Board of Directors Public meeting

Wed 07 June 2023, 14:00 - 16:15

Boardroom, Trust Headquarters

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Agenda

14:00 - 14:01
1 min

13. Declarations of Interest

Information *Mark Jones*

Verbal item

14:01 - 14:02
1 min

14. Minutes of Previous Meeting

Approval *Mark Jones*

14. Minutes_Board of Directors - Public Meeting_050423 (1).pdf (6 pages)
Public Board Action Log - April 2023.pdf (1 pages)

14:02 - 14:12
10 min

15. Chair's Opening remarks

Information *Mark Jones*

Verbal Item

14:12 - 14:22
10 min

16. Chief Executive's report

Information *Silas Nicholls*

16. Board Report_CEO_June_2023_FINAL.pdf (3 pages)

14:22 - 14:52
30 min

17. Committee chairs' reports

Information *Non Executive Directors*

17.1. Finance and Performance

Julie Gill

Report to follow due to close proximity of the meeting.

17.2. People

Lynne Lobley

17.2 AAA _ People - May 2023.pdf (2 pages)

17.3. Quality and Safety

Francine Thorpe

17.3 AAA QSapril23.pdf (2 pages)

17.4. Audit

Ian Haythornthwaite

17.4 AAA Audit - May 2023.pdf (2 pages)

14:52 - 15:02
10 min

18. Board assurance framework

Decision *Paul Howard*

18. BAF Report Board June 2023.pdf (27 pages)

15:02 - 15:22
20 min

19. Integrated performance report

Discussion *Sanjay Arya/Tracy Boustead/Mary Fleming*

19. Board of Directors M1 23 24 M12 2223 Scorecard.pdf (8 pages)

15:22 - 15:37
15 min

20. Finance Report

Discussion *Tabitha Gardner*

20. Trust Financial Report 23-24 April Month 1 Board.pdf (10 pages)

15:37 - 15:37
0 min

21. Consent Agenda

21.1. Committee terms of reference - Quality and Safety

Decision *Nina Guymer*

21.1. ToR - QSCommittee 2023.pdf (6 pages)

21.2. Board self-certification - Licence condition FT4

Decision *Paul Howard*

21.2 FT4 self-certification 2023.pdf (7 pages)

21.3. Review of well-led action plan

Decision *Paul Howard*

21.3 Well-led action plan - May 2023.pdf (17 pages)

15:37 - 15:37
0 min

22. Date, time and venue of next meeting

Information *Mark Jones*

Wednesday 02 August 2023, 1:15 - 4.15pm

Board of Directors - Public Meeting

Wed 05 April 2023, 13:30 - 16:15

Boardroom Trust Headquarters

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Attendees

Present:

Mr M Jones	Chair (in the Chair from item 14 only)
Prof S Arya	Medical Director
Prof C Austin	Non-Executive Director
Mr T Boustead	Chief People Officer
Lady R Bradley	Non-Executive Director (in the Chair until item 14)
Ms J Gill	Non-Executive Director
Mr I Haythornthwaite	Non-Executive Director
Mr P Howard	Director of Corporate Affairs
Ms T Gardner	Chief Finance Officer Designate
Mrs L Lobley	Non-Executive Director
Mrs AM Miller	Director of Communications and Stakeholder Engagement
Mr R Mundon	Director of Strategy and Planning
Mrs F Thorpe	Non-Executive Director
Ms R Tindale	Chief Nurse

In attendance:

Mrs N Guymer	Deputy Company Secretary (minutes)

Meeting minutes

44. Declarations of Interest

Information
Lynne Lobley

No declarations of interest were made.

45. Minutes of Previous Meeting

Approval
Lynne Lobley

The minutes of the previous two meetings in February and March 2023 were **AGREED** as a true and accurate record.

12. Minutes_Board of Directors - 1 Feb 2023 - Public Meeting.pdf

12. Public - Minutes Mar 2023 - Board of Directors - Year end items.pdf

46. Chief Executive's report

Information
Mary Fleming

The Deputy Chief Executive presented the update, on behalf of the Chief Executive. She thanked patients for bearing with the Trust through the rescheduling of appointments due to the juniors strike and staff for their support shown for the work around increasing discharge and reducing the number of no right to reside patients. She went on to express thanks to staff for participating in the staff survey and leaders who encouraged them to do so, since WWL were ranked number one in Greater Manchester and were in the top 10 nationally for morale. She welcomed Tabitha Gardner to her first board meeting as Chief Finance Officer and took a moment to remember WWL's previous Chief Executive, Andrew Foster CBE, who had recently passed away, noting condolences to his family on behalf of WWL's Board.

14. Board Report_CEO_April_2023_FINAL.pdf

47. Committee chairs' reports

Information

Non Executive Directors

The chairs of the respective committees presented the reports which had been shared in advance of the meeting. It was noted that, since Mr M Guymer had now come to the end of his interim appointment, Lady R Bradley would be presenting the Finance and Performance report on his behalf.

47.1. Finance and Performance

Rhona Bradley

Following presentation of the report, the Chief Finance Officer wished to emphasise that the issue with overheating is not due to incorrect use of resources but results from the age of the estate and the difficulty in cooling down various areas of the buildings, as well as the way that WWL report incidents, which is more stringent, in contrast to how other trusts report.

15.2 AAA F&P - 29 Mar 2023.pdf

47.2. People

Lynne Lobley

Before presenting the report, Mrs L Lobley noted that the meeting had taken place during the junior doctors strike period and expressed thanks to communications and those working in the control room during that time.

Following presentation, Mrs F Thorpe queried the timeframe for implementation of the long term workforce plan.

The Chief People Officer advised that there is no national framework in place and that whilst WWL does await provision of such guidance, in the meantime, it is keen to progress its own plans.

Lady R Bradley noted plans to reduce the social care workforce budget and wondered whether there would be the opportunity for joint consideration of alternative workforce models.

The Chief People Officer advised that the corporate objectives (COs) which would be discussed later in the meeting would address this, specifically through CO10.

15.3 AAA _ People - Mar 2023.pdf

47.3. Quality and Safety

Francine Thorpe

15. AAA QSfeb.23.pdf

47.4. Audit

Ian Haythornthwaite

Mr I Haythornthwaite added that the audit result for the risk management audit was one of high assurance.

Mr M Jones joined the meeting.

15.5 AAA Audit - Feb 2023.pdf

47.5. Research

Clare Austin

Following presentation, the Chair asked whether there is the opportunity to address the matter of projections for the research projects which will attract the research capacity funding required to meet the University Hospital Association's threshold for £200k worth of income. It was noted that this would be tracked and that work is being done to make links with research partners to support this. Achievement of this threshold is a requirement for achieving university status.

The Board recieved and noted the reports.

15.1 AAA - Research - March 2023.pdf

48. Chair's remarks

Information

Mark Jones

The Chair reported back on a meeting which he had just attended virtually with NHS England colleagues, including its Chair and Chief Executive. The key message was that 25% of financial plans have been agreed, 25% are close to being accepted, however circa 50% are not currently acceptable. He noted that they had clarified that trust Chief Executives and Chairs would be held to account for delivery of these plans, as would Medical Directors, Chief Nurses and Chief Finance Officers.

He recalled that he had attended the recent opening of WWL's research hub and reported positively on the ingenuity of the refurbishment, which included reconditioning of furniture for example, as well as the success of the research and communications teams in running the event.

The Board noted the update.

49. Board assurance framework 2022/23 closing report

Decision
Paul Howard

The Director of Corporate Affairs presented the report, which had been shared in advance of the meeting. He noted that the format of the report is now in its second year and that it has been well embedded across all levels of the organisation and is frequently used to guide questions around assurance.

Mrs F Thorpe noted that there are no final year end figures provided, to show how far away the Trust were from achieving the objective.

The Director of Corporate Affairs agreed that it would be useful to address this and suggested that this is done through the relevant assurance committee

ACTION: P Howard

Mr I Haythornthwaite noted that in respect of CO5 (page 9/29) and queried

Mrs L Lobley noted that some assurance committees struggle to manage their agendas within the allotted time.

A discussion ensued around achievement of CO X. The Director of Strategy and Planning advised that there is a national issue with booking appointments, since a lack of appointments means that patients are at risk of dropping of the booking database, due to an automated time lapse function. WWL would therefor scan to ensure that all patients who have dropped off have been identified and rebooked and that work would also be carried out to make changes to the system.

In response to a query from Lady R Bradley around CO13 and progress made with WWL's Green Plan, the Director of Strategy and Planning advised that this would be better monitored moving forward by the Finance and Performance Committee, through substantive agenda items which would be more regularly featured.

The Board **APPROVED** the risks set out confirming that they accurately represent the current significant risks to delivery of the strategic objectives.
16. BAF Report Board April 2023.pdf

50. Corporate Objectives 2023/24

Decision
Richard Mundon

The Director of Strategy and Planning explained that the Board had been consulted in respect of the objectives on several occasions and noted consultation with the governors. He explained the key changes which had been made for the year 2023/24.

Prof C Austin queried whether CO17 should be separated in to two aims and more specific detail included. It was agreed that herself and the Director of Strategy and Planning would discuss the rewording of this outside of the meeting, to ensure that it contained enough detail.

In response to a query around whether CO14 should be expanded to more thoroughly address its focus, the Deputy Chief Executive advised that there will be various points where inequality of access will be considered by sub committees of the Board throughout the following year. The Director of Strategy and Planning added data will be analysed by speciality, over various time periods and in respect of each type of characteristic, to establish where issues lie. He added that his team believe that there is an intrinsic link between patients living in deprivation and failing to attend appointments. It was noted that a report would be provided biannually to provide assurance to the Board in respect of the work done in this regard and noted that data from the locality as a whole could be considered and also split by post code area.

It was noted that, as a public document, refinements would be made in consultation with the communications team, to ensure that members of the public are able to understand the content.

The Board **APPROVED** the corporate objectives set out for 2023/24.
17. Corporate Objectives 2023-24 - Trust Board 06-04-23 Final v2.pdf

51. Staff survey report

Discussion
Tracy Boustead

The Chief People Officer presented the paper which had been chaired in advance of the meeting.

Thanks were expressed by the Board to all of the staff involved in encouraging completion of the survey and it was noted that the response rate had improved by 5.5%.

A discussion ensued around the reduction in staff who would recommend WWL as a place of care for their friends or relatives, which was a concern for the Board, although it was noted that current pressures mean that the quality of care being provided is suffering.

The Board recieved and noted the report.
18. NSS 2022 Results Board of Directors April 2023 290323.pdf

52. Integrated performance report

Discussion
Sanjay Arya/Mary Fleming/Rabina Tindale

The Deputy Chief Executive presented the report which had been shared in advance of the meeting. Lead executives went on to present their respective sections of the report.

Mrs F Thorpe queried whether any due diligence had been carried out in respect of the community beds which WWL would be taking responsibility for as part of the Healthier Wigan Partnership system discharge and flow work.

The Deputy Chief Executive advised that due diligence is yet to be completed but that WWL is familiar and comfortable with the model, which it has run previously, albeit commissioning of beds then sat within the Commissioning Group. She noted that WWL would commission the beds but that staffing would be provided by system partners.

Mrs F Thorpe noted that the divisions have raised the issue of survey fatigue and therefore the next survey conducted by WWL would be the national staff survey. She queried whether this is sufficiently nuanced to allow WWL to drill down in to responses which are specific to it as an organisation.

The Board heard that proper consideration of the data would allow for this. It recieved and noted the report.
19. Board of Directors M11 2223 Scorecard_v1.1.pdf

53. Finance Report

Discussion
Tabitha Gardner

The Chief Finance Officer presented the report which had been circulated prior to the meeting.

Mrs L Lobley noted that the medicine division is consistently overspent and therefore queried whether plans for that division are correctly set out from the outset.

The Chief Finance Officer advised that the medicine budget is noted to be overspent but advised that the figure stated is not yet included within the budget. She advised that as the year progresses, the executive team will take decisions as to whether requests for expenditure should be added to the budget or held as overspend.

The Board recieved and noted the report provided.
20. Trust Financial Report 22-23 February Month 11 Board.pdf

54. Safe nurse staffing quarterly report

Discussion
Rabina Tindale

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

The Chair noted the problem with staff retention within the community division and asked whether any themes have been identified with issues in that respect.

The Chief Nurse advised that work is ongoing to identify key concerns and reasons for nurses within the division leaving the Trust although did not have that data at that time.

Prof C Austin queried the level of retention for international nurses, given the time and cost involved in recruiting them.

The Chief Nurse advised that retention levels are satisfactory however, work to consider the development of these nurses through promotion and further learning is being considered.

The Board recieved and noted the report provided, acknowledging the staffing priorities identified for quarter four.
21. Safe Staffing 2022 - 2023 Q3 Update Report for Trust Board.pdf

55. 7-day services report

Decision
Sanjay Arya

The Medical Director presented the report which had been shared in advance of the meeting.

Mrs F Thorpe asked whether the data is reviewed by any groups which would have allowed discharge and flow to be tracked. She further asked whether similar reviews could be carried out across a range of activities, such as in pharmacy.

The Medical Director advised that the exercise is very labour intensive and to increase its frequency may be difficult. A discussion ensued around whether the report is therefore necessary.

The Deputy Chief Executive advised that a full piece of work, initiated to assist with the local piece of work being done to improve discharge and flow, does map where the delays are within the hospital, including during weekend discharges.

The Director of Corporate Affairs noted NHSE guidance issued in 2022 providing that the report must still be provided for the Board. He advised however that WWL as an organisation is free to decide how this should be reported.

The Chair summarised that the report should be scheduled in to the workplan and brought back to address a broader range of activities such as pharmacy, also including a larger number of patients.

ACTION: S Arya

The Board recieved and noted the report provided.

22. Seven Day Services Audit 2022-23 Final report SAv.pdf

56. Annual sustainability report

Discussion
Richard Mundon

The Director of Strategy and Planning presented the report which had been circulated in advance of the meeting. He suggested that some Board training in respect of net zero and carbon reduction would be useful. The opportunity to utilise clinical ambassadors to aid work considering how medical apparatus can be made more environmentally friendly was noted.

Mrs L Lobley highlighted that it would be useful for the Board to have further information in respect of the Wigan Galleries masterplan. The Chair suggested that this be scheduled for a future Board workshop.

ACTION: N Guymer

The Board recieved and noted the report provided.

23. Board and Committee sustainability report 22 23.pdf

57. Review of the statement of responsibilities of the Chair and Chief Executive

Approval
Paul Howard

The Board reviewed and **APPROVED** the statement as presented.

24. Statement of responsibilities.pdf

58. Consent Agenda

The papers having been circulated in advance and members having agreed to them appearing on the consent agenda, the Committee **RESOLVED** as follows:

58.1. Revised committee terms of reference

Approval

THAT the terms of reference be received and noted.

25.1. DRAFT Research Committee - ToR 2023 NG RM CA.pdf
25.1. DRAFT ToR - Audit Committee 2023.pdf
25.1. DRAFT ToR - CTC - 2023 NG SM.pdf
25.1. DRAFT ToR - People Committee 2023.pdf
25.1. DRAFT F&P Committee ToR 2023.pdf
25.1. Committee ToRs.pdf

58.2. Infection Prevention and Control Board Assurance Framework

Information

THAT the report be received and noted.

The Board noted that from Monday 3 April 2023 WWL have dispensed with the use of masks in clinical areas.

25.2. IPC BAF for Trust Board April 2023.pdf

58.3. Joint clinical academic workforce strategy

Ratification

THAT the report be received and noted.

25.3 Joint Clinical Academic Workforce Strategy v2.pdf

59. Date, time and venue of next meeting

Information

Wednesday 7 June 2023, 1:15 - 4.15pm

Mark Jones

Action log

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
5 Apr 2023	49/23	Board assurance framework 2022/23 closing report	Ensure that year-end figures in respect of achievement of corporate objective metrics are provided at the relevant assurance committee	P Howard		
5 Apr 2023	55/23	7-day services report	Bring the report back to a future meeting to address a broader range of activities such as pharmacy, also including a larger number of patients	S Arya		This is proposed to be covered in the next yearly report to the Board.
5 Apr 2023	56/23	Annual sustainability report	Schedule an update on the Wigan Galleries masterplan at a future Board workshop	N Guymer		

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	07/06/23
Presented by:	Deputy Chief Executive
Prepared by:	Director of Communications and Stakeholder Engagement
Contact details:	T: 01942 822170 E: anne-marie.miller@wwl.nhs.uk

Executive summary

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

Link to strategy

There are reference links to the organisational strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

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

Legal implications

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

People implications

There are no people risks associated with this report.

Wider implications

There are no wider implications associated with this report.

Recommendation(s)

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

Report
WWL's current position remains a challenging one, both operationally and financially, and together, internally, and with our partners in the Wigan Borough, Greater Manchester (GM) and the North West, we continue to work hard to improve this position for our patients, our communities and our staff.

Since the start of 2023, WWL has worked through five separate periods of industrial action involving the Royal College of Nursing and the British Medical Association (BMA) respectively, and we are soon due to experience a further period of strike action from the BMA from Wednesday 14th June to Saturday 17th June. Whilst we wholeheartedly understand and respect our colleagues who have taken part in these disputes with the Government, we have had to make significant changes to our services on each occasion to enable us to protect our urgent and emergency care provision. As a result, we have experienced some impact on our elective recovery programme, however, we are still making good progress and we have worked extremely hard to ensure that industrial action has had as minimal an impact as possible on this. We understand that delays with appointments or surgery can be frustrating, and we are deeply grateful for the support, understanding and patience from those waiting to be treated.

In terms of our operational pressures, and in particular our Emergency Department (ED) performance, we have noticed some improvements over the past few weeks in terms of the flow of patients through our hospitals. However, in line with GM and national performance targets, we know we need to continue to improve in terms of our time to be seen in ED, 12-hour waits and our discharges, and these are all areas we are actively addressing. This is a system-wide effort, and we are working closely with our Primary Care and Social Care colleagues to better analyse the data, understanding where our referrals to the Emergency Department are coming from and why, and where we could better provide alternatives to patients who attend ED through more appropriate services within our hospital and back out in the community. This work, much like our financial plans, has to be carried out with patient safety and quality of experience at its core.

On the subject of safety, quality and experience, we recently welcomed the Care Quality Commission (CQC), who carried out a planned inspection of our Maternity Services and the outcome of this inspection will be shared at the appropriate point. I want to thank colleagues who were involved in the inspection and also thank service-users and patients who took the opportunity to provide feedback to the CQC. The Trust has also recently received the Silver Award from the Royal Society for the Prevention of Accidents (RoSPA), demonstrating that we have achieved a high level of performance, underpinned by good management systems which are delivering consistent improvement and that we are working towards the level of excellence required for the Gold Award. WWL's Health and Safety Team have led this area of work, but it is a Trust-wide culture at all levels of the organisation that has helped to achieve this. This is a great example of our commitment to patient safety and experience.

From a financial perspective, like most Trusts across the country, we have the task of reducing our expenditure over the course of this financial year, and through thorough planning, we are already seeing savings and efficiencies coming into place in this quarter. The most important thing is that although we need to reduce our spending, we will make sure that quality, safety and value for money are maintained at the highest possible standard without negatively impacting patient experience or outcomes. Safely reducing our costs can work hand-in-hand with the quality improvement programmes we are witnessing across the Trust, whereby projects from our staff are not only creating better experiences for our patients, but they are also reducing cost and saving valuable time. A recent example of this from our Community Division is that of the Health Outreach and Inclusion Team, who have introduced a new point of care test for HIV and Hepatitis B and C. This has reduced the waiting time for test results from two-weeks to just 30 minutes, saving money, saving valuable time for patients and staff, and reducing anxiety when waiting for results.

In the last two months we have also seen further development across our sites and services, most notably at the end of May when we received verbal confirmation of a £11.9million investment into our endoscopy service from the National Endoscopy Programme. This will help us increase the

number of endoscopy rooms at Leigh Infirmary from three to six, and upgrade the current facilities at the Royal Albert Edward Infirmary (RAEI) site to support the achievement of the Royal College of Physicians Joint Advisory Group accreditation. This investment will give us the ability to transfer lists from RAEI to the Leigh Infirmary site, whilst also future proofing our endoscopy facilities to address forecasted increases in population demand. This project complements the investment we have seen in our Community Diagnostic Centre which is currently under construction at Leigh and will have a significant role to play in reducing health inequalities through further improving access to key diagnostic tests and supporting an improvement in outcomes. Our cross-site developments are achievements we must champion, as they are already having a positive impact for our patients and our staff.

At the RAEI site, teams continue to put the finishes touches to the Makerfield Suite which will provide a new mental health service for patients who attend the ED with mental health issues and needs, rather than a physical condition or illness. The unit will be officially opened in July, but the service itself, which is provided in partnership with Greater Manchester Mental Health NHS Foundation Trust (GMMH), is already fully functional and making a big difference. Wrightington Hospital continues to drive forward our elective recovery programme, and the addition of the Enhanced Care Unit (ECU) over the past six months has only served to help us with our targets. The ECU offers a smoother patient experience by taking patients away from waiting for beds at RAEI, instead providing beds at Wrightington Hospital to those with post-operative complex needs. We have also seen some excellent progress in the facilities we provide for our patients who are on Palliative Care pathways, and the Palliative Care Team have recently had a complete refurbishment of their Palliative Care Hub at RAEI, which will open at the beginning of this month.

Trust leadership also continues to develop and our Medical Director, Professor Sanjay Arya has recently finalised appointments within the Medical Director Office. Dr Ashish Abdul and Professor Nirmal Kumar have been appointed as deputies, our Divisional Medical Directors have also been appointed, including Dr Stephen Gulliford, Mr Christos Zipitis, Mr Ben Coupe and Dr Habib Rahman, and Dr Martin Farrier will continue in his role as WWL's Chief Clinical Information Officer. We have also made an appointment to the Board of Directors and at the end of May I was delighted to announce Juliette Tait as WWL's new Chief People Officer. Juliette brings a huge amount of knowledge and experience to the role, having worked in various human resources and organisational development roles within the NHS, most recently with our partners at GMMH. Further to this, I would also like to confirm that our Chief Nurse, Rabina Tindale, will now remain at WWL and will continue to lead our nursing workforce.

Finally, I would like to reflect on some of the Trust's recent celebrations, achievements, and upcoming anniversaries. Our RAEI site celebrated its 150th anniversary on Sunday 4th June, kicking off a month-long celebration, which will also include the 90th anniversary of Wrightington Hospital and WWL's Radio's 50th birthday, culminating in the NHS's 75th birthday on Wednesday 5th July. Amongst the challenges that we are continually facing, it's just as important to reflect, remember and champion our achievements, as well as focusing on staff morale. These dates offer our colleagues the opportunity to celebrate WWL and its heritage, and we have already seen how much this means to them through the activities taking place. At WWL we take pride in showing our appreciation for our past, present and future, and we have also recently celebrated days such as International Nurses Day, International Day of the Midwife and Operating Department Practitioners Day, along with non-medical staff celebrations such as Human Resources Day and Administrative Professionals Day. These types of celebrations will continue alongside what we are calling our 'Big Birthday Month', and I hope to see many more members of the public join our staff in doing so.

Committee report

Report from:	People Committee
Date of meeting:	9 May 2023
Chair:	Lynne Lobley

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

ALERT
▪ The Committee noted that industrial action may continue and that the consultants are balloting before the end of July 2023 as to whether to hold a period of industrial action. Trusts are yet to be notified as to the Royal College of Nursing's intent and whether they will hold any further periods of action. ▪ The Committee noted the need moving forwards, to ensure that equality diversity and inclusion items feature as standing on some board and committee agendas.
ASSURE
▪ The plans which had been put in place to manage the periods of industrial actions were set out for the Committee and provided assurance that strikes moving forward will be effectively managed. The Staff Story provided further assurance around the experience of staff who were involved. ▪ In respect of doctors' pay, WWL will no longer be an outlier in respect of paying the BMA rate card rate. ▪ Both of the above risks are set out on the corporate risk register. ▪ The People Dashboard was presented as usual, this has become a key monitoring tool for the Committee, allowing it to see clearly where WWL is performing well and areas where further monitoring and assurance is required. ▪ WWL published its Equality Delivery System 3 pilot results before the set deadline, receiving a rating of 'developing'. The Committee agreed to set its equality diversity and inclusion objectives for the year moving forwards, these will be considered at a future meeting.
ADVISE
▪ Building on the success of the Guardian Service exit interview provision, the Committee received the proposal for how data collected around staffs' reasons for leaving the Trusts would be gathered via survey feedback moving forwards, and how this would be implemented. ▪ The Talent Program was presented and the Committee heard how this will begin by piloting in three areas (estates and facilities, information management and technology and board level). It noted how well this triangulated with the appraisal work; recruitment and retention work and will act as the mechanism for taking forwards the Shadow Board program. ▪ The Committee reviewed the previous years' corporate objectives through the board

assurance framework and agreed that these will be closed down.

- For the first time, the Committee received and considered data from the NHS National Education and Training Survey and was given verbal information to evidence that WWL were performing well.
- The Committee received the Freedom to Speak Up Guardian's Report and the audit and risk report.
- On receiving the 'fair experience for all report' the Committee noted that a three-year action plan will be developed to deliver timely, long-lasting improvement in closing the gap in disproportionate rates of disciplinary action between BAME and white colleagues into non-adverse range between 0.8-1.25.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- See above.

Committee report

Report from:	Quality and Safety Committee
Date of meeting:	12th April 2023
Chair:	Francine Thorpe

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

ALERT

- Corporate Objectives for 2022/23
  - The committee received confirmation that due to the sustained demands across the Trust during the year we have been unable to achieve objectives C01, C02, C05.
  - Partial acheivement of objective C03 was noted in terms of the expected numbers of staff trained in Human Factors and significant progress has been made in the reduction of pressure ulcers.
  - It is expected that we will achieve objective C04 in relation to the ward accreditation programme
  - Due to the timing of the committee year-end reports that provide information on the level of progress made with each objective were not available; these will be presented in June
- The Urgent and Emergency Care Governance report and the Divisional Highlight report for Medicine provided some information on actions taken as a result of learning from incidents, patient and staff feedback. However further assurance has been requested for the next meeting in relation to safety and patient experience whilst corridor care is being provided. The devleopment of Standard Operating Procedures was reported but the committee requested evidence that these are being fully implemented.

ASSURE

- An audit report was received from maternity services providing assurance that there were no lapses in care in relation to the administration of steroids during premature labour.
- The spotlight report from the Division of Medicine provided assurance that:
  - Patient safety priorities are directly aligned to STEIS (serious incidents) reportable incidents as well as patient complaints, concerns raised by staff and corporate objectives
  - High levels of compliance with the emergency department safety checklist
  - Standard Operating Procedures developed to support safe corridor care

- Evidence of shared learning through weekly bulletins
- Regular huddles (3 x daily) to deploy staff according to patient need
- Patient experience improvement priorities aligned to the themes identified through complaints analysis

- The committee received a bi-annual quality impact assessment report providing assurance of the the scrutiny given to quality impact assessments.
- Information received from the CQC Stakeholder Group and the Medicine Divisional Highlight report provided assurance of ongoing work to prepare for a CQC inspection. This included review of recent CQC reports from other organisations to identify any learning that is relevent for WWL so that appropriate action can be taken
- The corporate objectives for 2023/24 were discussed and committee members confirmed their support for the improvement plans outlined. The use of Advancing Quality (AQ) measures to track progress against sepsis and AKI were particularly welcomed.
- The Trust-wide pressure ulcer improvement plan developed in response to Mersey Internal Audit (MIA) undertaken in early 2021, has been reviewed and all actions aligned to the original themes completed. The subsequent MIAA audit undertaken in August 2022 received substantial assurance.
- The Aspire Accreditation report provided assurance that the process continues despite the organisational pressures and during quarter 3 was rolled out into community settings. A year-end report is expected at the next meeting.

ADVISE

- The Q4 Harm Free Care report highlighted:
  - An increase in Hospital Acquired Pressue Ulcers with a slight increase in lapses of care
  - A reduction in Community Acquired Pressure Ulcers with no lapses in care identified
  - A reduction in the total number of falls across the Trust, however an increase in the number of falls with moderate or above harm
  - 4 wards have achieved a full year without any reportable pressure ulcers
  - The report contunues to provide the committee with detailed information and analysis of the harm ocurring across the organisation and assurance that this is being closely monitored with improvements being targeted appropriately
- Further work continues in relation to the them of patients being lost to follow up with 2 deep dives having been undertaken in different areas. A full report is expected at the next meeting.
- Information received from the Patient Safety Group indicated that the Trust is on track in the implementaion of the new Patient Safety Incident Response Framework

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- Risks relating to the BAF for 2022/23 were discussed and potential risks for the 2023/24 corporate objectives were highlighted. These will be considered at the next meeting.
- The 3 high risks relating to potential safety issues within the ED were discussed as part of the Divisional Highlight report along with the mitigating actions being taken

Committee report

Report from:	Audit Committee
Date of meeting:	4 May 2023
Chair:	Ian Haythornthwaite

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

ALERT

▪ In the last round of internal audit reviews, the Trust received one 'limited' assurance report relating to medical e-rostering. This report has been deferred to the 19 June 2023 meeting so that the appropriate executive lead is in attendance for the discussion.
▪ The Committee raised concerns around the progress being made with outstanding audit recommendations, in particular those pertaining to private patients and overseas visitors.
▪ The Committee wishes to alert the Board that four audits will be reported later than scheduled, at either the June or September 2023/24 meeting, these are those relating to:
  ▪ Safe and timely discharge of patients
  ▪ The Global Training and Education Centre
  ▪ Safeguarding
  ▪ Patient Access System upgrade

ASSURE
▪ The Committee agreed that the safeguarding report would make reference to the prior audit report in this area, to ensure consistency in application of controls. ▪ Two internal audit reports were completed in this period, one of which was 'limited' as described above, the other was 'substantial'. ▪ The Committee received satisfactory assurance around the single tender waivers report; losses and special payments report and the counter fraud report. ▪ The Committee received the fraud risk strategy and assurance that this has now been implemented, with fraud risks now added to the organisational risk register and reviewed by Risk Management Group. ▪ The Committee received the internal audit opinion for the year which provided 'substantial' assurance. ▪ The Committee received assurance from the external auditors (KPMG) that the final accounts audit had commenced and that no issued have been identified to date.
ADVISE

- The Committee received the risk register and associated deep dives, although there was no opportunity for queries to be raised.
- The Committee received the draft annual accounts and the going concern declaration in advance of external audit and recommended these for the approval of the Board.
- It approved the changes to accounting policies.
- The Committee also received via consent:
  - Freedom to Speak Up Guardian
  - Legal services annual report
  - Register of interests
  - Minutes of reporting Committees

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- Not applicable.

Title of report:	Board Assurance Framework (BAF)
Presented to:	The Board
On:	7 June 2023
Presented by:	Director of Corporate Affairs
Prepared by:	Head of Risk Director of Corporate Affairs
Contact details:	E: paul.howard@wwl.nhs.uk

Executive summary

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

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 three financial performance risks within this report.

Legal implications

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

People implications

There are two people risks within this report.

Wider implications

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

Recommendation(s)

The Board asked to approve the risks and confirm that they are an accurate representation of the current significant risks to the delivery of the Trust's strategic objectives.

1. Introduction

1.1 Our Board Assurance Framework (BAF) provides a robust foundation to support our understanding and management of the risks that may impact the delivery of Our Strategy 2030 and the annual corporate objectives 2023/24.

1.2 The Board of Directors is responsible for reviewing the BAF to ensure that there is an appropriate spread of strategic objectives and that the main risks have been identified.

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

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

2. BAF Review

2.1 The latest assessment of the trust's key strategic risks is presented here for approval by the Board. The BAF is included in this report with detailed drill-down reports into all individual risks and integration with the 2023/24 risk appetite statement and risk scoring matrix.

2.2 **Patients:** Current risks have been reviewed and updated in line with the 2023/24 corporate objectives. The Quality and Safety Committee Meeting next meet on 14 June 2023. There are no new risks to report. All risks have been carried over from the 2022/23 BAF and aligned with the 2023/24 corporate objectives.

2.3 **People:** Current risks have been reviewed and updated in line with the 2023/24 corporate objectives. The following risks have been closed as all actions have been completed:-

2.3.1 ID3532 Person centred people management
2.3.2 ID 3287 Fairness and compassion - workforce EDI expertise and supporting infrastructure

New risks which relate to the achievement of 2023/24 corporate objectives will be considered at the next People Committee Meeting on 11 July 2023.

2.4 **Performance:** Current risks have been reviewed and updated in line with the 2023/24 corporate objectives prior to the F&P Committee meeting on 31 May 2023 and the following risks have been revised.

2.4.1 Risk ID3292 Financial Performance: Failure to meet the agreed I&E position – the likelihood risk score has been increased from unlikely (2) to possible (3) since the last Board meeting.

2.4.2 Risk ID3295 Estates Strategy - Capital Funding – the likelihood risk score has been increased from unlikely (2) to possible (3) since the last Board meeting.

2.5 **Partnership:** Current risks have been reviewed and updated in line with the 2023/24 corporate objectives and the following risk has been revised.

2.5.1 Risk ID3296 Estate Strategy - net carbon zero requirements - risk has been moved to the partnership objectives from the performance objectives in line with the 2023/24 corporate objectives.

3. New Risks Recommended for Inclusion in the BAF

3.1 No new risks have been added to the BAF since the last Board meeting in April 2023.

4. Risks Accepted and De-escalated from the BAF

4.1 ID3532 Person centred people management
4.2 ID 3287 Fairness and compassion - workforce EDI expertise and supporting infrastructure.

5. Review Date

5.1 The BAF is reviewed bi-monthly by the Board. The next review is scheduled for August 2023.

6. Recommendations

6.1 The Board are asked to:

- Approve 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:

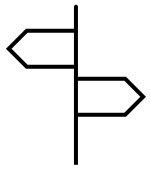
Board of Directors	April 2023
Quality and Safety Committee:	February 2023
Finance and Performance Committee:	May 2023
People Committee:	May 2023
Executive Team:	May 2023

“ **assurance** (/əˈʃɔːrəns/) *noun*

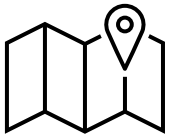
(In relation to board assurance) Providing confidence, evidence or certainty that what needs to be happening is actually happening in practice ”

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

How the Board Assurance Framework fits in

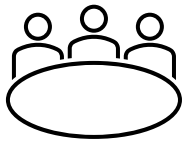


Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how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

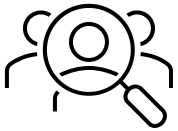


Corporate objectives: Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives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

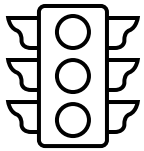
Board Assurance Framework: The board assurance framework provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains risks that are most likely to materialise and those that are likely to have the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



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



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



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

Understanding the Board Assurance Framework

RISK RATING MATRIX (LIKELIHOOD x IMPACT)

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

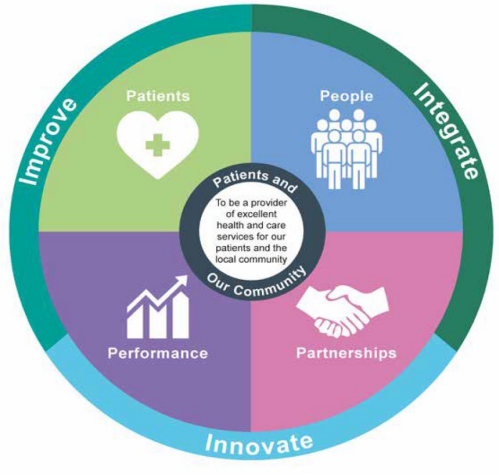
DIRECTOR LEADS

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

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

Our approach at a glance

Our Strategy 2030



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

Patients:	To be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience
People:	To ensure wellbeing and motivation at work and to minimise workplace stress
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

FY023/24 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 diabetes care for our population
- Improve the delivery of harm-free care
- Promote a strong safety culture within the organisation
- Improve the quality of care to our patients
- Listen to our patients to improve their experience

People

We will…
- Enable better access to the right people, in the right place, in the right number, at the right time
- Improve experience at work by actively listening to our people, and turning understanding into positive action
- Develop system leadership capability whilst striving for true place-based collaboration for the benefit of our people

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

Partnerships

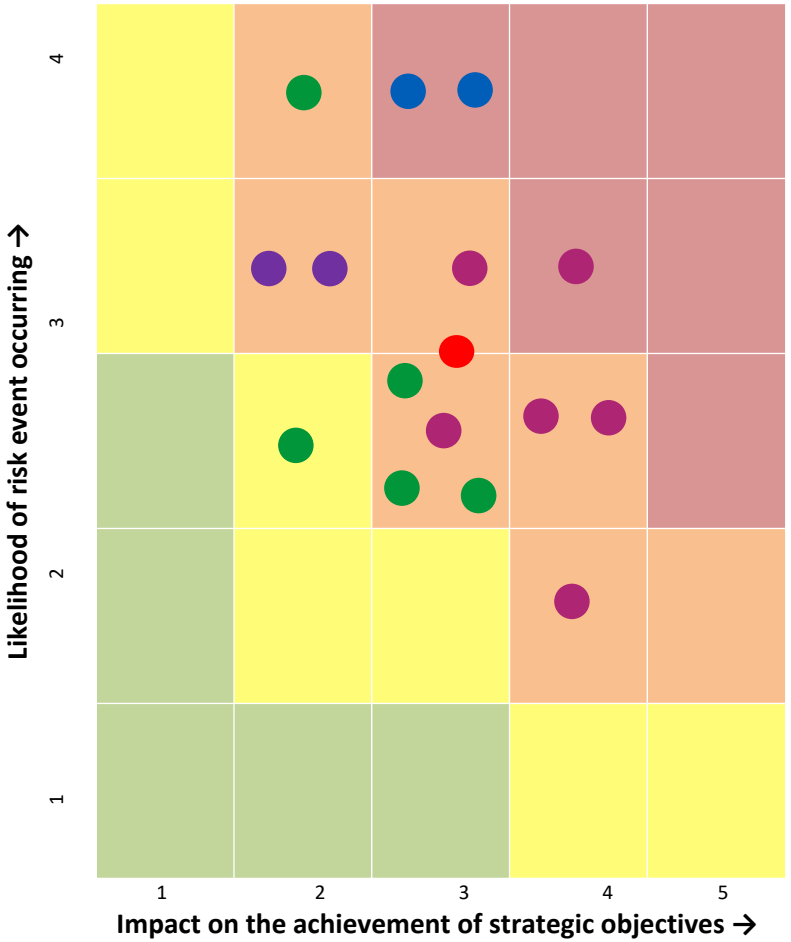
We will…
- Improve the health and wellbeing of the population we serve
- Develop effective partnerships within the new statutory environment
- Make progress towards becoming a Net Zero healthcare provider
- To increase research capacity and capability at WWL and in collaboration with EHU plan to make progress towards our ambition to be a University Teaching Hospital

Risk management

Our risk appetite position is summarised in the following table:

Risk category and link to principal objective	Threat		Opportunity	
	Optimal	Tolerable	Optimal	Tolerable
Safety, quality of services and patient experience	≤ 3 Minimal	4 - 6 Minimal	≤ 6 Cautious	8 - 10 Cautious
Data and information management	≤ 3 Minimal	4 - 6 Minimal	≤ 6 Cautious	8 - 10 Cautious
Governance and regulatory standards	≤ 3 Minimal	4 - 6 Minimal	≤ 6 Cautious	8 - 10 Cautious
Staff capacity and capability	≤ 6 Cautious	8 - 10 Cautious	≤ 8 Open	≤ 12 Open
Staff experience	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 15 Eager
Staff wellbeing	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 15 Eager
Estates management	≤ 6 Cautious	8 - 10 Cautious	≤ 8 Open	≤ 12 Open
Financial Duties	≤ 3 Minimal	4 - 6 Minimal	≤ 6 Cautious	8 - 10 Cautious
Performance Targets	≤ 6 Cautious	8 - 10 Cautious	≤ 8 Open	≤ 12 Open
Sustainability / Net Zero	≤ 6 Cautious	8 - 10 Cautious	≤ 8 Open	≤ 12 Open
Technology	≤ 6 Cautious	8 - 10 Cautious	≤ 8 Open	≤ 12 Open
Adverse publicity	≤ 3 Minimal	4 - 6 Minimal	≤ 6 Cautious	8 - 10 Cautious
Contracts and demands	≤ 3 Minimal	4 - 6 Minimal	≤ 6 Cautious	8 - 10 Cautious
Strategy	≤ 6 Cautious	8 - 10 Cautious	≤ 8 Open	≤ 12 Open
Transformation	≤ 6 Cautious	8 - 10 Cautious	≤ 15 Eager	≤ 15 Eager

The heat map below shows the distribution of all 15 strategic risks based on their current scores:



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

Patients

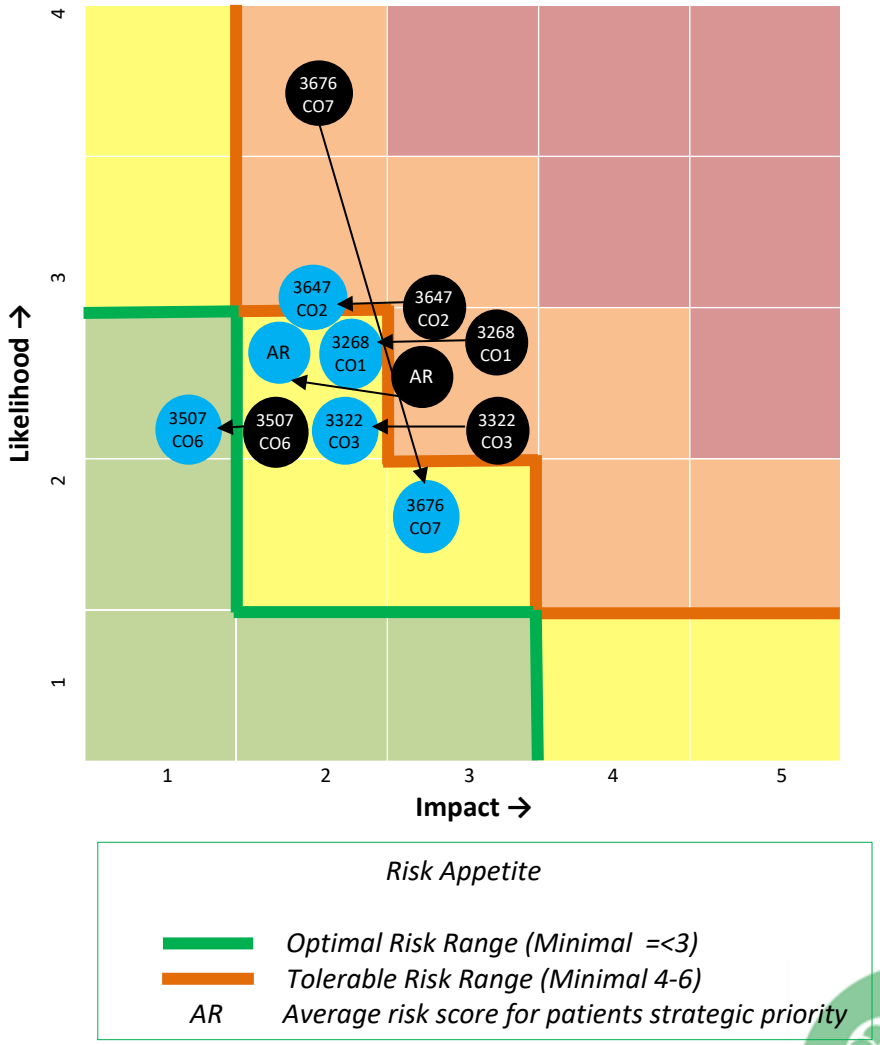
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

Monitoring: Quality and Safety Committee

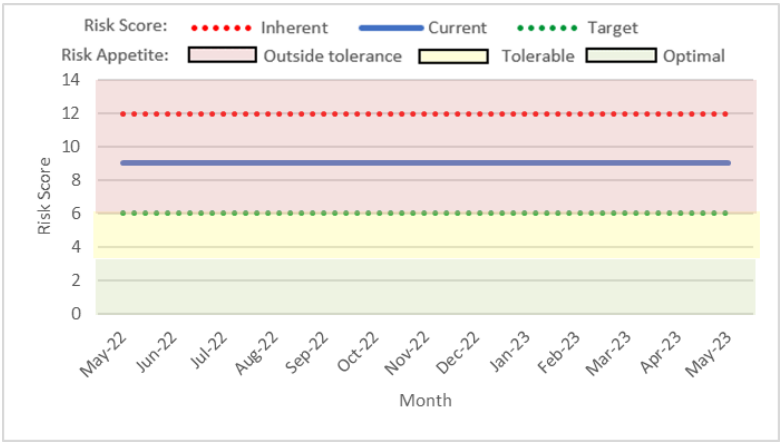
The following corporate objectives are aligned to the **patients** strategic priority:

Ref.	Purpose of the objective	Scope and focus of objective
CO1	To improve the safety and quality of clinical services	To improve the compliance of Sepsis-6 care bundle as per Advancing Quality Audit, with aim to reduce mortality from sepsis.
CO2	To ensure patients and their families receive personalised care in the last days of life	To reduce the number of patients admitted to the hospital on an end of life pathway, through enhancing and expanding the excellent end of life care provided by the District Nursing team (current audit shows that 89% of all patients referred to the team die at home or in hospice).
CO3	To improve diabetes care for our population	Work with our partners across primary care to deliver the diabetes transformation programme.
CO4	To improve the delivery of harm-free care	Continue improvements Pressure Ulcer Reduction. System Wide improvement for reducing pressure ulcers.
CO5	To promote a strong safety culture within the organisation	Continue to strengthen a patient safety culture through embedding Human Factor awareness. Continue to increase staff psychological safety.
CO6	To improve the quality of care for our patients	Continue and build upon the accreditation programme and to include escalated areas within ED.
CO7	Listening to our patients to improve their experience	Deliver timely and high quality responses to concerns raised by patients, friends and families.

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

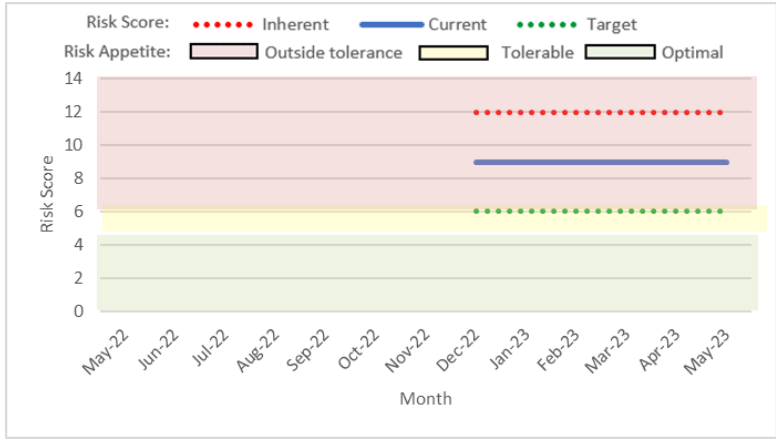


Corporate Objective: **CO1** To improve the safety and quality of clinical services							**Overall Assurance level**	**Low**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 1: Clinical Services - Recognition, screening and treatment of the deteriorating patient**						
	Risk Statement:	There is a risk that patients who are deteriorating are not appropriately clinically escalated due to non-identification of sepsis, AKI or baseline observations resulting in mortality related to sepsis and AKI.						
Lead Committee	**Quality and Safety**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal	
Lead Director	**MD**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Safety, quality of services & patient exp.	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	3270	
Date of last review	**12.04.23**	**Risk Rating**	12. High	9. High	6. Moderate	**Risk treatment**	Treat	



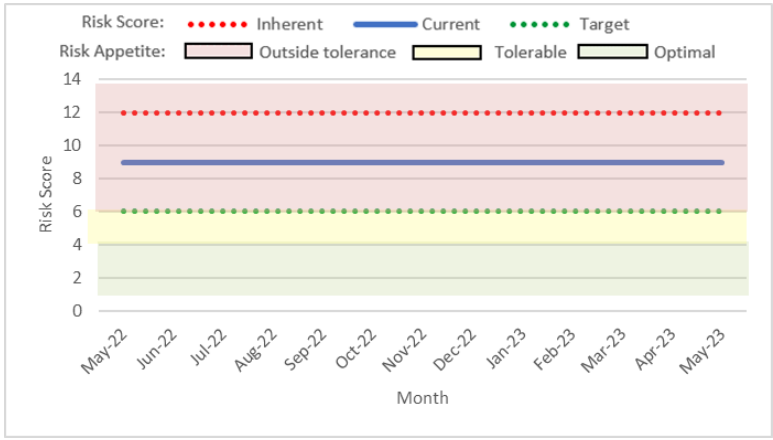
Strategic Opportunity / Threat Linked Risk	Existing controls	Gaps in existing controls	Assurances (and date last seen)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3268)** 3270 – Consultant cross cover from SRFT for AKI service	• Rapid Improvement Group. • Sepsis QI group. • Sepsis Improvement Plan. • Sepsis live in HIS. • Visibility of AKI and Sepsis Nurse in clinical areas • AKI and sepsis audits undertaken. • Themed SIRI panel on sepsis focused on improvement work and highlighted achievements to date. • Improved AKI pathways to ensure that there is no avoidable harm caused by WWL.	• Workload demands for AKI and Sepsis nurses. • AKI Improvement Plan needs to be developed.	**2nd Line:** • Quality & Safety Committee April 2023.	• No gaps currently identified	1. Deteriorating Patient Improvement Group continues to meet monthly.	Monthly

Corporate Objective: **CO2** To ensure patients and their families receive personalised care in the last days of life							**Overall Assurance level**	**Medium**
Principal risk	**Risk Title:**	**PR 2: Preferred Place of Death**						
	Risk Statement:	There is a risk that a high proportion of our patients may not die in their preferred place of death, due to lack of community resources and increased operational pressures across all teams, resulting in patients and families not receiving their preferred personalised care in the last days of life.						
Lead Committee	**Quality and Safety**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal	
Lead Director	**MD**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Safety, quality of services & patient exp.	
Date risk opened	**13.12.22**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	-	
Date of last review	**12.04.23**	**Risk Rating**	12. High	9. High	6. Moderate	**Risk treatment**	Treat	



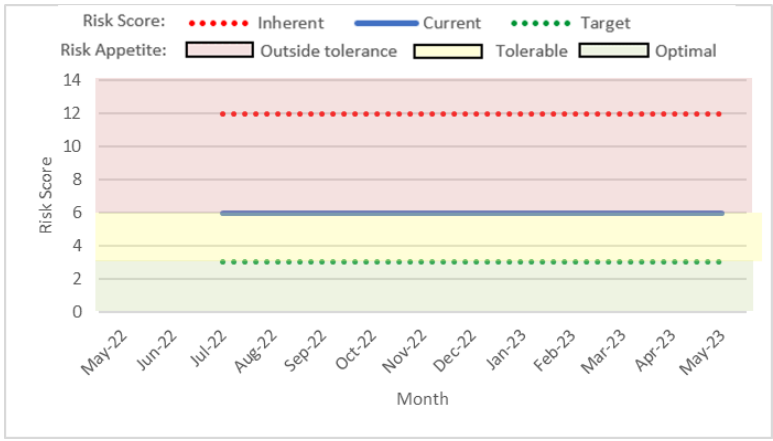
Opportunity / Threat	**Existing controls**	**Gaps in existing controls**	**Assurances (and date last seen)**	**Gap in assurances**	**Risk Treatment**	**Due Date / By Whom**
Threat: **ID 3647**	• Dedicated Palliative Care Hospital team, consisting of clinical and nursing staff and dedicated palliative care lead for community • GM link now live on HIS identifying patients with an advance care directive • Weekly deaths audits which will identify areas of concern • Multi-professional mortality meetings which will address any immediate concerns/learning • Working Group (Acute Trust, Community, Hospice and Primary Care) meeting. • Electronic Palliative Care Co-ordination System (EPaCCS) -this includes detail of preferred place of death and prognosis and available within the Community/Acute and Hospice • Single Point of Access base in the Hospice. Wrap around end-of-life care to support patients and families to remain in their own home • Baseline audit has indicated that when a preferred place of death was listed as home 92% died at home and 8% in hospital. If there was no listed preferred place of death it was 77% died at home and 23% in hospital.	• Lack of community resources • Night support for End-of-Life Patients dying at home • Delays in commencing package of care for patients requesting dying at home (ongoing work to develop pathway for dying patients with better at home) • Increased operational pressures across all teams • Recovery phase following COVID	**2nd Line:** • Working Group (Acute Trust, Community, Hospice and Primary Care) meeting. • Quality & Safety Committee April 2023.	• Progression of working group • Additional audit to be commissioned looking at the appropriate use of EPaCCS to be completed by Community Palliative Care Lead • Some patients are reluctant to discuss preferred place of death and therefore this information is not available for healthcare professionals at EOL stage • If full wraparound care not available then families may not be able to support patient at home	1. Quarterly Mortality Group chaired by the Medical Director	Monthly

Corporate Objective: **CO3** To improve the delivery of harm-free care								**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 3: Harm Free Care - Avoidable Pressure ulcers**							
	Risk Statement:	There is a risk that our systems and processes, coupled with challenged staffing, may not facilitate the swift identification of potentially avoidable pressure ulcers resulting in harm to our patients.							
Lead Committee	**Quality and Safety**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal		
Lead Director	**CN**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Safety, quality of services & patient exp.		
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	3323		
Date of last review	**12.04.23**	**Risk Rating**	12. High	9. High	6. Moderate	**Risk treatment**	Treat		



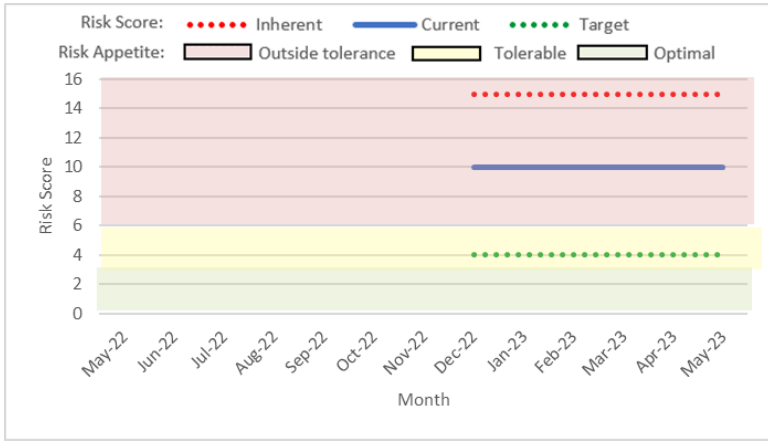
Strategic Opportunity / Threat Linked risk	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3322)** 3323 – Tissue viability team capacity	• Pressure ulcer link nurses trained within areas. • Introduced human factors training with over 330 staff trained so far. • Grade 2/DTI Pressure ulcer Panels in place. • Grade 3/4 & Unstageable Pressure ulcer panels in place. • New pressure ulcer rapid Review template launched for pressure ulcers. • New Pressure ulcer policy and procedure. • Datix improvements started to better capture pressure ulcer management. • Reduced number of pressure ulcers identified as lapses in care by WWL.	• Staff being able to be released to undergo training. • Junior workforce. • Investigation of developed ulcers are not investigated to a level to allow for full identification of learning. • Equipment issues. • Beds owned by individual Divisions. • Under resourcing of Tissue Viability Team.	**2nd Line:** • Quality & Safety Committee April 2023	• No gaps currently identified.	1. Continue to accurately record NEWS, PEWS and MEWS. 2. Continue the roll out of human factor training.	June 2023 CN June 2023 CN

Corporate Objective: **CO6** To improve the quality of care for our patients								**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 4: Ward accreditation programme**							
	Risk Statement:	There is a risk that silver accreditation levels may not be achieved, due to operational pressures affecting the supernumerary status of ward leaders and the single person service having paper based scoring and reporting, resulting in a reduction in the speed of the roll out.							
Lead Committee	**Quality and Safety**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal		
Lead Director	**CN**	**Likelihood**	4. Likely	2. Unlikely	1. Rare	**Risk category**	Safety, quality of services & patient exp.		
Date risk opened	**20.07.22**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	-		
Date of last review	**12.04.23**	**Risk Rating**	12. High	6. Moderate	3. Low	**Risk treatment**	Treat		



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3507)**	• Introduced the ASPIRE ward accreditation programme and have already accredited 6 wards as SILVER status.	• Accreditation project plan to be developed.	**2nd Line:** • Quality & Safety Committee April 2023	**2nd Line:** • Project plan to go to NMAHP, NMALT and new Quality Assurance Group.	1. Accreditation project plan to be developed by Clinical Quality Lead and service transformation lead.	June 2023 CN

Corporate Objective: **CO7** Listening to our patients to improve their experience								**Overall Assurance level**	**Low**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 5: Complaint response rates**							
	Risk Statement:	There is a risk that complaints received may not be responded to and acted upon within our agreed timeframes, due to operational pressures and COVID backlog resulting in missed targets, unresolved complaints and adverse publicity.							
Lead Committee	**Quality and Safety**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal		
Lead Director	**CN**	**Likelihood**	5. Almost certain	5. Almost certain	2. Unlikely	**Risk category**	Safety, quality of services & patient exp.		
Date risk opened	**24.01.23**	**Impact**	3. Moderate	2. Minor	2. Minor	**Linked risks**	-		
Date of last review	**12.04.23**	**Risk Rating**	15. Significant	10. High	4. Moderate	**Risk treatment**	Treat		



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3676)**	• Complaints SOP in place with defined roles, processes and timescales. • How to respond to a complaint training is being delivered with further sessions planned. • Patient relations team provide support and guidance.	• Releasing staff to attend training.	**2nd Line:** • Quality & Safety Committee April 2023	**2nd Line:** • No gaps currently identified.	1. Complaints backlog to be addressed. 2. Further training for staff to be arranged with staff given time to attend the training.	June 2023 CN June 2023 CN

People

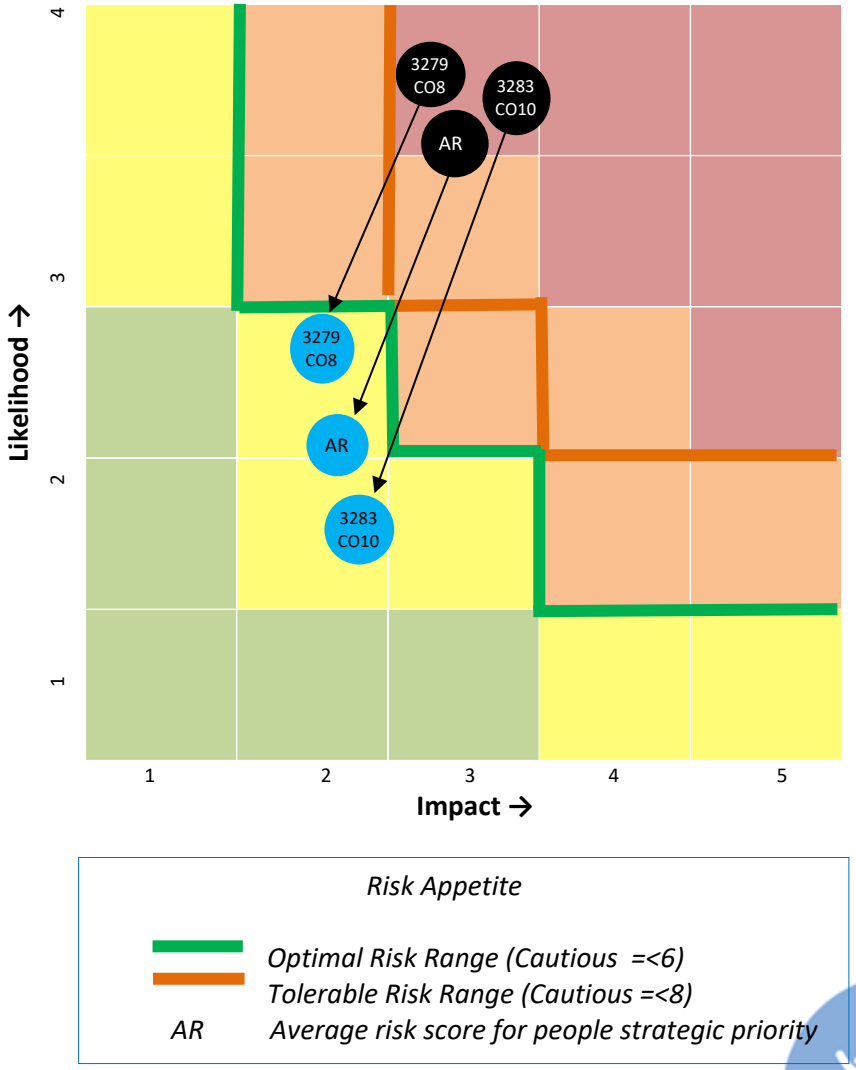
To ensure wellbeing and motivation at work and to minimise workplace stress.

Monitoring: People Committee

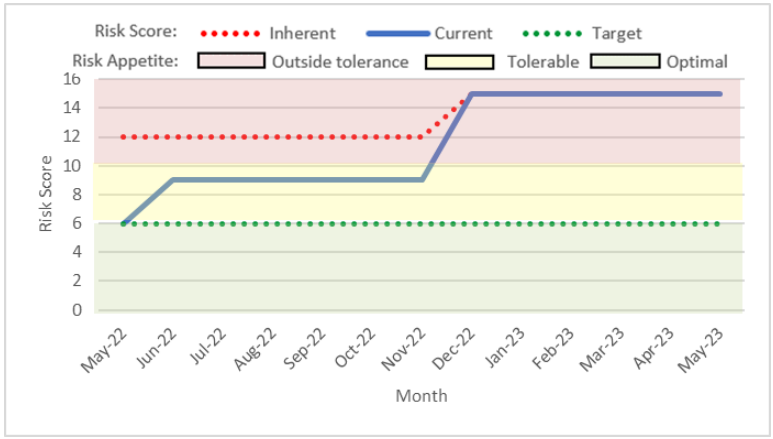
The following corporate objectives are aligned to the **people** strategic priority:

Ref.	Purpose of the objective	Scope and focus of objective
CO8	To enable better access to the right people, in the right place, in the right number, at the right time.	As part of our workforce sustainability agenda we will deliver the HR fundamentals brilliantly to: ✓ Reduce sickness absence from 6.58% to 5% ✓ Reduce vacancy rate from 6.85% ✓ Improve time to hire ✓ Reduce employee relations cases ✓ Improve employee relations timeline
CO9	To ensure we improve experience at work by actively listening to our people and turning understanding into positive action.	As part of Our Family, Our Future, Our Focus cultural development we will: ✓ Continue to prioritise our staff voice ✓ Co design our just and learning culture ✓ Improve the quality of meaningful conversations with our people ✓ Create an inclusive, person centred experience ✓ Showcase how we are acting on concerns raised by staff and patients
CO10	To develop system leadership capability whilst striving for true placed collaboration for the benefit of our people.	The WWL leadership community will baseline where we are now, map where we wish to be, and bridge the gap to focus our collective effort: We will regularly participate in leadership development events so that we: ✓ Continue to develop inclusive and compassionate leadership capability ✓ Achieve higher levels of mutual trust and respect ✓ Reduce demand by empowering our colleagues to improve the discharge & patient flow for our residents

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

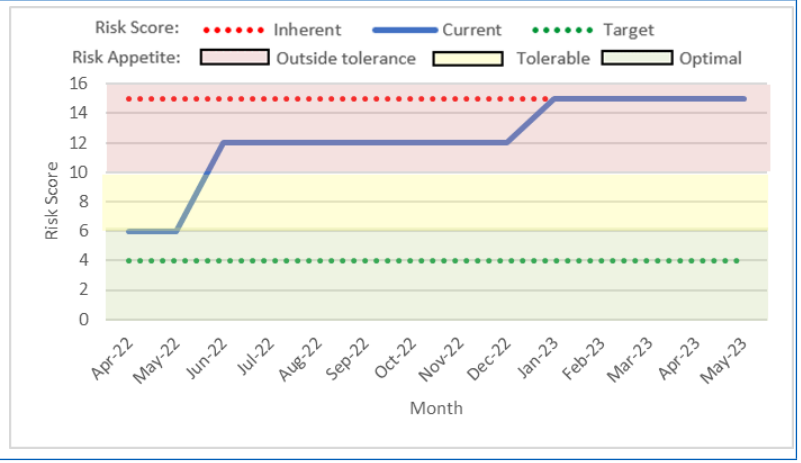


Corporate Objective: CO8 To enable better access to the right people, in the right place, in the right number, at the right time							**Overall Assurance Level**	**Low**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 6: Participation in preventative and restorative wellbeing activities**						
	Risk Statement:	There is a risk that sufficient time may not be available for staff to participate in preventative and restorative wellbeing activities within working hours, due to workload pressures and vacancies, resulting in lower engagement levels and evidence suggests this will reduce the success of the programme.						
Lead Committee	**People**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**CPO**	**Likelihood**	5. Almost certain	5. Almost certain	2. Unlikely	**Risk category**	Staff Wellbeing	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	-	
Date of last review	**03.03.23**	**Risk Rating**	15. Significant	15. Significant	6. Moderate	**Risk treatment**	Treat	



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **ID 3279**	• Your Voice Survey – well-being score. • Steps 4 Wellness Service enhancements. • Targeted in-reach activities in high-risk areas. • Wellbeing walkabouts. • Re-prioritisation and amendment of offers. • Strategic needs assessment completed. • Divisional wellbeing plans	• Commitment to roster time for people to be released as needed. • Recruitment & retention update (People Committee October 2022 and January 2023) • Increasing operational pressures impacting on release	**2nd Line:** • All staff Team Brief session (July 2022) • Team stress management pilot completion (evaluation at People Committee September) • Well-being update (staff engagement steering group September 2022) • Divisional well-being plan pilot completed in Medicine (November) – roll out to other Divisions commences w/c 21/11 • Divisional assurance meetings (October & November) sickness absence levels • People dashboard (ETM) and Our FFF (November) – issues of turnover in Band 2/3 roles associated with working conditions and pay level competition – deep dive using Guardian Service and task & finish group • Safe staffing report (Q&S & ETM – November / December 2022)	None identified.	1. Recruitment to B5 Nursing & HCA vacancies (including international recruitment) – performance against trajectory. 2. Staffing levels must reflect the acuity and flow of patients – biannual staffing review (to be extended to cover all clinical staff groups)	1.March 2024 - Consultant clinical Psychologist 2. March 2024 – CNO & MD

Corporate Objective: CO10 To develop system leadership capability whilst striving for true placed collaboration for the benefit of our people.							**Overall Assurance Level**	**Low**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 7: Personal Development**						
	Risk Statement:	There is a risk that the prioritised learning needs analysis cannot be delivered due to funding constraints and / or inability to release staff for training, resulting in increased turnover and / or a lack of continued professional development for colleagues.						
Lead Committee	**People**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**CPO**	**Likelihood**	5. Almost Certain	5. Almost Certain	2. Unlikely	**Risk category**	Staff Capacity & Capability	
Date risk opened	**19.10.21**	**Impact**	3. Moderat	3. Moderate	2. Minor	**Linked risks**	-	
Date of last review	**03.03.23**	**Risk Rating**	15. Significant	15. Significant	4. Moderate	**Risk treatment**	Treat	



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **ID 3283**	• Full LNA completed and prioritised. • Mandatory and job specific training requirements reviewed and updated. • Agreed principles of apprenticeship and HEE funding allocations first.	• Ability to roll forward HEE funding allocations. • Ability to release staff due to vacancies / workload pressures. • Recurrent budget for training & development aligned to LNA.	**2nd Line:** • ETM review and in principle (LNA and apprenticeship plan) – May 2022 • People Committee report – June 2022 • HEE CPD investment schedule (Education Governance -July) • 2022/23 LNA business case (ETM September) • Funded training opportunities overseen at Education Governance Committee	None identified.	1. Business case paused and will review in March 2024. 2. Benchmarking review of nurse staffing establishment uplift to cover time for training. 3. Recurrent budget setting principles to be agreed as part of annual business planning round. This is linked to business case. 4. Bi-annual staffing review and matching patient acuity / flow with staffing establishment	1. March 2024 2.TBC – CNO 3. March 2024 4. March 2024– CNO

Performance

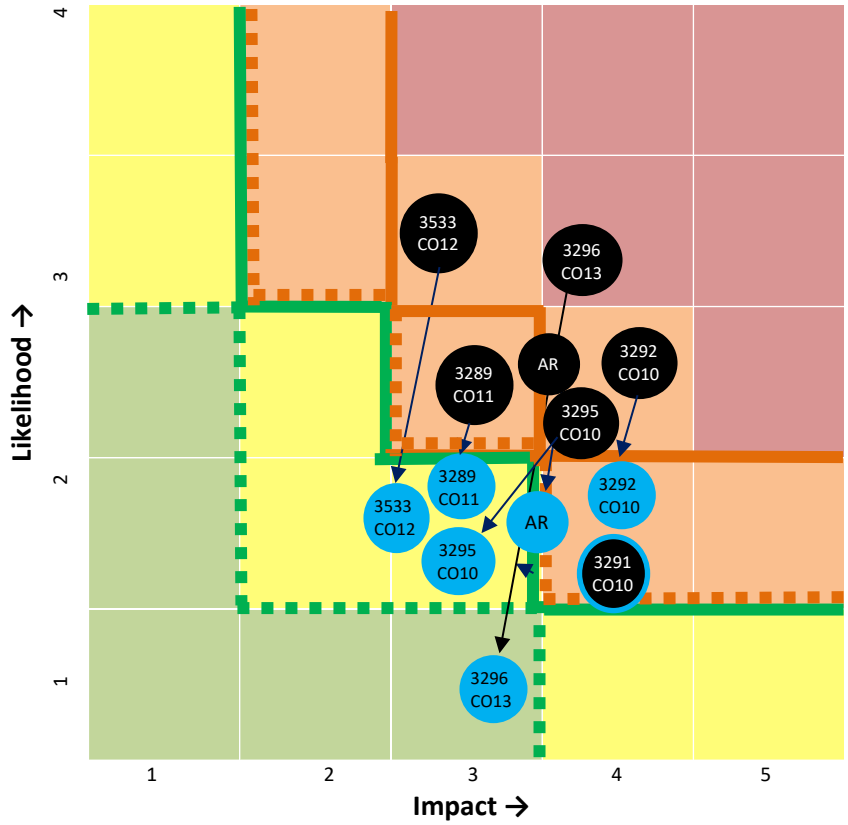
Our ambition is to consistently deliver efficient, effective and equitable patient care

Monitoring: Finance and Performance Committee

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

Ref.	Purpose of the objective	Scope and focus of objective
CO11	To deliver our financial plan, providing value for money services	✓ Delivery of the agreed capital and revenue plans for 2023/24. ✓ Proactive development of a long term sustainable financial strategy focused on positive value and success within a financially constrained environment.
CO12	To minimise harm to patients through delivery of our elective recovery plan	✓ Delivery of more elective care to reduce elective backlog, long waits and improve performance against cancer waiting times standards, working in partnership with providers across Greater Manchester to maximise our collective assets and ensure equity of access and with locality partners to manage demand effectively.
CO13	To improve the responsiveness of urgent and emergency care	✓ Working with our partners across the Borough, we will continue reforms to community and urgent and emergency care to deliver safe, high-quality care by preventing inappropriate attendance at EDs, improving timely admission to hospital for ED patients and reducing length of stay. ✓ We will work collaboratively with partners to keep people independent at home, through developing and expanding new models of care, making use of technology where appropriate (e.g. virtual wards) and ensuring sufficient community capacity is in place.

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



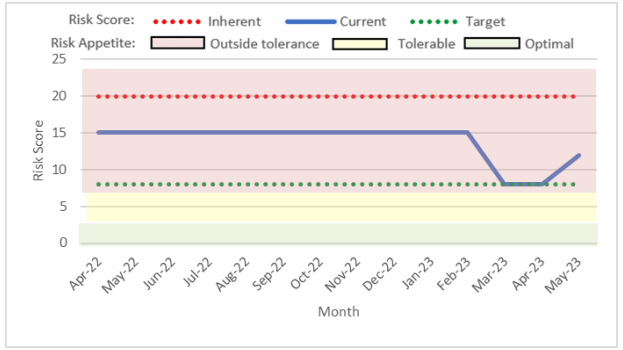
Risk Appetite

Optimal Risk Range (Financial Duties: Minimal ≤ 3) (Other: Cautious ≤ 6)

Tolerable Risk Range (Financial Duties: Minimal 4-6) (Other: Cautious 8-10)

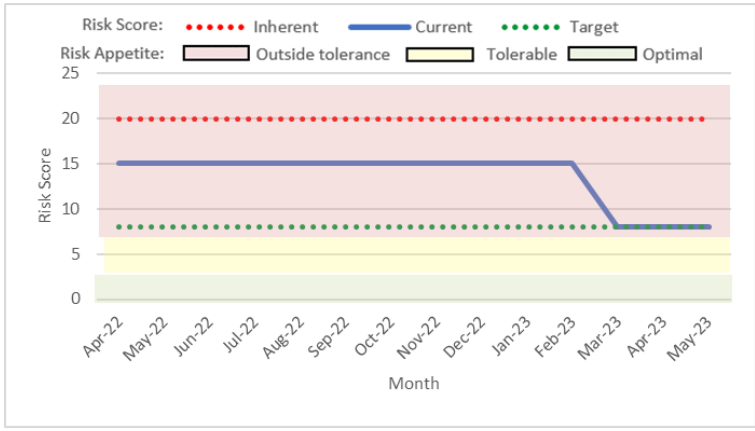
AR — *Average risk score for performance strategic priority*

Corporate Objective: **C10** Deliver our financial plan, providing value for money services							**Overall Assurance level**	**High**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 8: Financial Performance: Failure to meet the agreed I&E position**						
	Risk Statement:	There is a risk that the Trust may fail to fully mitigate in year pressures to deliver key finance statutory duties resulting in the Trust receiving significantly less income than the previous financial year.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current**	**Target Risk**	**Risk Tolerance**	Minimal	
Lead Director	**CFO**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Financial Duties	
Date risk opened	**19.10.21**	**Impact**	5. Critical	4. Major	4. Major	**Linked risks**	-	
Date of last review	**17.05.23**	**Risk Rating**	20. Significant	12. High	8. High	**Risk treatment**	Treat	



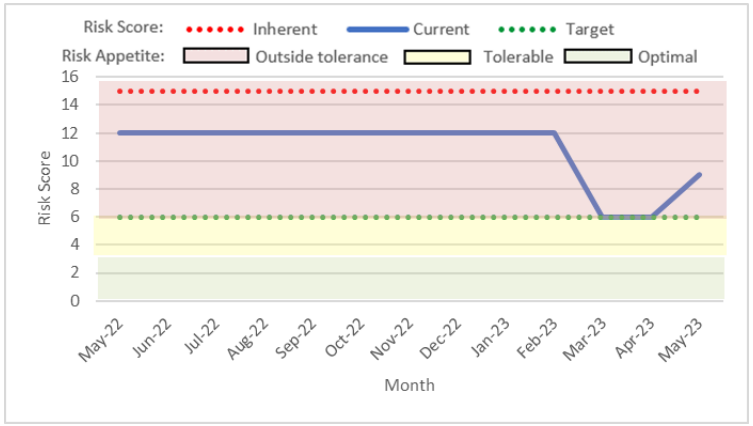
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3292)**	• Final plan signed off by Board and submitted to NHSEI – 4th May 23 • All divisions accepted budgets in April 23 • CIP target agreed with programme for delivery and actions. • Continued lobbying via Greater Manchester in respect of additional funding which is appropriate for current clinical capacity and operational and inflationary pressures (Ext.) • Robust forecasting including scenario planning for worst, most likely and best case. • Executive oversight and challenge of CIP & Financial performance through RAPID, Transformation Board & Divisional Assurance Meeting • Pay control group established with scrutiny and rigour over agency spend in line with national agency controls. • Stringent business case criteria to ensure only business critical investments are approved. • Escalation meeting held with NHSE in April 23 to review financial plan • Full review of financial position by locality partners • RAPID meetings held for all divisions in April • Additional funding agreed to cover escalation costs in first half of 2023/24 • Escalation reduction plan agreed through ETM • PWC concluded diagnostic into the drivers of financial and operational performance and key actions being progressed	• System and locality reporting in infancy • No additional funding available for NRTR, additional beds and escalation in H2. • No additional funding expected to cover increased costs associated with industrial action. • No medium to long term resource confirmation or financial planning	**1st Line:** Monthly RAPID meetings for applicable divisions **2nd Line:** Finance & Performance Committee May 23	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Locality discussions ongoing around reducing escalation costs over H1 23/24 2. GM System PMO established to support delivery of I&E position	Sept 23/ CFO Mar 24/ CFO

Corporate Objective: **C10** Deliver our financial plan, providing value for money services							**Overall Assurance level**	**High**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 9: Financial Sustainability: Efficiency targets & Balance Sheet**						
	Risk Statement:	There is a risk that efficiency targets will not be achieved, resulting in a significant overspend and that there is insufficient balance sheet flexibility, including cash balances, to mitigate financial problems.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current**	**Target Risk**	**Risk Tolerance**	Minimal	
Lead Director	**CFO**	**Likelihood**	4. Likely	2. Unlikely	2. Unlikely	**Risk category**	Financial Duties	
Date risk opened	**19.10.21**	**Impact**	5. Critical	4. Major	4. Major	**Linked risks**	-	
Date of last review	**17.05.23**	**Risk Rating**	20. Significant	8. High	8. High	**Risk treatment**	Treat	



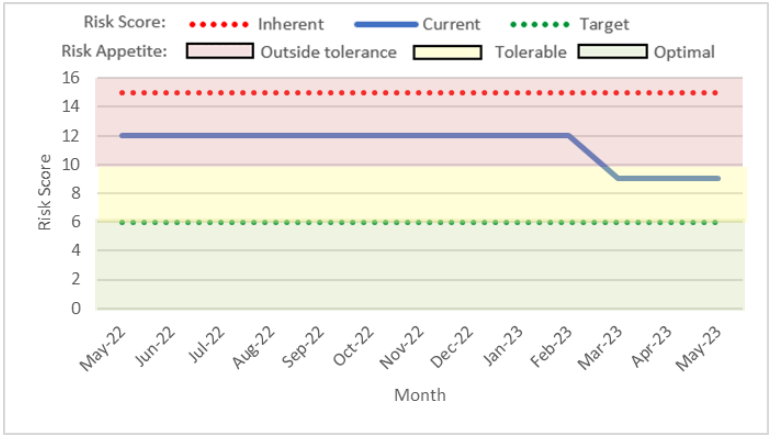
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3291)**	• Robust CIP delivery approach and governance. • Monitored via Divisional Assurance Meetings, with additional escalation through RAPID if Divisional delivery is off plan. • Further oversight at Executive Team, Transformation Board, F&P Committee and Board of Directors. • Work is ongoing across the GM system on developing a joint approach to productivity and cross cutting efficiency (Ext). • Transformation Board input & oversight of strategic programmes. • Effective credit control including monitoring debtor and creditor days and liquidity with oversight through SFT. • Effective monthly cash flow forecasting reviewed through SFT. • RAPID recovery metrics include recurrent CIP delivery.	• Limited mechanisms to facilitate delivery of system wide savings. • GM system efficiency requirement with no plan • Unidentified divisional CIP 16% in year and 13% recurrently • GM Cash Management Strategy not yet developed (Ext)	**1st Line:** Monthly RAPID meetings for applicable divisions **2nd Line:** Finance & Performance Committee May 2023	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Monthly updates on CIP presented to Executive Team, with regular updates to Divisional Teams. 2. Engagement in GM Efficiency Programme work including productivity workstream co-chaired by WWL Deputy CEO (Ext)	Throughout 2023/24 CFO/DCEO Throughout 2023/24 CFO/DCEO

Corporate Objective: C10 Deliver our financial plan, providing value for money services							**Overall Assurance level**	**High**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 10: Estates Strategy - Capital Funding**						
	Risk Statement:	There is a risk that there is inadequate capital funding to enable priority schemes to progress. Due to uncertainties around capital funding arrangements the strategy may assume that more investment can be made than is available.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal	
Lead Director	**CFO**	**Likelihood**	3. Possible	3. Possible	2. Unlikely	**Risk category**	Financial Duties	
Date risk opened	**19.10.21**	**Impact**	5. Critical	3. Moderate	3. Moderate	**Linked risks**	-	
Date of last review	**17.05.23**	**Risk Rating**	15. Significant	9. High	6. Moderate	**Risk treatment**	Treat	



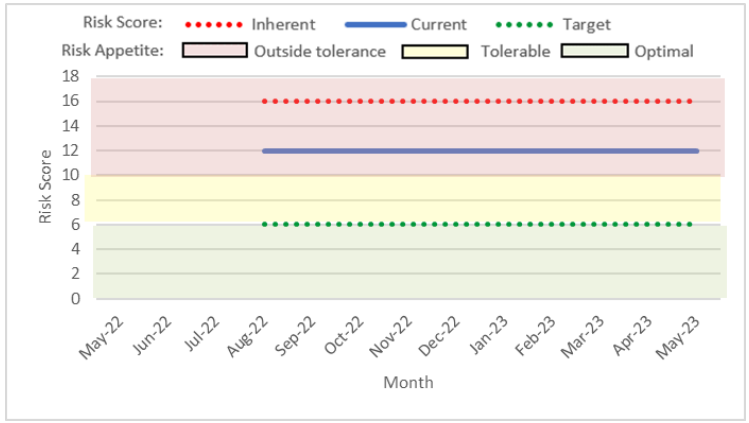
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3295)**	• Lobbying via Greater Manchester (Ext) • Capital Priorities agreed by Executive Team & Trust Board. • Cash for Capital investments identified. • Reprioritisation of additional capital schemes to ensure the capital programme is reflective of organisational priorities. • 3 year capital allocations available to inform more longer term system planning. • Strategic capital group established with oversight of full capital programme. • Operational capital group established to manage the detailed programme • Attendance at GM capital leads group (Ext) • Programme Boards established for major capital schemes. • Work ongoing to bid for additional PDC funding	• Impact of cost of living rise in terms of project costs and timescales • GM overcommitment on CDEL plan with no confirmation on how schemes will be prioritised	**1st Line:** Monthly Capital Strategy Group **2nd Line:** Finance & Performance Committee - May 2023	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Close monitoring of Capital spend in line with trajectory 2. Development of capital reporting through the refreshed DFM App	Throughout 2023 CFO Q2 2023/24 CFO

Corporate Objective: **CO12** To minimise harm to patients through delivery of our elective recovery plan								**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 11: Elective services**							
	Risk Statement:	There is a risk that demand for elective care may increase beyond the Trust's capacity to treat patients in a timely manner, due to demand management schemes not resulting in a reduction in demand, patients not visible on waiting lists and insufficient diagnostic capacity to deliver elective waiting times, resulting in potentially poor patient experience, deteriorating health, more severe illness and late cancer diagnosis.							
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious		
Lead Director	**DCE**	**Likelihood**	5.Almost Certain	3. Possible	2. Unlikely	**Risk category**	Performance Targets		
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks IDs**	3572, 3718		
Date of last review	**17.05.23**	**Risk Rating**	15. Significant	9. High	6. Moderate	**Risk treatment**	Treat		



Opportunity / Threat Linked Risks	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3289)** **3572** Industrial action 3718 Elective Recovery	• Divisions have signed off activity plans. • Monitor through divisional assurance meetings with clear escalation protocols to exec team meetings and F&P Committee - developed into an app. • Transformation Plan - elective productivity and capacity aims to increase diagnostics and support delivery of electives and develop elective capacity. • Providing and receiving mutual support from GM and region for high volume high complexity work. • WWL to receive complex orthopaedic work.	• Issues with national choose and book system. Significant patients waiting over 78 weeks. External factors influence delivery of this objective. • Risk patients are not visible on waiting list resulting in patients waiting who can't be treated on time. • Demand for patients on cancer pathways exceeds capacity and impacts on delivery of non-cancer elective work. • Diagnostic capacity insufficient to deliver elective waiting times. • Reduce follow ups. • DNAs. • Increase productivity to meet organisational targets	**2nd Line:** • Integrated performance report through Finance & Performance Committee.	•No gaps in assurance	1. Implementation of Transformation Programme	March 2024 DCE

Corporate Objective: CO13 Improve the responsiveness of urgent and emergency care							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic	**Risk Title:**	**PR 12: Urgent and Emergency Care**						
	Risk Statement:	There is a risk to urgent and emergency care delivery, due to insufficient capacity, resulting in the number of no right to reside patients substantially increasing, lack of capacity, longer waits, delayed ambulances, reduced patient flow and more scrutiny through NHS England.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current**	**Target Risk**	**Risk Tolerance**	Cautious	
Lead Director	**DCE**	**Likelihood**	4. Likely	4. Likely	2. Unlikely	**Risk category**	Performance Targets	
Date risk opened	**05.09.22**	**Impact**	4. Major	3. Moderate	3. Moderate	**Linked risks IDs**	3423	
Date of last review	**17.05.23**	**Risk Rating**	16. Significant	12. High	6. Moderate	**Risk treatment**	Treat	



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3533)** **3423** ED – Increase in attendances and insufficient patient flow	• **2 Programmes of work:** - **WWL Transformation Plan 2023/24** - **Healthier Wigan Partnership – discharge and flow priority.** • Virtual hub optimisation • SDEC – Medical and frailty • Ward improvement • Management of care beds • Aligned Wigan borough programmes. • Integrated delivery board – operational arm • Delivery of independence team through transfer of care hubs. • Mental Health alternations to Emergency Department. • New model of care for community beds. • Closure of escalated areas. • Timeliness of discharges. • Out of hospital programme of work, alternative delivery of models of care. Creating the right circumstances where more patients go home with support. • Intermediate care home. More packages of care – less reliant on nursing and care home sector. • Tier 1 NHS England – internal/external programme.	•Insufficient capacity •Number of no rights to reside patients. •Work required further upstream regarding higher acuity of patients in borough.	**2nd Line:** • Integrated performance report through Finance & Performance Committee	•No gaps in assurance	1. Work closely with colleagues in Wigan locality to progress WWL Transformation Plan and Discharge and flow priority.	March 2024 DCE

Partnerships

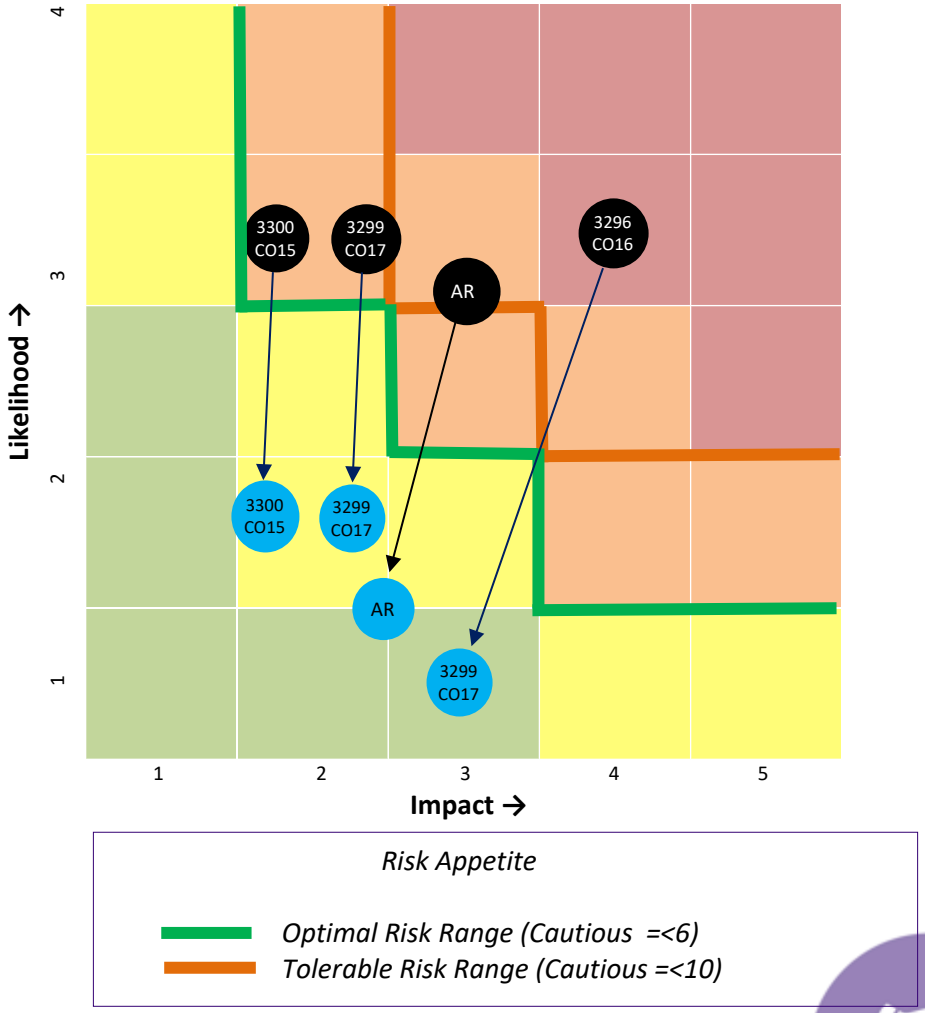
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

Monitoring: Board of Directors

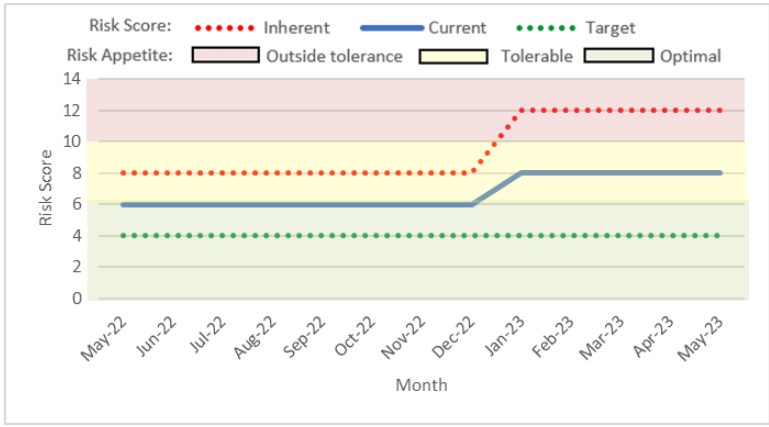
The following objectives are aligned to the **partnerships** strategic priority:

Ref.	Purpose of the objective	Scope and focus of objective
CO14	To improve the health and wellbeing of the population we serve	✓ As an Anchor institution we will work with partners to improve the health of the whole population we serve, supporting development of a thriving local economy and reducing health inequalities.
CO15	To develop effective partnerships within the new statutory environment	✓ Develop effective relationships across the Wigan locality and the wider Greater Manchester Integrated Care Board, supporting delivery of our other corporate objectives. ✓ We will ensure that the effectiveness of our diabetic, children & young people and urgent and emergency care services are considered and acted upon in line with the locality transformation programmes.
CO16	To make progress towards becoming a Net Zero healthcare provider	✓ Specific focus to be refined based on deliverables (yet to be agreed) for 2023/24.
CO17	To increase research capacity and capability at WWL in collaboration with EHU with a plan to make progress towards our ambition to be a University Teaching Hospital	✓ Continuation of this three to five year strategic objective to: ✓ Increase the NIHR Research Capability Funding to achieve an average of £200k/annum over 2 years in Year 4 and Year 5. ✓ Progress joint clinical academic appointments between WWl amd EHU to help meet the requirements of the University Hospitals Association i.e. achieving a minimum of 6% of the consultant workforce with substantive contracts of employment with EHU by Year 5.)

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

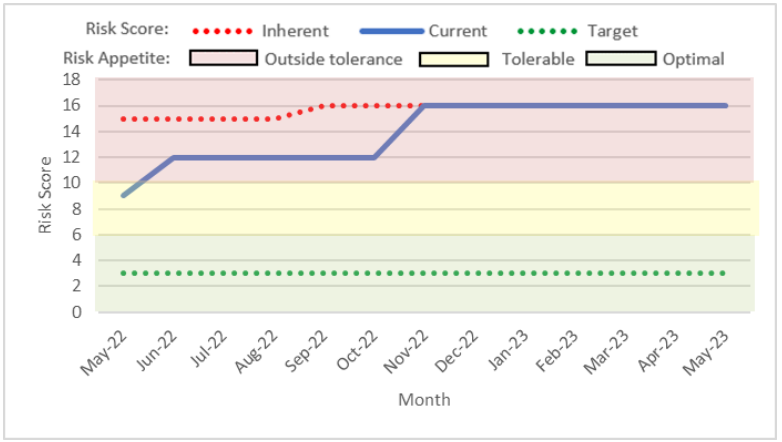


Corporate Objective: **CO15** To develop effective partnerships within the new statutory environment							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic	**Risk Title:**	**PR 13: Partnership working - CCG changes**						
	Risk Statement:	There is a risk that staff with local knowledge and understanding may be lost due to the changes within CCGs, resulting in uncertainty regarding partnership working.						
Lead Committee	**Board of Directors**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**DSP**	**Likelihood**	4. Likely	4. Likely	2. Unlikely	**Risk category**	Strategy	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	2. Minor	2. Minor	**Linked risks**	-	
Date of last review	**05.04.23**	**Risk Rating**	12. High	8. High	4. Moderate	**Risk treatment**	Treat	



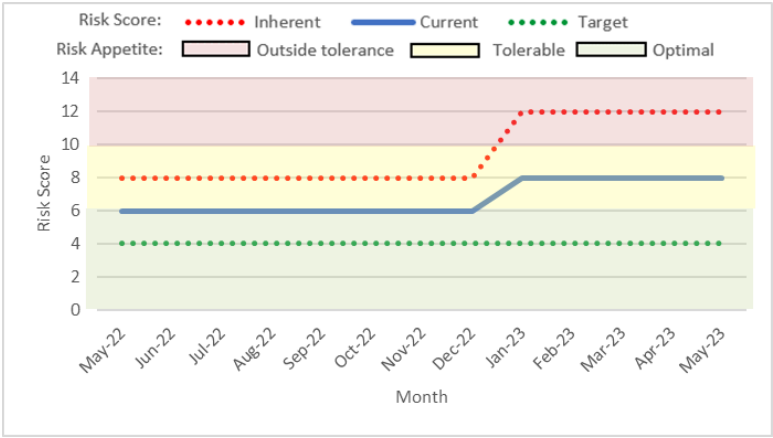
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3300)**	• Locality meeting structures in place to support lasting corporate knowledge.	• Uncertainty around CCG changes.	**2nd Line:** • Board of Directors April 2023 • **External:** System Board meetings – monthly	• Uncertainty around CCG changes.	1. Attendance at System Board meetings with Partners.	DPS - Monthly

Corporate Objective: C13 Progress towards becoming a Net Zero healthcare provider							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 14: Estate Strategy - net carbon zero requirements**						
	Risk Statement:	There is a risk that Net Zero may not be delivered, due to investment not being available, resulting in failure to deliver the Green Plan and legislative requirements						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**DSP**	**Likelihood**	4. Likely	4. Likely	1. Rare	**Risk category**	Sustainability /Net Zero	
Date risk opened	**19.10.21**	**Impact**	4. Major	4. Major	3. Moderate	**Linked risks**	-	
Date of last review	**05.04.23**	**Risk Rating**	16. Significant	16. Significant	3. Low	**Risk treatment**	Treat	



Strategic Opportunity /Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3296)**	• Sustainability Manager in post. Recruited band 4 support (not yet in post). • Greener WWL comms commenced, supported by recruiting to the Ambassadors programme. • Third party commissioned to complete baseline assessment, develop prioritised investment plan, Net Zero Strategy and update the Trust's Green Plan. • Net Zero and sustainability e-learning programme. • Bidding strategy has been developed with a view to securing Public Sector Decarbonisation Scheme (PSDS) funding.	• Baseline emissions assessment • Prioritised action and investment plan • Climate Change Adaptation plan • Sustainable Travel Plan • Comms and Engagement strategy • Sustainability Impact Assessment • Capital funds should PSDS not be secured	**2nd Line:** • Finance & Performance Committee January 2023. • Surgery Audit Day based around sustainability Bid submitted to Salix Low Carbon Skills Fund 14/06/22 to enable bid to PSDS. • Ricardo progress briefing (ETM Sept 2022) • Business planning process commenced • Net Zero oversight group – high level Ricardo outputs (November 2022).	• No substantive sustainability workforce resource to support delivery against strategic aims set out in the Net Zero NHS guidance document. • Investment schedule aligned to capital programme (based on Ricardo outputs)	1. Complete baseline assessment. 2. Supply chain Net Zero review (national, regional & local). 3. Green prescribing plan. 4. Sustainability and Net zero to be included in business planning process for 2023-24. 5. Estates Net Zero High level Investment Plan to be shared at ETM for prioritisation discussion	1 Ricardo – December 2022 - complete 2 Associate Director of Procurement – TBC awaiting national direction 3 Chief Pharmacist – TBC awaiting national direction 4 Director of Strategy – December 2022 - complete 5 Net Zero Lead – June 2023

Corporate Objective: **CO17** To increase research capacity and capability at WWL in collaboration with EHU with a plan to make progress towards our ambition to be a University Teaching Hospital							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 15: University Teaching Hospital - University Hospital Association criteria**						
	Risk Statement:	There is a risk that all the criteria that the University Hospital Association have specified may not be met, due to two key areas which we may find difficult to achieve, resulting in a potential obstacle towards our ambition to be a University Teaching Hospital.						
Lead Committee	**Board of Directors**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**MD**	**Likelihood**	4. Likely	4. Likely	2. Unlikely	**Risk category**	Strategy	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	2. Minor	2. Minor	**Linked risks**	-	
Date of last review	**05.04.23**	**Risk Rating**	12. High	8. High	4. Moderate	**Risk treatment**	Treat	



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3299)**	• Project documentation including action log in place. • 1 colleague confirmed as meeting the minimum criteria of 0.40wte affiliation to EHU.	•A core number of university principle investigators. There must be a minimum of 6% of the consultant workforce (for WWL likely to be between 9 and 12 PIs) 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. •No new NIHR grants have been awarded. We are not achieving the criteria currently (2 years' average of £200k/annum).	**2nd Line:** • Board of Directors • University Hospital Group – March 2023.	• None currently identified.	1. The key actions for key principle investigators are for the Head of Research to provide a list of those we currently have and the research and HR teams are going to look at contractual options with a view to increasing the number of PIs that we have. 2. Our target for 2023/24 is to submit a minimum of 3 NIHR grant applications to be able to attract another NIHR award, which should enable achieving the £200k in 2025/26 which will achieve this target.	MD June 2023 MD June 2023

Agenda item: [19]

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	WWL M1 23/24 and M12 22/23 Balanced Scorecards
Presented to:	Board of Directors
On:	7 June 2023
Presented by:	Director of Strategy & Planning
Prepared by:	Data, Analytics and Assurance Team
Contact details:	DAASupport@wwl.nhs.uk

The WWL Way

Executive summary

Two positions of the current iteration of the Trust's Balanced Scorecard and associated commentary are presented to the Board of Directors:
M1 23/24 and M12 22/23.

The Scorecard remains mostly manually populated monthly. During the Data Warehouse (DW) migration, Key Performance Indicators (KPIs) will continue to be developed using the new DW and will replace the need to populate them manually.

The interactive version on the Balanced Scorecard remains available and allows you to view trend, Statistical Process Control (SPC) and year on year comparison (where data available) charts for each KPI.

The Scorecard can be accessed via this link (when connected to the Trust's WiFi or VPN :
https://wwlqliksense1.xwwl.nhs.uk/sense/app/a0a252b8-9bad-47b7-b5ce-2661e8acd5c0/sheet/fd9b4a73-ca27-4754-91d7-d0338e47f56c/state/analysis

Or

Via the Qlik Cloud (when accessing on a mobile devices or when off site) :
https://wwl.eu.qlikcloud.com/sense/app/7a161be3-c0ae-4dbd-9746-5556f04c1369

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

Link to strategy
Patient
Partnership
Workforce
Site and Service

Risks associated with this report and proposed mitigations
None highlighted.

Financial implications
None currently highlighted.

Legal implications
None identified.

People implications
None identified.

Wider implications

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

Report: M1 WWL Balanced Scorecard: April 2023

Quality & Safety (Chief Nurse & Medical Director)

ID	KPI Title	Period Covered	Total	Target	On Target	Trend
1	Never Events	Apr-23	0	0	●	▼
2	Number of Serious Incidents	Apr-23	5	0	●	▼
3	Sepsis - Screening and Antibiotic Treatment (IN DEV)	-	-	-		▷
4	STEIS Reportable Category 3, 4 & Unstageable Pressure Ulcers	Apr-23	0	0	●	▼
5	STEIS Reportable Serious Falls	Apr-23	0	0	●	▷
7	Complaints Responses	Apr-23	67.57%	85%	●	▲
9	Patient Experience (FFT)	Apr-23	89.47%	TBC		▲
52	Methicillin-Resistant Staphylococcus Aureus (MRSA)	Apr-23	0	0	●	▷
53	Methicillin-Susceptible Staphylococcus Aureus (MSSA)	Apr-23	3	0	●	▼
54	Clostridium Difficile (CDT)	Apr-23	6	0	●	▼
78	SHMI Rolling 12 Months	Jan-23	114	100	●	▷

People (Chief People Officer)

ID	KPI Title	Period Covered	Total	Target	On Target	Trend
10	Vacancy rate	Apr-23	6.26%	5%	●	▲
13	Rate card adherence (Medical)	Apr-23	44.04%	80%	●	▼
14	Rostering timeliness	Apr-23	81.08%	75%	●	▲
15	% Turnover Rate	Apr-23	9.66%	10%	●	▲
16	Your Voice Score (QTR) - Engagement score	Jun-22	3.94	4	●	▷
18	Your Voice Score (QTR) - Well-being score	Jun-22	3.35	3.5	●	▷
19	Mandatory training compliance	Apr-23	95.58%	95%	●	▲
21	Sickness - %age time lost	Apr-23	4.87%	5%	●	▼
50	Usefulness of Trust wide communication	Nov-22	81.00%	70%	●	▷
51	Leaders Forum reach (Number of Leaders attending the Forum)	Apr-23	123	110	●	▲
62	Number of outputs per month (LF, AGTB, Executive Vlogs, CEO Vlog / Blog)	Apr-23	5	6	●	▼
63	FTSU contacts	Apr-23	7	n/a		-
64	Your Voice Score (QTR) - Psychological Safety	Jun-22	3.71	3.75	●	▷
65	Appraisal	Apr-23	88.16%	90%	●	▼

Performance (Deputy Chief Executive)

ID	KPI Title	Period Covered	Total	Target	On Target	Trend
60	Ambulance handovers 60+ minutes delay	Apr-23	149	0	●	▼
32	Reduce 12-hour waits in EDs	Apr-23	14.99%	10%	●	▼
80	A&E waiting times : patients seen within 4 hours	Apr-23	68.58%	66.01%	●	▲
25	G&A Bed Occupancy - Acute Adult Inpatient Wards	Apr-23	99.22%	95%	●	▲
90	85% Paediatric Bed Occupancy (IN DEV)	-	-	-		
91	85% Critical Care Bed occupancy for Adults and Children (IN DEV)	-	-	-		
81	Virtual ward patients (IN DEV)	-	-	-		
33	No Right to Reside Patients (excluding Discharges)	Apr-23	138	50	●	▼
31	Cancer - waits longer than 62 days	Apr-23	78	95	●	▲
42	Patients waiting over 78 weeks (except patient choice and clinically complex)	Apr-23	14	0	●	▼
88	Total patients waiting over 65 weeks (except patient choice and clinically complex)	Apr-23	524	474	●	▲
89	Reduce waits of over 52 weeks by 50% by March 2024	Apr-23	2,372	2500	●	▼
86	Number of diagnostics received completed within 6 weeks	Apr-23	81.02%	87%	●	▼
87	Diagnostic activity compared to 19/20 levels	Apr-23	13,428	9353	●	▼
85	Meet the cancer faster diagnosis standard by March 2024	Apr-23	74.76%	67.5%	●	▷
83	Reduction in outpatient follow-ups	Apr-23	23,159	23460	●	
84	Day case rate	Apr-23	84.31%	84%	●	
23	Elective Theatre Utilisation	Apr-23	73.94%	85%	●	▼
41	Elective Recovery Plan	Apr-23	91.58%	100%	●	
82	2-hour urgent community response (IN DEV)	-	-	-		

Finance (Chief Finance Officer)

ID	KPI Title	Period Covered	Total	Target	On Target	Trend
34	Adjusted Financial Performance (£'000s)	Apr-23	(682)	198	●	▼
35	Capital Expenditure (£'000s)	Apr-23	1,100	1791	●	▼
36	Cash (£'000s)	Apr-23	35,537	37756	●	▼
39	Agency Expenditure (£'000s)	Apr-23	932	285	●	▼
47	Cost Improvement Programme (CIP) (£'000s)	Apr-23	1,359	1972	●	▼
48	Better Payment Practice Code (BPPC)	Apr-23	94.76%	95%	●	▲

Quality & Safety (Chief Nurse & Medical Director)

During the month of April there were 6 incidents escalated to StEIS; these included x1 Never Event (NE) (retained product during laparoscopic surgery), x1 alleged abuse, x1 surgical invasive procedure meeting SI criteria (urology), x1 Maternity Incident meeting SI criteria, x1 psychological harm to a patient following a surgical procedure and 1x missed follow -up of a patient with glaucoma (resulting in vision loss).

It is important to note that NEs have been reported in the past under the same category, a thematic analysis (set out as an appreciative inquiry) is being completed to better understand what barriers are preventing staff from following the correct processes to prevent these incidents occurring, this is being discussed at the Themed SIRI Panel on the 26 June 2023

People (Chief People Officer)

Wellbeing: Salary finance offers now being shared with staff to their home address – worked with IG to find an approach for this as many staff are reluctant to do this via work channels.
Trim (Trauma Risk Management) Training Programme pilot available to staff across clinical areas – Emergency Village staff attending.
Engagement with Nursing Workforce to present the approach to TRiM and opportunities to develop staff in this methodology.
Wellbeing Health Checks with staff from SSDU - lots of engagement with this team
Psych Support Team – Stress Management Programme underway with SSDU
Steps4Wellness – Physio's delivering education awareness sessions for staff 'Back-chat' and 'Pain in the neck' to raise awareness of MSK related issues and prevention.
Leadership & teams: Culture programme – evaluation of programme with Endoscopy and Midwifery now completed. PPT evaluation will be completed in May. Evaluation with Midwifery teams is being prepared for the next cultural leadership group meeting on 26th April.
Analysis and qualitative review of national staff survey commentary being prepared for OFOFOF and then ETM. New Route Plan Appraisal has been approved and the Board are now starting to do their appraisals before rolling out to wider leadership teams. 131 requests (trust-wide) for staff to undertake an apprenticeship programme supporting their personal development. A new coaching development programme is being designed for WWL coaches and will be shared with ETM in May
Culture: Analysis on the exit interviews conducted by the guardian service will be reported to the May People Committee. New internal exit questionnaire now live, with qualitative and quantitative questions linked to Your Voice.
NSS – engagement with divisions is currently underway to shape divisional actions plans.
YVS – Currently paused following feedback from the most recent Leaders Forum
Comms and visibility: Three Executive Vlogs - plus CEO vlog and LF – NB One Executive Vlog and April ASTB were cancelled due to the Industrial Action
Personal development: Mandatory Training – National 95% target compliance achieved. Local compliances are steadily increasing. M&H level 2 & IPC level 2 need improvements on compliance rates Medics mandatory training compliance now aligned to appraisal dates – great progress here which allows for accurate reporting.
EDI – EDI Champions Network is now live and 22 people attended their induction to the network with a further 20 due to attend an induction.
Our WRES (Workforce Race Equality Standard) Action plan came back from NHS England with a score of 3 which is graded as outstanding (uses the same grading scale as CQC 0-3)

Performance (Deputy Chief Executive)

Bank holidays, high occupancy rates and strike action resulted in significant pressure on services. Despite this, the number of patients seen within 4 hours continues to improve along with national rankings, ambulance hand over delays over 60 minutes improved in April, the number of people waiting over 12 hours in the emergency department reduced and actions taken to increase Same Day Emergency Care, alongside system partner support, resulted in the elimination of patients being cared for on hospital corridors during the latter half of May for the first time in many months. Several of the Discharge & Flow Transformation Programme workstreams are in initial stages of implementation and are due to deliver throughout the year. The source of information to support reporting of the Community Urgent Response time reporting required automating and is part of the Data Analytics programme scheduled for later this year. April's position will be reported in May.

The Trust achieved the mandated 78 and 104 weeks by March 2023, in accordance with guidance, with an increase in April following an emerging issue with the national referral system. The Trust continues to work with NHSE to eliminate all long waiting patients by the end of June 2023. Elective activity was below plan primarily due to strike action. There is a data quality issue with reporting of Outpatient activity, a more accurate position will be available in July following a verification exercise. Cancer performance continues to improve, all 14-day targets were met in March 2023, the last validated month. 62-day performance in March was also the highest of the last fiscal year, and the 62-day plan for April was exceeded.

Virtual Ward programme continues with visits to Primary Care resulting is more patients stepped up from the community, avoiding admissions. Recruitment is ongoing, including the successful appointment of two international nurses joining the team. The service has been shortlisted for a Health Service Journal Award for Digital.
The operational reality is still not in line with NHSI/e key planning assumptions to support delivery of the elective recovery plan - significant pressures are still seen in urgent care demand, cancer referral rates and bed occupancy levels. The Trust continues to work with system partners both at locality and Integrated care Board levels to safely manage both urgent and planned care.

Finance (Chief Finance Officer)

Surplus/Deficit
The Trust reported an actual deficit of £0.7m in month 1 (April 2023), which is an adverse variance of £0.9m to the plan. In month 1, the Trust income is £0.4m favourable to plan. However, this does not reflect the potential underperformance against the Aligned Payment and Incentive scheme (API) which is estimated at £1.1m in month 1.
Adjusted Financial Performance
The adjusted financial performance is a deficit of £0.7m which is £0.9m adverse to the plan of £0.2m surplus.
Capital Expenditure
Expenditure against the capital plan was £1.1m which is £0.7m below plan in month 1. This is expected to be recovered during the financial year.
Cash
Cash is £35.5m at the end of month 1 which is £2.2m below plan. This has reduced by £7.5m from the previous month, of which £5.6m was due to payment of 2022/23 capital invoices and £1.9m due to timing in the settlement of debts from customers and payments to suppliers.
Agency Expenditure
Agency expenditure is £0.9m in month 1, which is comparable to previous months. This is £0.1m below the NHSE agency ceiling, which is set at 3.7% of total pay expenditure.
Cost Improvement Programme (CIP)
In month, £1.4m has been delivered against a plan of £2.0m, therefore there is an adverse variance of £0.6m. As at month 1, there is an unidentified gap of £3.6m (30%) year and £2.8m (23%) recurrently, which whilst challenging is a better position than compared to this time last year.
Better Payment Practice Code (BPPC)
BPPC for month 1 is 94.8% by volume and 92.8% by value. Performance by volume and value has improved from the previous month (93.8% and 90.4%). Work is ongoing with SBS, financial services and procurement teams to look at ways in which performance could be improved further.

Report: M12 WWL Balanced Scorecard: March 2023

Quality & Safety (Chief Nurse & Medical Director)

ID	KPI Title	Period Covered	Total	Target	On Target	Trend	YTD
1	Never Events	Mar-23	2	0	●	▲	5
2	Number of Serious Incidents	Mar-23	8	0	●	▲	95
3	Sepsis - Screening and Antibiotic Treatment (IN DEV)	-	-	-		▷	-
4	STEIS Reportable Category 3, 4 & Unstageable Pressure Ulcers	Mar-23	1	0	●	▷	16
5	STEIS Reportable Serious Falls	Mar-23	0	0	●	▼	6
7	Complaints Responses	Mar-23	62.50%	85%	●	▼	55.34%
9	Patient Experience (FFT)	Mar-23	86.91%	TBC		▼	85.77%
52	Methicillin-Resistant Staphylococcus Aureus (MRSA)	Mar-23	0	0	●	▷	1
53	Methicillin-Susceptible Staphylococcus Aureus (MSSA)	Mar-23	5	0	●	▷	41
54	Clostridium Difficile (CDT)	Mar-23	10	0	●	▷	112
78	SHMI Rolling 12 Months	Jan-23	114	100	●	▷	114

People (Chief People Officer)

ID	KPI Title	Period Covered	Total	Target	On Target	Trend	YTD
10	Vacancy rate	Mar-23	5.76%	5%	●	▼	8.30%
13	Rate card adherence (Medical)	Mar-23	52.27%	80%	●	▼	53.99%
14	Rostering timeliness	Mar-23	75.68%	75%	●	▲	55.49%
15	% Turnover Rate	Mar-23	9.56%	10%	●	▲	10.12%
16	Your Voice Score (QTR) - Engagement score	Jun-22	3.94	4	●	▷	3.94
18	Your Voice Score (QTR) - Well-being score	Jun-22	3.35	3.5	●	▷	3.35
19	Mandatory training compliance	Mar-23	95.21%	95%	●	▲	91.13%
21	Sickness - %age time lost	Mar-23	5.16%	4%	●	▼	6.36%
50	Usefulness of Trust wide communication	Nov-22	81.00%	70%	●	▷	86.33%
51	Leaders Forum reach (Number of Leaders attending the Forum)	Mar-23	109	110	●	▼	1,421
62	Number of outputs per month (LF, ASTB, Executive Vlogs, CEO Vlog / Blog)	Mar-23	7	6	●	▲	73
63	FTSU contacts	Mar-23	5	n/a		-	77
64	Your Voice Score (QTR) - Psychological Safety	Jun-22	3.71	3.75	●	▷	3.71
65	Appraisal	Mar-23	80.24%	90%	●	▲	78.33%

Performance (Deputy Chief Executive)

ID	KPI Title	Period Covered	Total	Target	On Target	Trend	YTD
60	Ambulance handovers 60+ minutes delay	Mar-23	205	0	●	▲	3,106
59	Ambulance handovers under 30 minutes	Mar-23	69.67%	95%	●	▲	68.43%
58	Ambulance handovers under 15 minutes	Mar-23	45.70%	65%	●	▼	46.64%
32	Reduce 12-hour waits in EDs	Mar-23	15.92%	10%	●	▼	13.62%
25	G&A Bed Occupancy - Acute Adult Inpatient Wards	Mar-23	98.61%	95%	●	▲	97.91%
33	No Right to Reside Patients (excluding Discharges)	Mar-23	147.2	50	●	▲	134.7
75	Cancer Referrals - 115% of pre -covid averages	Mar-23	1,720	1310	●	▲	19,220
31	Cancer - waits longer than 62 days	Mar-23	52	25	●	▼	52
24	Patients waiting over 104+ weeks (except patient choice & clinically complex)	Mar-23	1	0	●	▲	1
42	Patients waiting over 78 weeks	Mar-23	17	0	●	▼	17
28	Outpatient Utilisation (IN DEV)	Apr-22	0	IN DEV		▷	0
68	Outpatient DNA Rates	Mar-23	7.78%	6%	●	▼	9.34%
67	Virtual Outpatient Consultations	Mar-23	25.71%	25%	●	▼	27.63%
23	Elective Theatre Utilisation	Mar-23	75.76%	85%	●	▼	78.75%
41	Elective Recovery Plan	Mar-23	90.98%	100%	●	▼	92.82%
76	Total Waiting List - RTT position	Mar-23	49,008	-	●	▲	49,008

Finance (Chief Finance Officer)

ID	KPI Title	Period Covered	Total	Target	On Target	Trend	YTD
80	Surplus /Deficit (£000s)	Mar-23	270	(950)	●	▼	(6,754)
34	Adjusted Financial Performance (£'000s)	Mar-23	-110	(938)	●	▼	(2,946)
35	Capital Expenditure (£'000s)	Mar-23	12,233	6830	●	▲	24,386
36	Cash (£'000s)	Mar-23	43,098	38123	●	▲	432,283
39	Agency Expenditure (£'000s)	Mar-23	1,176	692	●	▲	13,339
47	Cost Improvement Programme (CIP) (£'000s)	Mar-23	3,663	1992	●	▲	25,826
48	Better Payment Practice Code (BPPC)	Mar-23	91.98%	95%	●	▲	90.32%

Quality & Safety (Chief Nurse & Medical Director)

During the month of March 2023, the Trust reported 8 incidents to StEIS; these included 1x lost to follow-up, 2x maternity incident meeting SI criteria, x2 ward closure due to norovirus outbreak, 1x serious fall, 1x hospital acquire pressured ulcer, 1x treatment delay resulting in the unexpected death of a patient.

It is important to note that lost to follow-up continues to feature as an escalated incident, the Medical Director has organised a Themed SIRI (Serious Incidents Requiring Investigation), the themed panel and will be focussing on lost to follow-ups. A Corporate Risk has been completed, outlining a concern that patients may have been lost to follow up across multiple specialities; the risk is currently scoring a 20 on the register. A lost to follow-up task and finish group is being set up by the Associate Director of Governance and Patient Safety.

People (Chief People Officer)

Wellbeing: Salary finance offers now being shared with staff to their home address – worked with IG to find an approach for this as many staff are reluctant to do this via work channels.
Trim (Trauma Risk Management) Training Programme pilot available to staff across clinical areas – Emergency Village staff attending.
Engagement with Nursing Workforce to present the approach to TRiM and opportunities to develop staff in this methodology.
Wellbeing Health Checks with staff from SSDU - lots of engagement with this team
Psych Support Team – Stress Management Programme underway with SSDU
Steps4Wellness – Physio's delivering education awareness sessions for staff 'Back-chat' and 'Pain in the neck' to raise awareness of MSK related issues and prevention.
Leadership & teams: Culture programme – evaluation of programme with Endoscopy and Midwifery now completed. PPT evaluation will be completed in May. Evaluation with Midwifery teams is being prepared for the next cultural leadership group meeting on 26th April.
Analysis and qualitative review of national staff survey commentary being prepared for OFOFOF and then ETM. New Route Plan Appraisal has been approved and the Board are now starting to do their appraisals before rolling out to wider leadership teams. 131 requests (trust-wide) for staff to undertake an apprenticeship programme supporting their personal development. A new coaching development programme is being designed for WWL coaches and will be shared with ETM in May
Culture: Analysis on the exit interviews conducted by the guardian service will be reported to the May People Committee. New internal exit questionnaire now live, with qualitative and quantitative questions linked to Your Voice.
NSS – engagement with divisions is currently underway to shape divisional actions plans.
YVS – Currently paused following feedback from the most recent Leaders Forum
Comms and visibility: Three Executive Vlogs - plus CEO vlog and LF – NB One Executive Vlog and April ASTB were cancelled due to the Industrial Action
Personal development: Mandatory Training – National 95% target compliance achieved. Local compliances are steadily increasing. M&H level 2 & IPC level 2 need improvements on compliance rates Medics mandatory training compliance now aligned to appraisal dates – great progress here which allows for accurate reporting.
EDI – EDI Champions Network is now live and 22 people attended their induction to the network with a further 20 due to attend an induction.
Our WRES (Workforce Race Equality Standard) Action plan came back from NHS England with a score of 3 which is graded as outstanding (uses the same grading scale as CQC 0-3)

Performance (Deputy Chief Executive)

Please refer to M1 commentary for a combined narrative.

Finance (Chief Finance Officer)

Surplus/Deficit: The Trust reported an actual surplus of £0.3m in month 12 (March 2023), favourable to plan by £1.2m. The full year position is an actual deficit of £6.7m, which is £1.9m favourable to the planned deficit of £8.6m.

Adjusted Financial Performance: The adjusted financial performance is a deficit of £2.9m full year, which is £5.5m favourable to plan. This is £1.5m higher than the month 11 forecast due to a final agreement with GM to increase the Trust deficit to £2.9m. The final position includes the £9.0m additional income (reported last month) agreed by GM wide system.

Capital Expenditure: Capital expenditure is £12.2m in month 12 which is £0.1m above plan. Full year, capital spend is £24.4m which is £0.1m above the planned expenditure of £24.3m. The Trust agreed a £0.1m overspend with GM ICS to support delivery of the system capital program. This was associated with an additional £0.1m of capital to support falls prevention.
Cash: Cash is £43.1m at the end of month 12 which is £5.0m above the plan. This has improved by £0.4m from the previous month and was an improvement on the previous forecasts due to receipt of capital PDC cash of £12.6m, timing in settlement of debts from customers and payments to suppliers.

Agency Expenditure: Agency expenditure was £1.2m in month 12 and £13.3m full year, which is £5.0m above the ceiling. Agency expenditure is £4.6m (53%) higher than for the last financial year.
Cost Improvement Programme (CIP): The Trust exceeded the in-year CIP target by £1.9m. However, only £3.5m of this CIP has been delivered recurrently, with £20.4m being delivered non-recurrently. The Trust is currently working through its 23/24 CIP plan as part of the final planning submissions to NHSE.

Better Payment Practice Code (BPPC): BPPC for 22/23 full year is 90.4% by volume and 93.8% by value. Performance by volume has improved slightly from the previous month (90.2%). Work is ongoing with SBS, financial services and procurement teams to address the root causes.

Change log:

Ref	ID	Metric	Change	Date	Requested by:
23/24 01	21	Sickness Absence	Change target from 4% to 5%	22/05/2023	Deputy Chief People Officer
23/24 02	59	Ambulance Handovers under 30 minutes	Remove metric	13/04/2023	Chief Operating Officer
23/24 03	58	Ambulance Handovers under 15 minutes	Remove metric	13/04/2023	Chief Operating Officer
23/24 04	75	Cancer referrals - 115& of pre-covid average	Remove metric	13/04/2023	Chief Operating Officer
23/24 05	24	Patients waiting over 104+ weeks (except patient choice or clinically complex)	Remove metric	13/04/2023	Chief Operating Officer
23/24 06	28	Outpatient utilisation (In Dev)	Remove metric	13/04/2023	Chief Operating Officer
23/24 07	68	Outpatient DNA rates	Remove metric	13/04/2023	Chief Operating Officer
23/24 08	67	Virtual Outpatient Consultations	Remove metric	13/04/2023	Chief Operating Officer
23/24 09	76	Total Waiting List - RTT position	Remove metric	13/04/2023	Chief Operating Officer
23/24 10	80	A&E waiting times : patients seen within 4 hours	Add metric	13/04/2023	Chief Operating Officer
23/24 11	90	85% Paediatric Bed Occupancy	Add placeholder for metric	13/04/2023	Chief Operating Officer
23/24 12	91	85% Critical Care bed occupancy for Adults and Children	Add placeholder for metric	13/04/2023	Chief Operating Officer
23/24 13	81	Virtual ward patients	Add metric	13/04/2023	Chief Operating Officer
23/24 14	88	Patients waiting over 65+ weeks (except patient choice or clinically complex)	Add metric	13/04/2023	Chief Operating Officer
23/24 15	89	Patients waiting over 52+ weeks by 50% by Mar 24	Add metric	13/04/2023	Chief Operating Officer
23/24 16	81	Virtual ward patients	Add metric	13/04/2023	Chief Operating Officer
23/24 17	86	Number of diagnostics received completed within 6 weekd	Add metric	13/04/2023	Chief Operating Officer
23/24 18	87	Diagnostic activity compared to 19/20 levels	Add metric	13/04/2023	Chief Operating Officer
23/24 19	85	Meet the cancer faster diagnosis standard	Add metric	13/04/2023	Chief Operating Officer
23/24 20	83	Reduction in outpatient follow - ups	Add metric	13/04/2023	Chief Operating Officer
23/24 21	84	Day case rate	Add metric	13/04/2023	Chief Operating Officer
23/24 22	82	2 hour urgent community response	Add placeholder for metric	13/04/2023	Chief Operating Officer

Agenda item: [20]

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Monthly Trust Financial Report – Month 1 (April 2023)
Presented to:	Board of Directors
On:	7th June 2023
Presented by:	Tabitha Gardner [Chief Finance Officer]
Prepared by:	Senior Finance Team
Contact details:	E: Heather.Shelton@wwl.nhs.uk

Executive summary

Description	Performance Target	Performance	Explanation
Revenue financial plan	Achieve the financial plan for 2023/24.	Amber	The month 1 position is a deficit of £0.7m, which is £0.9m adverse to plan. However, this does not include any reduction in income associated with an underperformance on the activity plan for the Aligned Payment and Incentive (API) payment mechanism. The key drivers for the adverse variance are the continued escalated position, underperformance against CIP, and the impact of industrial action.
Activity	Achieve the elective activity plan for 2023/24.	Red	The month 1 activity data highlights that the Trust has not achieved the elective activity plan that was submitted to NHSE. This has been impacted by the 4 days of industrial action by the junior doctors during which activity was partially stepped down.
Cash & liquidity	Effective cash management ensuring financial obligations can be met as they become due.	Amber	Cash is £35.5m at the end of month 1 which is £2.2m below plan. This has reduced by £7.5m from the previous month, of which £5.6m was due to payment of 2022/23 capital invoices and £1.9m due to timing in the settlement of debts from customers and payments to suppliers.
Capital expenditure (CDEL)	Achieve CDEL for 2023/24.	Green	Expenditure against the capital plan was £1.1m which is £0.7m below plan in month 1. This is expected to be recovered during the financial year.
Cost Improvement Programme (CIP)	Deliver the planned CIP of £24.4m, of which £19.7m is recurrent.	Amber	In month £1.4m has been delivered against a plan of £2.0m, therefore there is an adverse variance of £0.6m. As at month 1, there is an unidentified gap of £3.6m (30%) year and £2.8m (23%) recurrently, which whilst challenging is a better position than compared to this time last year.
Temporary expenditure	To remain within the agency ceiling set by NHSE and reduce bank expenditure.	Amber	Agency expenditure is £0.9m in month 1, which is comparable to previous months. This is £0.1m below the NHSE agency ceiling, which is set at 3.7% of total pay expenditure. Bank expenditure was £2.9m in month 1, driven largely by escalation. The margins between agency and bank expenditure have reduced and therefore

			there is a significant premium associated with bank expenditure, as well as agency expenditure, although not included within the NHSE ceiling.
Business conduct	Comply with the Better Payments Practices Code (BPPC) of paying 95% of invoices within 30 days.	Amber	BPPC for month 1 is 94.8% by volume and 92.8% by value. Performance by volume and value has improved from the previous month (93.8% and 90.4%). Work is ongoing with SBS, financial services and procurement teams to look at ways in which performance could be improved further.
Financial risk	Report the financial risks through the Board Assurance Framework.	Amber	The financial environment for 2023/24 for both revenue and capital will be highly constrained and may impact on the ability of the Trust to deliver its strategic objectives. April has seen a £0.9m deficit to the financial plan, which will need to be recovered over the coming months if the trust is to land its full year plan. There are a range of risks which are driving an underlying deficit and further industrial action is probable. Other risks to achieving the plan include delivery of the activity plan, high volumes of no right to reside patients, length of stay, temporary staffing spend, delivery of the CIP plan and inflationary pressures.

Link to strategy

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

Risks associated with this report and proposed mitigations.

The level of risk within the 2023/24 revenue plan increased with each iteration of the plan. The most material risks are:

- Delivery of the planned CIP of £24.4m
- Delivery of the activity plan to meet the planned levels of income (estimated risk up to £14m)
- Safe reduction in expenditure associated with escalation (£7.0m reduction required in month 7 to 12)

- Management of other cost pressures in year, including industrial action for which there is no provision within the plan.

Further work is ongoing within the trust transformation programmes as well as the ICB and the locality to address escalation, and to identify further opportunities for CIP with a view to recover the deficit seen in April.

The Trust plans to have sufficient cash for 2023/24 assuming that all the CIP is cash releasing and that costs do not exceed the plan; this will be closely monitored throughout 2023/24. A cash management strategy is under development both locally and across Greater Manchester.

Financial implications

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

Legal implications

There are no direct legal implications in this report.

People implications

There are no direct people implications in this report.

Wider implications

There are no wider implications in this report.

Recommendation(s)

The Board of Directors are asked to note the contents of this report.

Financial Performance

Key Messages

In month 1, The Trust has reported an actual deficit of £0.7m, which is an adverse variance of £0.9m to plan.

The adjusted financial performance is the same, with a deficit of £0.7m which is £0.9m adverse to the plan of £0.2m surplus.

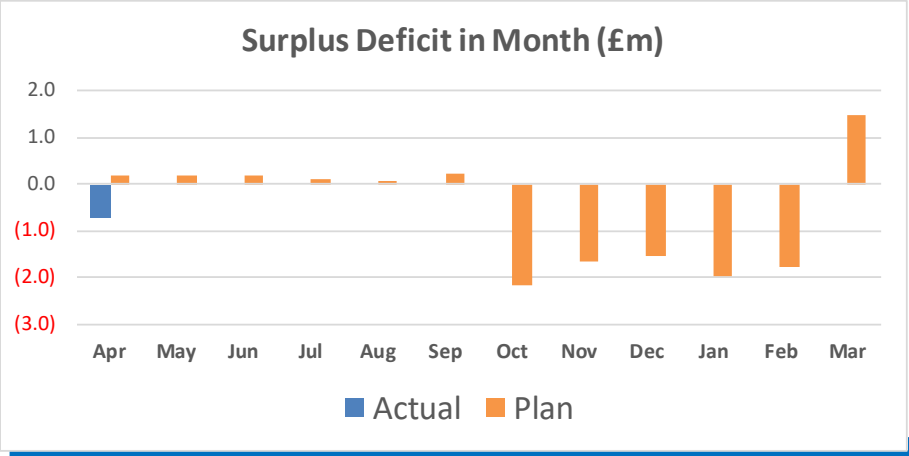
Thes month 1 position excludes any reduction in income for underperformance on the activity plan, estimated to be £1.1m. This is a significant risk under the Aligned Payment Incentive tariff mechanism.

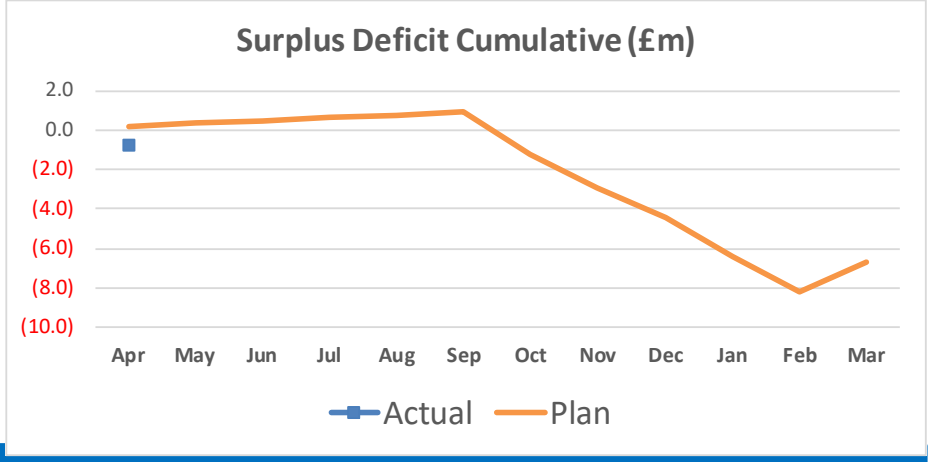
The Trust reported an actual deficit of £0.7m in month 1 (April 2023), which is an adverse variance of £0.9m to the plan.

In month 1, the Trust income is £0.4m favourable to plan. However, this does not reflect the potential underperformance against the Aligned Payment and Incentive scheme (API) which is estimated at £1.1m in month 1.

Operating expenditure is £1.1m adverse to plan and reflects divisional pressures with Medicine and Surgery, including the impact of the junior doctor industrial action, under performance against CIP and escalation expenditure.

The phasing of the plan reflects £7.0m of income from Wigan Council in the first half of the year which is to support escalation, it is assumed that this expenditure ceases by the end of September. There is a budget of £2.5m for winter resilience phased over the second half of the year. The month 12 plan includes a benefit of £2.3m for the GM system efficiency.





Key Financial Indicators

Key Financial Indicators	In Month (£000)			Year to Date (£000)			Full Year (£000)
	Actual	Plan	Var	Actual	Plan	Var	Plan
Financial Performance							
Income	42,095	41,668	428	42,095	41,668	428	495,655
Pay	(29,542)	(28,169)	(1,373)	(29,542)	(28,169)	(1,373)	(340,587)
Non Pay	(11,174)	(11,492)	319	(11,174)	(11,492)	319	(139,932)
Financing / Technical	(2,079)	(1,832)	(246)	(2,079)	(1,832)	(246)	(21,829)
Surplus / Deficit	(699)	174	(872)	(699)	174	(872)	(6,693)
Adjusted Financial Performance *	(682)	190	(872)	(682)	190	(872)	(6,500)
Memo Items							
CIP	1,359	1,972	(612)	1,359	1,972	(612)	24,406
Bank Expenditure	2,734	858	(1,876)	2,734	858	(1,876)	12,136
Agency Expenditure	932	285	(647)	932	285	(647)	3,629
Cash Balance	35,537	37,756	(2,219)	35,537	37,756	(2,219)	30,403
Capital Spend - CDEL	757	970	213	757	970	213	11,640
Capital Spend - PDC	343	821	478	343	821	478	13,150

* Used to measure system performace (based on surplus / deficit less donated capital and other technical adjustments).

Financial Performance

- Income is £0.4m favourable to plan in month.
- Operating expenditure is £1.1m adverse to plan which is split £1.4m adverse on pay and £0.3m favourable on non pay.
- Trust financing is £0.2m adverse to plan in month due to depeciation and the PDC dividend.

Temporary Spend

- Bank spend £2.7m in month.
- Agency Spend £0.9m in month.

CIP

- £1.4m transacted in month, which is £0.6m behind plan.
- Split in month: Divisional £0.8m; Corporate CIP £0.6m..

Cash

- £35.5m cash balance.
- £2.2m behind plan.

Capital

- Capital spend of £1.1m against a plan of £1.8m.
- CDEL exependiture £0.8m which is £0.2m below plan.
- PDC expenditure £0.3m which is £0.5m below plan.

Divisional Performance

Medicine

- (£1.3m) Adverse to plan in month
- (£1.2m) Escalation
- (£0.2m) Industrial action
- (£0.2m) CIP not delivered
- £0.2m Non pay underspends
- £0.1m Other small variances

Surgery

- (£0.4m) Adverse to plan
- (£0.2m) Paeds/General Surgery medical staffing
- (£0.1m) Industrial action
- (£0.1m) International nurses
- (£0.1m) Ward costs
- £0.1m CIP over achieved

Specialist Services

- £0.3m Favourable to plan in month
- £0.1m Non Pay underspends
- £0.1m Vacancies (Theatres/Therapy)
- £0.1m other small variances

Community

- £0.1m Favourable to plan in month
- £0.3m Vacancies
- £0.1m Virtual Hub vacancies
- (£0.3m) Tempprary spend

Estates & Facilities

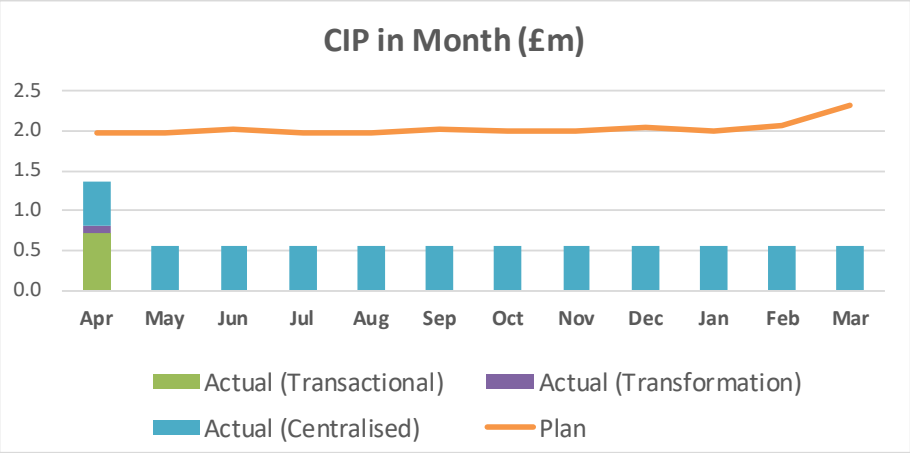
- In line with plan
- £0.1m Energy (where 2023/24 plan includes inflationary uplift)
- (£0.1m) CIP not delivered

Corporate Divisions

- (£0.1m) adverse to plan
- Small variances across each division

All divisions have triggered RAPID in month 1, primarily due to the CIP metrics. The intention is that Specialist, Community and E&F will have a light touch RAPID as each division has a CIP 'lock in' meeting to develop plans to achieve the CIP divisional targets. Medicine and Surgery will have the full RAPID meeting in May.

Cost Improvement Programme



The Trust has a planned CIP Target of £24.4m for 2023/24. The split is divisional recurrent CIP £12.0m, divisional non-recurrent stretch £4.7m, and centralised CIP £7.7m.

In month 1, actual CIP of £1.4m has been transacted which is £0.6m behind the plan of £2.0m. £0.8m has been transacted against the divisional CIP target (including the divisional stretch) and £0.6m against the centralised CIP target.

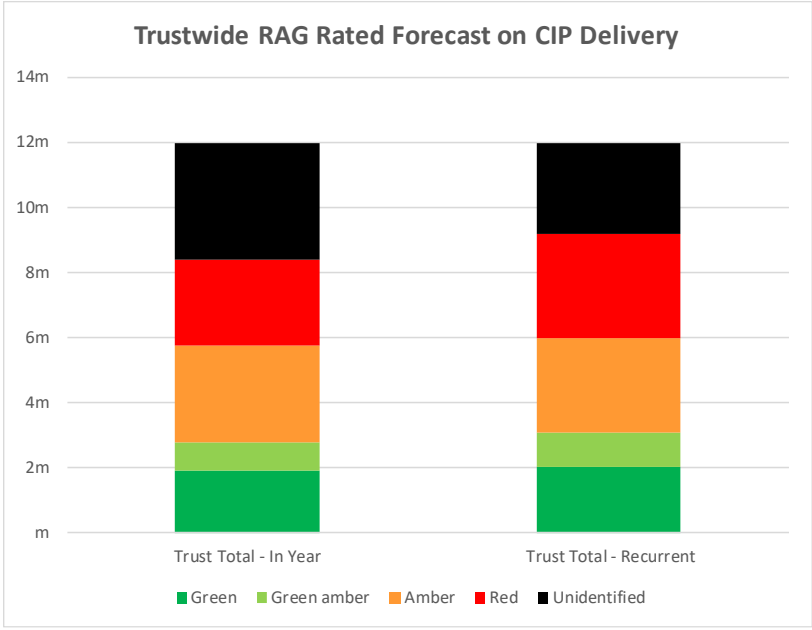
In month, the Divisional CIP transacted is split £0.1m for transactional schemes and £0.8m for transformational schemes.

The chart on the right, shows the Trust wide RAG rated forecast for the divisional CIP of £12.0m. As at month 1, there is an unidentified gap of £3.6m (30%) in-year and £2.8m (23%) recurrently. 22% of schemes are categorised as high risk.

Whilst challenging, this is a stronger position at the start of the year than in previous years. To support the delivery of the £24.4m CIP programme, each of the divisions are attending CIP 'lock in' sessions to provide time and space in a facilitated session. The aim is to accelerate development of CIP plans, unblock current schemes and drive creativity and innovation with the teams.

£2.0m has been transacted recurrently in year for divisional CIP. £1.0m relates to private patient income and the majority of the remaining £1.0m are non-pay savings.

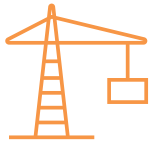
Transformational schemes make up £2.0m of the in-year forecast which includes income from private patients and a reduction in Endoscopy weekend working.



Forward Look

Greater Manchester ICS is establishing a recovery programme in response to the significant challenge in 2023/24 to deliver statutory objectives for both financial and performance indicators. A project management office (PMO) is being established for one year to drive this programme. Price Waterhouse Cooper (PWC) are supporting with this initially whilst recruitment takes place.

The NHS Staff Council has approved the Agenda for Change (AfC) pay offer and the Secretary of State has confirmed it will be implemented. The expectation is this will be processed in June salaries. This includes the consolidated pay award for 2023/24 (worth 5.2% on average) and a non-consolidated bonus payment for staff in post as at 31st March 2023. Trust's have been advised that the element of the pay award above the 2% funded in commissioner contracts will be funded nationally. The pay award for medical staff is yet to be agreed. Industrial action is expected to continue for both the British Medical Association (BMA) and the Royal College of Nursing (RCN).



The Trust submitted two short form business cases to the regional NHSE team on 5th May 2023. The first related to the additional theatre (theatre 11) at Wrightington via the Targeted Investment Fund (TIF) to support elective recovery. The second related to endoscopy and a development across both the Wigan and Leigh site, to deliver Joint Advisory Group (JAG) accreditation at Wigan and increase capacity at Leigh. These will be subject to regional scrutiny and will require ICB support before progressing for national consideration.

2023/24 Revenue Plan

The Trust Board approved a full year planned deficit of £6.7m (adjusted financial performance £6.5m). Achievement of the full year plan is contingent on:

- Delivery of the activity plan and associated tariff income.
- Full delivery of the CIP target of £24.4m.
- Escalation costs to cease from month 7 with additional funding support from Wigan Council in month 1 to 6.
- Non recurrent balance sheet support of £8.9m.
- In year mitigation of any other cost pressures or inflationary pressures.

The GM ICS has submitted a balanced revenue plan however this includes £123m of system savings (see below).

GM System Efficiency

Achievement of this plan is predicated on a number of assumptions and management of risk, and specifically requires the delivery of £123m system savings, which is in addition to the challenging efficiency targets already built into all organisational plans. For planning purposes, the £123m system target currently sits within the NHS GM plan, but all NHS organisations recognise that there is a collective responsibility of all organisations in the system to manage and mitigate this risk. To deliver savings at this level, all organisations and all parts of the system will be impacted.

Delivery of this level of savings needs to focus on cost reduction, rather than an expectation of new income, though every opportunity to mitigate will be explored. Current examples include:

- Output from the PWC diagnostic and productivity opportunities identified both for the system and at an organisational level.
- Review of enduring costs resultant from COVID, examples include additional G&A and Critical Care beds as well as specific COVID services such as testing and Medicine Delivery Unit.
- Wider efficiencies and productivity measures, above CIP plans, which could include reviewing more sustainable commissioning of services including decommissioning.

As a result of the findings from the Carnall Farrah review, governance in the GM system is expected to be revised. The current proposal to oversee not just the delivery of the £123m system savings, but also the wider underlying financial pressures and risks, is to develop a system wide PMO that will report into the NHS GM ICB Board via a Board Committee. The PMO will also ensure that GM has sufficient narrative to adequately articulate why the system has seen material increases in its workforce, but a corresponding reduction in activity when compared to pre-COVID levels. The PMO will facilitate the process and agree with system partners the impact on money, workforce, activity and performance metrics, and agree the changes on the impacted organisations.

Delivery of financial and wider performance indicators is not the sole responsibility of finance; leaders across all disciplines must by accountable, recognising that decisions ultimately may impact patients. Consequently, the system must undertake appropriate engagement and complete Quality Impact Assessments (QIA) to ensure there are no unintended consequences resultant from any proposed changes. The Joint Committee of the ICB will balance the QIA and financial benefits in making the decision to approve the implementation of any changes.

The GM system is facing a significant financial challenge, which has been building over several years, and will continue to increase unless recurrent savings are delivered at pace and at scale. It is expected that decisions taken that benefit the overall system could impact differentially on individual organisations. This might include cost reduction schemes that target specific organisations/ sectors as opportunities are identified and prioritised, or decisions about how income is allocated, recognising that whilst there will be engagement with partners, NHS GM has ultimate the responsibility and accountability for how resources allocated to the ICB are deployed.

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

QUALITY AND SAFETY COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

1.1. The Quality and Safety Committee ("the Committee") is constituted as a standing committee of the foundation trust's Board of Directors ("the Board"). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board meetings.

1.2. The Committee is authorised by the Board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee.

1.3. The Committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside the foundation trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

1.4. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. MAIN PURPOSE

2.1 The Committee will enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to:

(a) Promote safety and excellence in patient care;

(b) Identify, prioritise and manage risk arising from clinical care;

(c) Ensure effective and efficient use of resources through evidence-based clinical practice;

(d) Protect the health and safety of Trust employees;

(e) Ensure compliance with legal, regulatory and other obligations.

2.2 The Committee will also provide information to the Audit Committee, when requested, to assist that Committee in ensuring good structures, processes and outcomes across all areas of Governance.

2.3. The Chair of the Committee will work with other assurance committee Chairs as required, to ensure the delivery of a sound system of governance and assurance.

3. QUALITY STRATEGY ROLE

3.1 To review and recommend to the Board the Quality Strategy of the Trust, and to monitor progress against the strategy and other improvement plans that may impact on clinical quality.

3.2 To ensure there are robust systems for monitoring clinical quality performance indicators within Divisions and to receive reports on clinical quality performance measures.

3.3 Review and monitor the process and outcomes of Quality Impact Assessments relating to significant service changes and transformation programmes to gain assurance that there will be no unforeseen detrimental impact on quality of care for patients.

3.4 In response to requests from Board, or where appropriate as decided by the Committee, monitor the implementation of improvement plans in respect of quality of care, particularly in relation to incidents (never events), survey outcomes (safety culture elements of the NHS staff survey) and similar issues.

4. COMPLIANCE AND REGULATION ROLE

4.1 To receive and consider the necessary action in response to external reports, reviews, investigations or strategies (from the Care Quality Commission, NHS England and NHS Improvement, HM Coroner, PHSO and other NHS bodies such as Royal Colleges).

4.2 To monitor the Trust's responses to relevant external assessment reports (including reports from the Care Quality Commission) and associated implementation plans.

4.3 To receive commentary on the Care Quality Commission's Insight Report in respect of the Trust.

5. CLINICAL GOVERNANCE AND RISK MANAGEMENT ROLE

5.1 To review assurance reports mandated to be received by the Board that may impact on clinical quality, for example, quarterly mortality reports, maternity compliance against NHS Resolution safety standards.

5.2 Through reports from the Quality Governance Group monitor and obtain assurance regarding the effectiveness of processes, systems and structures for good clinical governance at the Trust, and to seek their continuous improvement.

5.2 To received regular reports on the ASPIRE clinical quality accreditation and internal mock inspection reports, to ensure effectiveness and that actions arising from them are addressed in a timely and appropriate manner under the management oversight of the Quality Governance Group.

5.3 To receive regular reports from the following groups to gain assurances of the completion of improvement plans to arising from areas of concern: Mortality, Medicines Management, Infection Prevention and Control, Safeguarding, Occupational Safety and Health.

5.4 To review the Board Assurance Framework (Patients) and corporate risks escalated by the Risk Management Group in accordance with the Trust's risk management strategy to seek assurances regarding mitigating action.

6. SAFETY CULTURE ROLE

6.1 To review the themes, trends and monitor improvements related to incident management (including incidents involving staff and patients), inquests and litigation.

6.2 To gain assurance that appropriate feedback mechanisms are in place for those reporting incidents and that a culture of openness and transparency in respect to incident reporting is encouraged and supporting the speaking up agenda.

6.3 To ensure that where necessary, action plans to address incident related themes, trends and/or required improvements, are developed and monitored.

6.4 To ensure that the NHS England/Improvements Just Culture guide is implemented by all staff across the Trust.

7. PATIENT EXPERIENCE ROLE

7.1 To consider reports from the Patient Experience and Engagement Group and other sources of feedback (such as Healthwatch) on all formal and informal patient feedback, both positive and negative, and to consider further action in respect of matters of concern.

7.2 To consider the results of national patient surveys and reviews such as PLACE that may impact on clinical quality, to gain assurance that actions arising from them are addressed in a timely and appropriate manner under the management oversight of the patient Experience Group.

7.3 To review the themes, trends and monitor improvements relating to complaints and concerns.

7.4 To ensure that where necessary, action plans to address complaint themes and trends are developed and monitored.

8. CLINICAL AUDIT AND EFFECTIVENESS ROLE

8.1 To ensure there is a comprehensive clinical audit programme in place to support and apply evidence-based practice, implement clinical standards and guidelines, and drive quality improvement.

8.2 To ensure that care is based on evidence of best practice/national guidance and recommendations from national audits and external bodies such as the National Confidential Enquiry into Patient Outcomes and Death are responded to.

9. MEMBERSHIP

9.1 The membership of the Committee shall consist of:

(a) Four Non-Executive Directors, one of whom shall be Chair;

(b) Chief Nurse or his/her nominated deputy;

(c) Medical Director or his/her nominated deputy;

9.2 Deputies shall only be nominated to attend in exceptional circumstances and with the prior approval of the Chair;

9.3 A representative of the Council of Governors shall be entitled to attend meetings.

9.4 The Committee will be deemed quorate to the extent that two Non-Executive Directors and one Executive Director are present, provided that a deputy has been nominated to attend on behalf of the other Executive Director member.

9.5 In the event that the Chair is not able to attend a meeting, one of the other Non-Executive Directors shall take the chair.

10. SECRETARY

10.1 The Company Secretary or his/her nominee shall be secretary to the Committee.

11. ATTENDANCE

11.1 The following participants are expected to attend meetings of the Quality and Safety Committee:

(a) Associate Director of Governance and Patient Safety

(b) One clinical representative from each clinical division, being **either**:

(i) Divisional Nurse Director **or**

(ii) Divisional Medical Director

In addition, subject matter experts relevant to agenda items may be invited by the Chair to attend for their agenda item(s) only.

11.2 For the purposes of this document, the clinical divisions shall comprise:

(a) Community Services

(b) Medicine

(c) Midwifery and Neonates

(d) Specialist Services

(e) Surgery

11.3 The Committee may be attended by any other person who has been invited to attend a meeting by the Committee Chair, so as to assist in deliberations.

11.4 The Committee Chair may also approve the attendance of observers, particularly members of staff where attendance at assurance committee meetings is recommended as part of their development plan.

12. FREQUENCY OF MEETINGS

12.1 Meetings shall be held every two months. There will be six meetings a year.

12.2 Additional meetings may be held on an exceptional basis at the request of the Committee Chair or any three members of the Quality and Safety Committee.

13 MINUTES AND REPORTING

13.1 Formal minutes shall be taken of all Committee meetings.

13.2 Once approved by the Committee, the minutes should be presented to the Board for information.

13.3 The Committee will report to the Board after each meeting.

13.4 The following sub-groups shall report to the Quality and Safety Committee:

(a) Clinical Audit and Effectiveness Group

(b) CQC Stakeholder Group

(c) Divisional Quality Executive Groups

(d) Equality Diversity and Inclusion Steering Group (Patients)

(e) Infection Prevention and Control Group

(f) Medicines Management Strategy Group

(g) Mortality Group

(h) Occupational Safety and Health Group

(i) Patient Experience and Engagement Group

(j) Patient Safety Group

(k) Continuous Improvement Group

(l) Safeguarding Effectiveness Group

14. PERFORMANCE EVALUATION

14.1 As part of the Board's annual performance review process, the Committee shall review its collective performance.

15. REVIEW

15.1 The terms of reference of the Committee shall be reviewed by the Board when required, but at least annually.

Title of report:	Self-certification in respect of provider licence condition FT4
Presented to:	Board of Directors
On:	7 June 2023
Presented by:	Director of Corporate Affairs
Prepared by:	Director of Corporate Affairs
Contact details:	E: paul.howard@wwl.nhs.uk

Executive summary

Under the Provider Licence that was in place until 27 March 2023, NHS foundation trusts were required to self-certify whether they have complied with the conditions of the NHS provider licence and specifically conditions G6, CoS7 and FT4. Whilst this requirement is no longer included in the new Provider Licence, NHS England has confirmed that declarations should continue to be made in respect of FY2022/23.

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 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 England template and the relevant signatures applied.

There is no requirement to submit the self-certifications to NHS England. Rather, NHS England will undertake an audit of a sample of FTs to confirm that they have self-certified. A copy is also required to be provided on the foundation trust's website.

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 the 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 Director of Corporate Affairs 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 FY2021/22 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 Director of Corporate Affairs 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 England from time to time	**Confirmed** ▪ Compliance with NHS Foundation Trust Code of Governance is assessed each year as part of the annual reporting process. We are aware that this has been superseded by the Code of Governance for NHS Provider Trusts with effect from 1 April 2023, and a gap analysis has been prepared for presentation to Audit Committee in September 2023. ▪ 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; 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; (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.	**Confirmed** ▪ Risk Management Strategy in place and high assurance around risk management controls confirmed in an internal audit during FY2022/23 ▪ 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. ▪ 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; (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.	**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. ▪ 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 succession planning was discussed by the Remuneration Committee in May 2023

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. 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.

Title of report:	Well-led action plan
Presented to:	Board of Directors
On:	7 June 2023
Presented by:	Director of Corporate Affairs
Prepared by:	Paul Howard, Director of Corporate Affairs
Contact details:	E: paul.howard@wwl.nhs.uk

Executive summary

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

The attached action plan for each of the recommendations has been approved by the board and the executive team has updated each of the open items with progress to date. At today's meeting, the board is asked to close the action plans associated with the remaining recommendations.

Link to strategy

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

Risks associated with this report and proposed mitigations

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

Financial implications

There are no financial implications associated with this report.

Legal implications

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

People implications

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

Wider implications

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

Recommendation(s)

The Board of Directors is recommended to review the updates provided and:

- Approve the closure of the actions associated with recommendations 4,5, 10 and 15

Well-led review of leadership and governance
Action plan as at 31 May 2023

Open actions

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
4 High	The CEO should consider including senior divisional leaders in some executive team development activities to help further build cohesion between the executive and divisional leadership levels, as well as exploring ways in which leaders can further demonstrate the values and behaviours expected within the organisation.	As part of the executive development programme referenced at recommendation 1 above, divisional leaders will be invited to participate in at least 2 sessions in H2 2022/23.* *(Original intention to provide 1 session in H1 2022/23 and a second session in H2 2022/23 was amended by the Board in August 2022 to reflect the narrative above).*	Chief Executive	Sessions took place on 9 February 2023 and 20 April 2023.	

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

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
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 Q3 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. *(Original intention to complete by end of Q2 2022/23 was amended by the Board in October 2022).*	Deputy Chief Executive	As part of the development of the Divisional Assurance Meetings there has been a reset of the leadership roles and responsibilities to support delivery of the accountability and performance framework, and a relaunch of the requirements related to Trust priorities. There is a governance structure from Divisions to Board which describes agreed escalation routes and monitoring forums which roles and responsibilities at each level. The accountability and performance framework includes several key lines of enquiry, Harm, efficiency, risk, operational delivery, and scrutiny on financial position. Where appropriate, triggers in areas support rapid escalation, for example finance meetings have taken place throughout the year to support collaborative discussions and facilitate effective decision making. Executive review is also in place where difficult decisions need to be taken. The framework has supported a shared understanding of issues and agreed actions. The Assurance meetings are designed to adapt to	

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№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
				changing circumstances, for example moving from a period of pandemic to recovery, and are means of ensuring ownership of the position by the divisional triumvirate supported by the Executive portfolio lead. There is a wider Culture and Engagement programme of work which includes Just and Learning culture toolkits, Culture and Engagement Teams Programme, Divisional People Promise plan and You Said We did. Following completion of the pilot with three teams across the organisation, the programme is designed to be rolled out across WWL. Although not specific to the Deloitte recommendation, the divisions will benefit.	

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
10 High	The Board should consider more detailed oversight of the digital agenda through the introduction of tailored board seminars in this area and by building this agenda item into the board and committee annual plans. This could involve assigning responsibility for the digital strategy to one of the existing committees, for example the Finance and Performance Committee, which is already responsible for the oversight of material business cases.	By the end of Q4 2021/22, we will have agreed where oversight of the digital agenda will take place. At least one board seminar session in H2 2021/22 as well as H1 and H2 2022/23 will include an aspect of the digital agenda.	Chair	The board has agreed that oversight of the digital agenda will take place via the Finance and Performance Committee and this has been incorporated into the revised terms of reference. The H2 2021/22 board seminar session was held on 23 Feb 2022 and focused on cybersecurity. The H1 2022/23 seminar session took place on 20 July 2022 and focused on the digital strategy in action. The H2 2022/23 session took place on 1 March 2023.	

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

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
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.	Chief People Officer	The leadership development programmes are up and running and were launched as planned. These consist of bitesize, formal/informal and accredited leadership development programmes - details available and advertised on our intranet pages for leaders to access. We also launched our WWL coaching programme (Q3, 2022) and have a programme of CPD across the year for our Accredited WWL coaches being delivered from June onwards this year. We launched our leadership onboarding programme for leaders that are new to the trust or staff that may have been promoted internally into a leadership role Executive Coaching and 360 – remains accessible and available for leaders across the organisation Range of tools and workshops available to support talent management, both internally and via the Leadership Academy, and further work to following during 2023/24.	

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

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

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
1 High	The CEO should ensure that the pending executive team development programme explicitly captures good practice in providing focused executive presentations to board and committees and addresses the need to embed collective ways of working across the executive team.	Seven executive development sessions will be held between April 2022 and March 2023*. Each session will last around 3 hours and will focus on team and personal development. An additional executive development session on presenting to board and committee meetings will be delivered by 30 June 2022. Team members have agreed that attendance at all these sessions will be prioritised above all other items, including annual leave. *(*Deadline extended from 31 December 2022 to 31 March 2023 by the Board in August 2022.)*	Chief Executive	The session on presenting to board and committee meetings took place on 9 June 2022. The executive programme is underway and sessions have taken place on 8 April 2022, 6 September 2022, 17 October 2022 and 9 November 2022. The sessions planned to take place in December 2022 and January 2023 were cancelled as a result of operational pressures. The next session is scheduled to take place in February 2023. It is therefore not possible to achieve the revised target of 7 sessions before the end of March 2023. **Rather than further extend the deadline, it is recommended that the action is closed as completed**. Development will continue to take place in 2023, and new executive team members will participate too.	

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
2 High	The board should consider a board seminar session that takes stock of where WWL is with regard to enabling strategies and implementation of the corporate strategy. This should explicitly review the opportunity for accelerating the pace of strategy implementation, for enhancing board oversight of the process and in using a range of different communication methods to increase awareness within the organisation.	A board seminar will be scheduled during Q1 2022/23 to provide the board with dedicated time to review its enabling strategies and overall implementation of the corporate strategy. Any necessary actions to accelerate the pace of strategy implementation, enhance board oversight or increase awareness will be agreed and appropriate timescales and milestones developed.	Chair	The objectives that drive the strategy were challenged and updated at a Board away day on 23 February 2022 and at a workshop on 2 March 2022. They were approved in April 2022. A seminar which reviewed the strategy through the lens of place-based leadership took place on 4 May 2022. A Healthier Wigan Partnership session took place on 23 Mar 2022. Future work is planned in relation to reviewing the enabling strategies.	
3 High	The board should set aside time in a board seminar to review progress against the various initiatives aimed at positively influencing culture, to ensure it is appropriately apprised of activities and that suitable mechanisms are in place for it to monitor progress against plan over time.	By the end of Q1 2022/23, the board will have undertaken a dedicated session as part of a seminar or away day to review progress against the *Our Family, Our Future, Our Focus* programme and will have considered whether it is appropriately apprised of activities and whether it has appropriate mechanisms in place to monitor progress.	Chair	This session took place on 20 April 2022.	

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

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

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

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

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

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№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
9 High	The Trust should revisit engagement and communications around changes to the quality governance structure to ensure that there is greater understanding of the rationale for change and the intended impact of this, and to ensure that all involved across the organisation are clear regarding the purpose, timing and sequencing of the changes.	By the end of Q2 2022/23, we will have approved an updated quality governance meeting structure and shared this within the organisation. We will have shared the structure at a meeting of Leaders' Forum and our intranet site.	Chief Nurse	The review of the quality governance meeting structure has commenced and a first draft was circulated for review and comment on 29 Mar 2022. It was shared with the Quality and Safety Committee on 10 Aug 2022 and is scheduled for Leaders' Forum in October 2022.	

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 now in use at board and committee meetings, and further refinement will take place as additional metrics are automated, although this is anticipated to take up to 2 years in line with the timescales associated with the migration of the data warehouse into the cloud. All directors have access to the interactive version in addition to the static report presented. Three report writing training sessions for authors have been delivered (on 26 May 2022, 7 Jun 2022 and 26 Jul 2022). Around 30 report authors have taken part in the training so far, as well as members of the executive team. Executive directors have attended NED meetings to socialise topics, such as the BAF and the Shadow Board programme.	

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

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

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

№ and priority	Recommendation	Action plan and milestones	Lead director	Update	RAG
13 High	There is a need to revisit the role of the governor, both in relation to expectations regarding the participation of governors in trust forums, alongside how current activities could adapt and evolve in response to the emerging Integrated Care System. This should include the provision of bespoke training and development in order to further support governors with potential changes to their role in the coming months.	By the end of Q2 2022/23, we will have facilitated a workshop with governors to outline the trust's expectations around participation and to outline new ways of working. Bespoke training and development to support governors with potential changes to their role will take place during Q2 to Q4 2022/23.	Chair	A workshop was held with governors on 14 September 2022, and the focus is now on action planning; particularly in relation to external engagement. This will be supported by guidance from NHS England on the role of foundation trust councils of governors in system working and collaboration once published. At its meeting on 11 January 2023, the Council of Governors considered an outline for integrated working with Wigan Borough, GM Integrated Care's Wigan Place Team and other key stakeholders. The board is recommended to close this action.	

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№ 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. There was a further soft launch of the CI programme in Q3 2022/23 in order to target the continuous improvement capability to wider organisational challenges and work collaboratively with system partners. Work on the second part of the action plan is ongoing as part of the new place-based operating model currently being developed. The board is recommended to close this action.	

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)