minimum acceptable levels.	A risk event that, if it occurs, will have a moderate impact on achieving desired results, to the extent that one or more stated objectives will fall below goals, but above minimum acceptable levels.	A risk event that, if it occurs, will have a significant impact on achieving desired results, to the extent that one or more stated objectives will fall below acceptable levels.	A risk event that, if it occurs will have a severe impact on achieving desired results, to the extent that one or more of its critical objectives will not be achieved.

5.2. In addition to these high level descriptors, there is also a detailed matrix which provides definitions of each impact score as relevant to a number of different factors, to ensure consistency in scoring across the organisation.

5.3. Overall risk levels are calculated by multiplying the likelihood and consequence scores, as shown below:

	IMPACT →				
LIKELIHOOD ↓	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Critical (5)
Certain (5)	5 x 1 = 5 (M)	5 x 2 = 10 (H)	5 x 3 = 15 (E)	5 x 4 = 20 (E)	5 x 5 = 25 (E)
Likely (4)	4 x 1 = 4 (M)	4 x 2 = 8 (H)	4 x 3 = 12 (H)	4 x 4 = 16 (E)	4 x 5 = 20 (E)
Possible (3)	3 x 1 = 3 (L)	3 x 2 = 6 (M)	3 x 3 = 9 (H)	3 x 4 = 12 (H)	3 x 5 = 15 (E)
Unlikely (2)	2 x 1 = 2 (L)	2 x 2 = 4 (M)	2 x 3 = 6 (M)	2 x 4 = 8 (H)	2 x 5 = 10 (H)
Rare (1)	1 x 1 = 1 (L)	1 x 2 = 2 (L)	1 x 3 = 3 (L)	1 x 4 = 4 (M)	1 x 5 = 5 (M)

5.4. The risk scores are then used to determine the frequency of review:

Score	Level	Review frequency
1 – 3	Low (L)	Annually
4 – 6	Moderate (M)	Every six months
8-12	High (H)	Every three months
15 to 25	Extreme (E)	Every month

6. Risk appetite matrix, aggregated risk scores and statements

6.1. The proposed risk appetite matrix shown in appendix 1 is comprised of risk categories, alongside which the relevant risk appetite and tolerable risk position scores are shown.

6.2. One key change this year is that separate risk appetites are shown in relation to risks which present opportunities for the organisation and for those which pose a threat to the achievement of objectives. This reflects the fact that risks can be positive as well as negative and will help to inform decision-making, such as whether to pursue a particular business opportunity.

6.3. A selection of risk appetite positions are provided for each of the risk categories – averse, minimal, cautious, open, and eager. Example risk appetite positions for opportunities and threats have been included in the matrix to illustrate how the matrix can be utilised.

6.4. The aggregated risk scores shown recommend acceptable aggregated risk scores for each of the risk appetite positions within the matrix. Aggregated risk scores promote a portfolio management approach to risk management, where risk scores can be balanced across risk

categories and principal objectives. Aggregate risk scoring enables actions to be prioritised which will bring the risk score to within the risk appetite level for the risk category, whilst encouraging the pursuit of opportunities for those risk categories with a higher risk appetite level. Too great a risk appetite can jeopardise achievement of an objective whilst too little could result in lost opportunity.

7. Recommendations

7.1 The board is asked to approve the high-level risk appetite matrix at appendix 1 for use during FY2022/23.

Appendix 1:
Proposed high-level risk appetite matrix 2022/23

For each risk category, a risk appetite has been set based on whether the risk poses a threat or an opportunity. Detail on the optimal and tolerable risk scores is also provided to guide risk owners in their decision-making.

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 scores shown in the matrix above provide guidance to risk owners as to the optimum and tolerable score for each individual risk. More specific definitions for each of these will be provided by the risk team once the high-level matrix is approved by the board.

In line with recommended practice, a one-word description of our risk appetite has also been provided using the scale below:

Least risk		← →		Most risk
Averse	Minimal	Cautious	Open	Eager

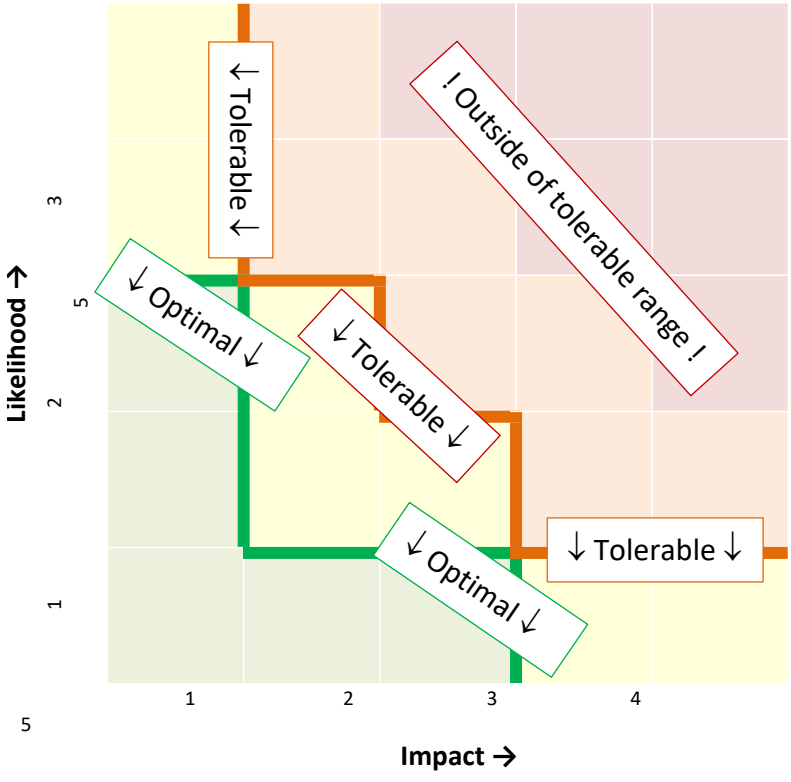
This approach allows us to consider risks to each principal objective holistically as well as specifically considering each individual risk.

A holistic view

Using the 'patients' principal objective as an example, the high-level risk appetite matrix above sets the holistic threat risk appetite as 'minimal' and the holistic opportunity risk appetite as 'cautious'. The table below shows how this maps across in terms of risk scores at an aggregated level:

	Averse	Minimal	Cautious	Open	Eager
Aggregated optimal position	1	≤3	≤6	≤8	≤16
Aggregated tolerable position	2-3	4-6	8	10-12	>12

We can then apply this holistic approach to map acceptable parameters onto the heatmap. Anything left of the orange line is tolerable, and anything left of the green line is optimal.



Individual risks

Having mapped the holistic risk appetite onto the heatmap for the 'patients' principal objective, using the example below we can see at a glance that most of the current risk scores, with the exception of risks 1.2 and 1.3, are outside the tolerable level and that all the target risks scores are either within the tolerable or optimum levels.

You will also see that circles marked 'AR' has been included for the first time in 2022/23. This shows the average risk score for the principal objective at both the current (black circle) and target (blue circle) level.