# Board of Directors - Public Meeting

*Wed 04 October 2023, 13:15 - 16:15*

**Boardroom, Trust Headquarters**

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

## Agenda

**13:15 - 13:17**
2 min

### 11. Declarations of Interest

*Information* *Mark Jones*

Verbal item

**13:17 - 13:20**
3 min

### 12. Minutes of Previous Meeting

*Approval* *Mark Jones*

12. Minutes_Board of Directors - Public meeting_020823.pdf (6 pages)

**13:20 - 13:30**
10 min

### 13. Chair's Opening remarks

*Information* *Mark Jones*

Verbal Item

**13:30 - 13:50**
20 min

### 14. Chief Executive's report

*Information* *Silas Nicholls*

14. Board Report_CEO_October_2023 FINAL.pdf (3 pages)

**13:50 - 14:05**
15 min

### 15. Update on WWL's response on the Lucy Letby verdict

*Information* *Sanjay Arya*

15. Assurance following Lucy Letby case.pdf (9 pages)

**14:05 - 14:35**
30 min

### 16. Committee chairs' reports

*Information* *Non Executive Directors*

#### 16.1. Finance and Performance

*Information* *Julie Gill*

Report sent to follow due to close proximity of the meeting.

#### 16.2. People

*Information* *Lynne Lobley*

AAA _ People - September 23.pdf (2 pages)

#### 16.3. Research

*Information* *Clare Austin*

AAA - Research - Sept 2023.pdf (2 pages)

### 16.4. Audit

*Information only*

AAA - Audit Committee - 20 Sep 2023.pdf (2 pages)

### 16.5. Quality and Safety

*Information only*

AAAQ&SAugust23.pdf (2 pages)

**14:35 - 14:50**
15 min

## 17. Board assurance framework

*Discussion* *Paul Howard*

17. BAF Report Board October 2023.pdf (26 pages)

**14:50 - 15:05**
15 min

## 18. Integrated performance report

*Discussion* *Sanjay Arya/James Baker/Mary Fleming/Mary Fleming*

M5 Board of Directors Balanced Scorecard Report V3.pdf (8 pages)

**15:05 - 15:20**
15 min

## 19. Finance Report

*Discussion* *Tabitha Gardner*

19. Trust Financial Report 23-24 August Month 5 ETM.pdf (26 pages)

**15:20 - 15:35**
15 min

## 20. Maternity

*Information* *Rabina Tindale*

### 20.1. Maternity and Neonatal Dashboard

20.1 Oct Board Maternity and Neonatal Dashboard report August 2023.pdf (5 pages)
20.1a. Oct Board Maternity and Neonatal Safety Dashboard August 2023.pdf (12 pages)

### 20.2. Perinatal quality surveillance report (Q4)

20.2. Oct Board Maternity Perinatal Quality Surveillance Q4 ( For Board)1.pdf (22 pages)
20.2. Oct Board August 2023 Perinatal Monthly Surveillance Dashboard.pdf (3 pages)

**15:35 - 15:50**
15 min

## 21. Winter Planning

*Information* *Mary Fleming*

21. Winter Planning 23-24.pdf (3 pages)
Appendix 1 GM - Wigan Locality KLOE Submission Sep 23.pdf (22 pages)
Appendix 2 GM Winter Plan - GM KLOE Submision.pdf (25 pages)

**15:50 - 15:50**

## 22. Item no longer required

0 min

# Consent Agenda

**15:50 - 15:55**
5 min

## 23. Review of changes to Standing Financial instructions

*Approval*

- 23. SFI Changes Board.pdf (5 pages)
- SFIs 22-23 after changes.pdf (65 pages)

**15:55 - 16:00**
5 min

## 24. Maternity Papers

*Information*

### 24.1. CNST update

- 24.1a. Oct Board Consent agendaCNST Training plan and compliance 2023.pdf (4 pages)
- 24.1 Oct Board Consent agenda CNST BOARD REPORT UPDATE OCT 2023.pdf (15 pages)

### 24.2. CQC maternity action plan

- 24.2 Oct Board Consent agenda CQC action plan september 2023.pdf (5 pages)

### 24.3. Saving babies lives compliance update

- 24.3 Oct Board Consent agenda SBL - board report update.pdf (2 pages)

**16:00 - 16:05**
5 min

## 25. Date, time and venue of next meeting

*Information* *Mark Jones*

Wednesday 6 December 2023, 1:15 - 4.15pm

# Board of Directors - Public meeting

*Wed 02 August 2023, 13:45 - 16:15*

Boardroom. Trust Headquarters

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

## Attendees

### Board members

Mark Jones (Chief Executive (Chair)), Mary Fleming (Deputy Chief Executive), Tabitha Gardner (Chief Finance Officer), Francine Thorpe (Non-Executive Director), Julie Gill (Non-Executive Director), Terry Hankn (Non-Executive Director), Rabina Tindale (Chief Nurse), Anne-Marie Miller (Director of Communications and Stakeholder Engagement), Richard Mundon (Director of Strategy and Planning), Ian Haythornthwaite (Non-Executive Director), Sanjay Arya (Medical Director), Paul Howard (Director of Corporate Affairs), Lynne Lobley (Non-Executive Director)

### In attendance

James Baker (Deputy Chief People Officer), Nina Guymer (Deputy Company Secretary (Minutes))

## Meeting minutes

### 11. Declarations of Interest

Information

No declarations of interest were raised.

Mark Jones

### 12. Minutes of Previous Meeting

Approval

The minutes of the previous meeting were **AGREED** as a true and accurate record.

Mark Jones

12.Minutes_Board of Directors Public meeting_070623.pdf
12a. Public Board Action Log - June 2023.pdf

### 13. Chair's Opening remarks

Information

Mark Jones

The Chair noted the current ongoing pressures faced by the NHS and expressed thanks to the executive team and their teams for their hard work in tackling these and noted that there is data available now which shows that the Wigan locality has frailer, older patients with more co-morbidities, making it even more difficult for Wigan in particular, as a borough to overcome these issues.

He advised that himself and the Chief Executive had recently attended a system leadership event for GM and that they were pleased to report that current focus is very much local rather than moving too much towards the Integrated Care Board (ICB). The two sovereign organisations of WWL and Wigan Council are to work together to ensure that their governance process are consistent and aligned appropriately to ensure that progress is made. He advised that himself and the Chief Executive would soon meet with the Leader and Chief Executive of Wigan Council.

He further noted that the meetings of the Quality and Safety Committee will be rescheduled so that they are more close temporally to the Board's meetings. The People Committee and Finance and Performance Committees will begin holding their meetings on Tuesdays. All changes would come in to effect from January 2024. He advised that the Three Wishes Charity would soon begin to consider how it can reduce the number of funds which it holds, to facilitate a more strategic use of its donated funds.

The Medical Director advised that the Capital Medical Equipment Group have linked with fund holders who have assisted them to identify whether any equipment would be eligible to be paid for by charitable funds.

Finally, the Chair advised that the Trust would be taking forward an associate NEDs programme, which proposes to create some unpaid positions for those in groups which are under represented on WWL's Board, allowing them to shadow non-executive directors and receive training which would prepare them to take on a paid role in the position.

The Board noted the update provided.

## 14. Chief Executive's report

Information

Mary Fleming

The Deputy Chief Executive provided a summary of the report which had been shared in advance of the meeting.

The Board received and noted the report.

14. Board Report_CEO_August_2023 FINAL.pdf

## 15. Committee chairs' reports

Information

Non Executive Directors

The Non Executive Chairs of the Board's sub-committees presented their respective reports.

### 15.1. Finance and Performance

Information

Julie Gill

The Chair asked for more details in respect of how the winter funding expenditure, which had been approved, would be used.

The Chief Finance officer advised that WWL hold funds which are spent in the later part of the year, each year, to support the pressures which created by the effect of the cold winter weather, highlighting that much of this expenditure is on locum and bank staff. She advised however that this year, plans had been put forward to recruit to key positions in advance of winter and on a recurrent basis and that this plan would be put in place immediately, given that the current pressures are similar to those usually faced in winter. This would consume £1.5m of the funding with a remaining £0.5m ear marked for the surgery division to open additional paediatric beds, as is the usual requirement.

AAA F&P - 26 Jul 2023 .pdf

### 15.2. People

Information

Lynne Lobley

In respect of the ongoing doctors' strikes, the Deputy Chief People Officer reported positively that the approach to handling the strikes across the Integrated Care System is very much joined up.

The Medical Director agreed that the Trust are confident in handling the strikes now and that despite that additional strikes have been planned for, the trust had determined that the additional amount of locums required to cover the resulting capacity reduction would not be significant.

15.2 AAA _ People - Jul 2023.pdf

### 15.3. Quality and Safety

Information

Francine Thorpe

In response to a query from the Chair, the Medical Director advised that a Sepsis Group has now been established and noted an improvement in the amount of antibiotics administered within the golden hour. He further confirmed that WWL now have relevant operating procedures in place for corridor care.

15.3 AAA QSjune23.pdf

### 15.4. Audit

Information

Ian Haythornthwaite

Mr I Haythornthwaite noted that following the meeting, the members of the Audit Committee met privately with both the internal and external auditors, with no concerns raised.

15.4 AAA - Audit Committee - 19 Jun 2023.pdf

### 15.5. Research

Information

Richard Mundon

This report was presented by the Director of Strategy and Planning, since the Chair of the meeting was absent. It was agreed that moving forwards, the Board should see a 'research story', in place of its usual staff or patient story item.

The Board received and noted the papers and additional verbal updates provided.

15.5 AAA - Research - June 2023.pdf

## 16. Board assurance framework

**Discussion**

Paul Howard

The Director of Corporate Affairs presented the item.

The Chair noted that on page 24 of the document, in relation to the 'partnerships' corporate objective (CO) 15 and associated risk PR11, that only the System Board is noted. He was keen to see this expanded upon to reflect other ongoing relationships.

Mrs L Lobley asked whether CO14 should include reference to communities, rather than population.

The Director of Corporate Affairs advised that this objective is about the population and there is no risk specifically to communities, although there is work going on separately around strengthening this.

The Deputy Chief Executive asked whether the financial position creates any a risk to the way that the Trust operates as an anchor institution.

The Director of Strategy and Planning noted that the amount that WWL spends within the locality, in terms of procurement, is increasing, further, the number of employees from the local areas is also significant. However, he agreed to review the impact of financial position on other 'partnership' corporate objectives.

**ACTION: R Mundon**

The Board received and noted the paper.

16. BAF Report Board August 2023v3.pdf

## 17. Integrated performance report

**Discussion**

Sanjay Arya/James Baker/Mary Fleming/Mary Fleming

The lead executive director for each of the areas set out presented the relevant section of the scorecard.

**Performance**

In addition to the information provided, it was noted that the NHS's emergency care improvement support team (ECIST) would be attending the acute site to consider the current pressures within the hospital and work with the Trust, as they have done previously, to identify further improvements and efficiencies. The Deputy Chief Executive described issues being faced by the Trust's booking teams, which now must cancel appointments at short notice where strikes are confirmed as taking place but noted positively that trusts are permitted to strip out the impact of industrial action on their activity.

Mrs F Thorpe asked whether, in respect of both unscheduled and scheduled care, there has been any consideration of restarting the use of first contact practitioners and whether the Trust should look at this as a possible transformation project.

The Deputy Chief Executive advised that this has not been considered for a while but when it was last in place, it was very positively received. She therefore agreed to look into this.

Mrs L Lobley asked for a summary of the concerns around waiting list growth.

The Deputy Chief Executive advised that GM Chief Operating Officers have highlighted the risk around this. During the pandemic, trusts moved to treating patients in clinical priority and as that continues, the Trust is now having to consider stopping all new referrals in some areas. She agreed to carry out a more detailed piece of work to set out the concerns around waiting lists and also arrange for this to be added to the risk register.

**ACTION: M Fleming**

**Quality and safety**

It was highlighted that WWL's hospital standardised mortality ratio is below 100 and at that, the best in GM.

**People**

The Chair noted that, on termination of the contract with the Guardian Service, who provided a freedom to speak up (FTSU) service for the Trust, WWL would recruit its own FTSU Guardian. He wished to clarify what level the FTSU guardian would be, as he was concerned to make sure that the individual would be working at a level allowing them to feel comfortable to work with staff across all levels of management. The Deputy Chief People Officer advised that the role will be graded as an 8a, agenda for change position and advised that consideration will also be given as to whether there is any possibility of covering this service within existing resource.

**Finance**

This element of the score card was considered as part of the discussion around the finance report. The Chair noted that the Board now require sight of the risk analysis carried out in terms of the financial challenge that the Trust faces.

The Board received and noted the report and the additional verbal updates provided.

17. Board of Directors M3 2324 Scorecard.pdf

## 18. Finance Report

**Discussion**

Tabitha Gardner

The Chief Finance Officer presented the paper which had been shared prior to the meeting.

Mr I Haythornthwaite noted that the Trust is considerably far away from achieving its year-to-date target and asked, even if the Trust had a deficit, what failure to achieve this means statutorily for the Trust, as a going concern. He further asked whether the Trust must comply with the new financial control of requiring the reporting of any expenditure of above £10k which is over the run rate.

The Chief Finance Officer agreed to report back on this at the next meeting.

**ACTION: T Gardner**

The Board received and noted the report.

18. Trust Financial Report 23-24 June Month 3 Board.pdf

## 19. Maternity

Information

Rabina Tindale

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

### 19.1. Maternity Dashboard

The Deputy Chief Executive asked whether the category 1 cesarean sections referred to in the report are elective or emergency and how there had been delays experienced here since there is a now dedicated cesarean theatre.

The Medical Director advised that at times there may be a need for a second emergency theatre and suspected that this may be the reason.

The Board received and noted the report.

19.1 Maternity Dashboard report June 2023.pdf
19.1a MaternityDashboard June 2023.pdf
19.1b Neonatal Dashboard.pdf

### 19.2. Perinatal quality surveillance report

The Board received and noted the report, recognising that the Trust is not fully compliant in respect of the maternity incentive scheme and the Ockenden essential actions but taking assurance that the relevant actions are taking place to address any issues outlined and mitigate any associated risks.

19.2 Maternity Perinatal Quality Surveillance Q1 ( For Board).pdf
19.2a. Copy of June 2023 Perinatal Monthly Surveillance Dashboard.pdf

### 19.3. Neonatal staffing report

The Chief Nurse clarified that the request within the paper is being presented to ensure compliance with Clinical Negligence Scheme for Trusts (CNST) requirements and that the staffing proposals would be worked up in to a business case which would then follow the required governance processes before being approved.

The Board received and noted the report and supported the staffing proposals.

19.3 NNU STAFFING PAPER July 2023 for TB.pdf

### 19.4. Maternity Safety Report

It was noted that all non-executive board safety champions, the Medical Director and the Chief Nurse had signed on to the FutureNHS Safety Culture-Maternity & Neonatal Board Safety Champions Collaborative Platform, as required by safety standard 9 of the Maternity Incentive Scheme, prior to 1 August 2023.

The Board received and noted the report.

19.4. Maternity Safety update report may-june 23.pdf

### 19.5. CNST ATAIN (avoiding term admissions into neonatal) action plan

The Board received and noted the report, expressing that they were satisfied with the assurance provided.

19.5. ATAIN ACTION PLAN CNST YEAR 5 June 2023 (002) For TB.pdf

## 20. IPC board assurance framework

Information

Rabina Tindale

The Board suggested that they receive the report provided on a biannual basis and felt it was not required for every meeting.

Mrs L Lobley expressed concern around lack of a substantive microbiologist in place. She asked how WWL can improve handwashing given the current clostridium difficile rates

The Medical Director explained that meetings would take place in the following week around how WWL may share a joint service with another trust.

The Chief Nurse advised that the divisional directors of nursing are progressing a plan and that hand hygiene is included as a metric within the ASPIRE programme, which will encourage wards to hold this as a key priority.

The Board received and noted the report.

20. IPC BAF, Version 1.0. To 30 June 2023. 9.7.2023.pdf

## 21. Consent Agenda

### 21.1. Guardian of Safe Working Hours report

Information

James Baker

The Board received and noted the report and endorsed the approach set out therein.

21.1. Quarter 3 Report GoSWH Feb 2023.pdf
21.1a. Quarter 4 Report GoSWH May 2023.pdf
21.1b. Annual Report GoSWH 2023.pdf

### 21.2. Freedom to Speak Up Guardian's report

Information

James Baker

The Board received and noted the report and endorsed the approach set out therein.

21.2. FTSU Update - ETM 20.07.23.pdf
21.2a. WWL Annual FTSU Guardian Report 2022-2023.pdf

### 21.3. Medical revalidation report

Information

The Board received and noted the report.

21.3 2022-2023 Annual Submission to NHS England North West Final updated.pdf

### 21.4. Review of statutory and mandatory recommended posts

Information

The Board received and noted the report.

21.4 Report - statutory, mandatory and recommended posts - Aug 2023.pdf

## 22. Date, time and venue of next meeting

Information

Mark Jones

The Chair noted a request made at a recent GM Chairs meeting, for Trusts to make a statement that they are anti-racist. He was keen for WWL to do this but wanted to ensure that there was a piece of work sitting behind it to ensure that the statement is robust.

Wednesday 4 October 2023, 1:15 - 4:15pm

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

| | |
|---|---|
| **Title of report:** | Chief Executive's Report |
| **Presented to:** | Board of Directors |
| **On:** | 04/10/23 |
| **Presented by:** | Chief Executive |
| **Prepared by:** | Director of Communications and Stakeholder Engagement |
| **Contact details:** | T: 01942 822170 E: anne-marie.miller@wwl.nhs.uk |

**Executive summary**

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

**Link to strategy**

There are reference links to the organisational strategy.

**Risks associated with this report and proposed mitigations**

There are no risks associated with this report.

**Financial implications**

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

**Legal implications**

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

**People implications**

There are no people risks associated with this report.

**Wider implications**

There are no wider implications associated with this report.

**Recommendation(s)**

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

**Report**

August and September were yet again busy months at WWL and firstly, I want to thank all our staff for their collective efforts to ensure we continue to deliver high quality and safe care for our patients, day and night.

Like previous months, we experienced sustained pressures within our urgent and emergency care services, and we continued to drive to reduce waiting list times for our patients who are waiting on elective operations and procedures. We are still seeing high attendance figures and a high acuity of patients to our Emergency Department, which unfortunately in turn creates prolonged waits for our patients. Along with our system partners, we have joint improvement plans in place to create better flow and safe discharges; this improvement work is progressing well. All of this activity is maintained against a backdrop of safely addressing our financial challenges and the industrial action, with action being taken against the Government by Junior Doctors and Consultants from the British Medical Association. The latest period of industrial action provided us with a new challenge, in that for the first-time consultants and junior doctors took action together on Wednesday 20 September. During the industrial action 'Christmas Day cover' was provided, which included protecting emergency treatment, intensive care, new-born care, maternity, trauma – and some limited planned care. Our services remained under pressure throughout the industrial action and regretfully a number of non-urgent operations and clinics were postponed to ensure patient safety at all times.

In August, the Care Quality Commission (CQC) published the outcome of an inspection that they undertook in May this year, which rated our maternity services at the Royal Albert Edward Infirmary as GOOD. This inspection was carried out as part of the CQC's national maternity services inspection programme. The programme aims to provide an up-to-date view of the quality of hospital maternity care across the country, and a better understanding of what is working well to support learning and improvement at a local and national level. We welcomed this inspection and subsequent report as it was an opportunity to showcase the excellent work we do in maternity services; the support we provide to our patients and staff and the improvements we continue to make. It was also an opportunity to demonstrate how we gain feedback from our patients and staff, how we learn and continuously improve, provide safe, effective and caring treatment and support to our patients, their families or carers. As well as maternity services remaining good overall, the rating for being well-led also remains rated as good. CQC did not look at effective, caring and responsive which still remain rated as good from their previous inspection. However, the safe part of the rating has changed from good to requires improvement. The rating was reduced due to not all staff being up to date with some elements of mandatory training at the time of inspection. It was pleasing to see that the CQC had recognised that the maternity staff felt respected, supported and valued. The CQC also highlighted that the service promoted equality and diversity in daily work with an open positive, culture where women, their families and staff could raise concerns without fear.

As a dedicated supporter of Wigan Borough's biggest celebration of the LGBTQIA+ community, we proudly took part in the Wigan Pride event in August. It was a great opportunity for WWL to show the Wigan community that we are a place of diversity, inclusion and equality and we accept everyone. In addition to many colleagues taking part in the parade and enjoying the main stage activities, we had two stalls at the event that provided sexual health testing, breast screening advice and advice/signposting to support groups for our LGBTQIA+ community. All of this wouldn't have been possible without a number of teams working together to plan and deliver event participation, including our True Colours Staff Network, Patient Experience, Staff Experience and staff volunteers. Throughout the year our True Colours Staff Network has focused on many LGBTQIA+ awareness days, have decorated the main corridor at the Royal Albert Edward Infirmary in rainbow colours - which remains as our symbol of equality, diversity and inclusion – and, working alongside The Rainbow Badge Project, have made changes to policies and procedures on how to help WWL's environment to be more inclusive.

WWL colleagues and services continue to gain significant peer and sector recognition, our Daisy Team based at Boston House recently won the Maternity and Midwifery Initiative of the Year Award at this year's Health Service Journal Patient Safety Awards. The team were nominated for all of the work they do with our most vulnerable patients. WWL's Research Department have been shortlisted for the Greater Manchester Health and Care Research Awards under two categories: Inclusive Involvement Excellence - Patient Research Advisory Group, Best Public Engagement - Introducing the Greater Manchester research van to the community (shared with Manchester University NHS Foundation Trust). Staff from each team have been invited to the winner's ceremony on Thursday 5th October, organised by Clinical Research Network (CRN) Greater Manchester.

Our 'Accreditation System Providing Improvement and Recognition in the care Environment' (ASPIRE) recognition and reward event took place in September and was a huge success. On the day a number of our ward leaders were invited to share their journey and learning from the ASPIRE process. Presentations were given on continuous improvement and research, which is now an essential measure within the programme. Plaques were awarded to teams and these are now proudly displayed in the ward areas for patients, visitors and staff to see.

It was great to finally cut the ribbon in September to our new ultrasound suite, funded by over £100,000 of generous donations to our Three Wishes charity following four years of WWL's 'In Pink' campaign. A special event was held at the Thomas Linacre Centre with the town's Mayor and gathered guests of key contributors, including Boot Out Breast Cancer, were in attendance. The new ultrasound suite will enable the Trust's Breast Consultants to diagnose patients more effectively and efficiently and will make a positive impact on reducing the waiting list for patients waiting for an ultrasound examination. It will also mean the Trust can take part in new and innovative research trials and futureproof the service to be able to bring in new technology, such as artificial intelligence.

A brilliant first for research in September with WWL recruiting the first patient to a UK-wide study. The LOVE DEB Registry, ("Large de-nOVo coronary artEry disease treated with sirolimus Drug Eluting Balloon"), is led by the Cardiology Team and will explore whether drug-coated balloons can be safely used in large coronary arteries instead of stents in patients undergoing an angioplasty procedure. Chief Investigator and WWL Cardiology Consultant, Dr Abhishek Kumar, recruited the first patient to the study at the Royal Albert Edward Infirmary, Wigan, with plans to expand the research to a further nine NHS hospitals across the UK. It is a matter of great pride for the Trust to sponsor this national multi-centre study and while there are no personal benefits to taking part in this study for patients, in it is hoped in time that the information we acquire will result in better treatments for future patients.

Our teams at Leigh Infirmary were delighted to welcome the Greater Manchester Mayor Andy Burham to the hospital in September. Mr Burnham was invited as part of the celebrations to commemorate the Hanover Building 10th Anniversary as he had officially opened the building originally. It was a great opportunity to showcase some of the fantastic services provided at Leigh Infirmary with a tour of the urology department, women's health unit, and the endoscopy unit and reprocessing service. The visit culminated with a quick tour of our new £6.5m Community Diagnostic Centre which is currently being built on the site.

Finally, Rabina Tindale, our Chief Nurse, will be leaving WWL in January 2024, to take up position as Executive Director of Nursing & Quality Assurance (Chief Nurse) for the Leeds Teaching Hospitals Trust. We are extremely grateful for everything Rabina has achieved with us at WWL, particularly her commitment to implementing positive improvements across our services for patients and their families and for how she has helped our nursing colleagues maximise their potential. Interim arrangements will be in place for Rabina to handover before leaving the Trust and, in line with all Board appointments a rigorous recruitment process will take place to find Rabina's permanent successor.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

| | |
|---|---|
| **Title of report:** | Assurance Briefing following the verdict in the trial of Lucy Letby |
| **Presented to:** | Trust Board |
| **On:** | 4th October 2023 |
| **Item purpose:** | [Information / discussion / approval] |
| **Presented by:** | Professor Sanjay Arya, Medical Director |
| **Prepared by:** | Carrie McManus Head of Patient Safety |
| **Contact details:** | T: [ 01952 822026 ] E: [ sanjay.arya@wwl.nhs.uk ] |

**Executive summary**

- In response to recent court verdict and the correspondence received from NHS England (18 August 2023) about the Lucy Letby case, this paper provides assurance to the Trust Board on the policies and processes at WWL that enable staff to raise concerns without fear of reprisal.
- The paper also outlines:
  - The progress in a positive safety culture at WWL and the transition to the Patient Safety Incident Response Framework (PSIRF).
  - The Trust's approach to the Fit and Proper Person Test (FPPT) Framework published by NHS England on 2 August 2023 in response to the recommendations made by Tom Kark KC in his 2019 Review of the FPPT.
- For the last few years WWL has provided it's Freedom to Speak Up Service through an outsourced provider. WWL has recently made the decision to switch its Freedom to Speak Up Guardian provision to an alternative.
- WWL is currently in discussion with GM NHS in relation to the provision of a more affordable outsourced model of the Freedom To Speak Up Guardian service.
- Reports are received at ETM on a monthly basis on the numbers of concerns raised, the theme of the concern (including Patient Safety concerns), and the route the concern is taking.
- The current Interim Freedom to Speak Up Guardian has direct access to the Chief Executive and other members of the Executive Team, and any future arrangement will continue in this regard.

The WWL Way

- WWL are committed to an open, inclusive and just culture in which everyone feels valued, and can be confident that their feedback, ideas and concerns will be listened to and concerns acted on.
- The National Patient Safety Strategy, safer culture, safer systems, and safer patients was launched in July 2019 by NHS England and NHS Improvement. Part of this Patient Safety Strategy was the national development of PSIRF. This was delayed during the pandemic and published in August 2022.
- PSIRF is a contractual requirement under the NHS Standard Contract and will be launched at WWL in November 2023. A report detailing WWLs PSIRF policy and plan will be submitted to the Quality & Safety Meeting in October 2023
- Creating a safety culture where staff feel safe to speak up about concern is identified as a core part of the NHS Patient Safety Strategy.
- Corporate Patient Safety Group receives AAA reports from Governance groups describing the issues and risks that have been identified or discussed specifically in relation to patient safety incidents.
- The Medical Examiner (ME) system provides greater safeguards for the public by ensuring proper scrutiny of all non-Coronial deaths, ensure appropriate direction of deaths to a Coroner, provide a better service for the bereaved, provide an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased, improve the quality of death certification, and improve the quality of mortality data. The Medical Examiner Service has been in place at WWL since March 2020.
- Two thirds of deaths are reviewed at WWL weekly (acute) and monthly(community) and learning from these deaths are shared widely with the clinical (and wider) groups. This has recently been expanded to scrutinise deaths of non-coronial paediatric patients starting from the 1 October 2023.
- Trust Quality & safety Committee receives quarterly mortality report as part of the regular Learning from Deaths reviews. In addition, the Trust Board receives an annual learning from deaths report.
- The Medical Director chairs Monthly mortality group, which is multidisciplinary, including external bodies (AQuA, Dr Fosters, HED) where any deaths/disease conditions which alert the organisation are discussed.
- In addition, the Medical Director chairs a Quarterly mortality group which is also multidisciplinary, including external bodies, where audits/patient pathways/learnings are presented, following alerts raised from the monthly mortality group.

**Link to strategy and corporate objectives**

Patient, People, Partnership

**Risks associated with this report and proposed mitigations.**

The Trust must ensure that it has appropriate governance procedures to identify and address possible areas of concern at an early stage and ensure that patients and members of the public are always protected.

**Financial implications**
nil

**Legal implications**

There are clear legal implications for not reviewing themes and trends from a regulatory perspective as well as the forthcoming public inquiry regardless of how it is constituted.

**People implications**
Nil

**Wider implications**
Nil

**Recommendation(s)**

The Trust Board is asked to:

- Note the assurance provided regarding WWLs Freedom to Speak Up processes.
- Note the underpinning plans to create an open, just and inclusive culture

# Report

## 1. Purpose

1.1 In response to the recent court verdict and the correspondence received from NHS England (18 August 2023) about the Lucy Letby case, this paper provides assurance to the Trust Board on the policies and processes at WWL that enable staff to raise concerns without fear of reprisal.

1.2 The paper also outlines the progress in a positive safety culture at WWL and the transition to the Patient Safety Incident Response Framework (PSIRF).

## 2. Background

2.1 In August 2023, the jury in the trial of Lucy Letby, a neonatal nurse at the Countess of Chester Hospital, returned a guilty verdict and a sentence of life imprisonment for murder and attempted murder was handed down by the presiding Judge.

2.2 In a statement responding to the verdict, the parliamentary and health service ombudsman said that 'nobody listened' to the clinicians at the trust who had tried to raise concerns. A full public inquiry into the circumstances of the Lucy Letby case has been ordered by the government, which will include the handling of concerns and governance.

2.3 On 18 August 2023, the NHS England Executive Team wrote to all Integrated Care Boards and NHS Trusts regarding the outcome of the trial and reiterating the necessity of good governance along with assurance of proper implementation and oversight.

2.4 The letter reiterated commitment to prevent 'something like this happening again' and outlined the steps that had already been taken to strengthen patient safety and monitoring, namely the national rollout of medical examiners and the forthcoming implementation of the new Patient Safety Incident Response Framework.

2.5 The letter also recognised that NHS Boards must ensure proper implementation and oversight, specifically ensuring the following:

- All staff have easy access to information on how to Speak Up
- Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to it.
- Approaches or mechanisms are put in place to support those members of staff where there may be specific barriers to speaking up. These include cultural barriers, those in lower paid roles who may be less confident to do so, and those who work unsociable hours and may not always be aware of or have access to the policy or process supporting speaking up.
- Methods for communicating with staff to build healthy and supportive cultures where everyone feels safe to speak up should also be put in place.
- Boards should seek assurance that staff can speak up with confidence and that whistleblowers are treated well.
- Boards are regularly reporting, reviewing and acting upon available data.

2.6 The letter also referenced the expectation that by January 2024 all organisations providing NHS services should have adopted the updated, strengthened Freedom to Speak Up policy, and reiterated the obligations of all NHS organisations under the Fit and Proper Person requirements.

## 3. Freedom to Speak Up (FtSU) at WWL

**Easy access to FtSU for all staff**

3.1 For the last few years WWL has provided it's Freedom to Speak Up Guardian Service through an outsourced provider, The Guardian Service. Organisations offer this service in different ways, very often on an in-house provision basis and WWL has recently made the decision to review how this service is provided.

3.2 WWL is currently in discussion with GM NHS in relation to an alternative outsourced provision. GM NHS host Freedom to Speak Guardians for Primary Care Services across GM and have a robust support and infrastructure in place for the Guardians. In the interim the role is being carried out by the previous interim Chief People Officer.

3.3 The Freedom to Speak Up Guardian (both previous and the interim) maintain a visible presence in the organisation, specifically targeting those in lower paid roles or those who work regular unsocial hours.

3.4 The Trust has three formal Staff Networks established, FAME Network; Disability and Staff with Long Term Health Conditions Network and the True Colours Network. These networks have many roles, however, key to there success is the creation of a safe space for staff where there may be specific barriers to speaking up and members of the Executive Team regularly engage with this group to ensure voices are heard.

3.5 Details on how to contact the Freedom to Speak Up Service, with details on the service can be found on the Trusts Intranet Page.

3.6 WWL will support any member of staff who wishes to explore whether they are eligible for the structured speaking up support offered by the national scheme for those who have experienced a significant adverse impact (in their professional or personal life) following a formal speaking up process. The scheme is currently closed for applications however the Trust will continue to review this, and will explore alternative ways to support those who raise concerns in the meantime.

3.7 The Trust offers the Level 1 national Freedom to Speak Up training to all staff as a mandatory requirement. All Freedom to Speak Up training and awareness materials are available on the WWL Learning Hub.

Executive Team members continue to regularly promote the different ways that staff can raise concerns, recognising that the Freedom to Speak Up Guardian is an alternative route and one of many ways to where staff can speak up to.

**WWLs FtSU Policy**

3.8 The current version of WWLs FtSU Policy was approved in October 2022. WWL has adopted the updated, strengthened national NHS Freedom to Speak Up policy, and reiterated the obligations of all NHS organisations under the Fit and Proper Person requirements.

**Regular Board Review**

3.9 The previous Guardian Service that provided Freedom to Speak up routes for staff have produced 6 monthly reports to the People Committee, and monthly reports are reported to the Executive Team

3.10 It is proposed that this report is shared with other groups so that there can be effective triangulation of information against themes and trends of incidents, complaints, legal claims and other data to identify any emerging issues within any areas.

3.11 Trust Board will be supported to work through the Freedom to Speak Up Review Tool to provide assurance in relation to areas of good practice and prioritise actions for further development.

**Healthy and Supportive Cultures**

3.12 WWL are committed to an open, inclusive and just culture in which everyone feels valued, and can be confident that their feedback, ideas and concerns will be listened to and acted upon appropriately.

## 4. Patient Safety Incident Response Framework (PSIRF)

4.1 The National Patient Safety Strategy, safer culture, safer systems, and safer patients was launched in July 2019 by NHS England and NHS Improvement. Part of this Patient Safety Strategy was the national development of PSIRF; this was delayed during the pandemic and published in August 2022.

4.2 The four key aims of PSIRF are:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening response system functioning and improvement.

4.3 PSIRF is a contractual requirement under the NHS Standard Contract and will be launched at WWL in November 2023. A report detailing WWLs PSIRF policy and plan will be submitted to the Quality & Safety Meeting in October 2023

**Safety Culture**

4.4 Creating a safety culture where staff feel safe to speak up about concern is identified as a core part of the NHS Patient Safety Strategy.

4.5 Work underway around PSIRF implementation will also work towards embedding a better and more robust safety culture. Our PSIRF Implementation Task and Finish Group has representatives from Staff Engagement to support the links to the 'Our Family, Our Focus, Our Future' work currently underway.

4.6 Following the transition to PSIRF the following meetings will be put in place to develop patient safety across the Trust:

- **Divisional Patient Safety Group** – this meeting will be chaired by the Divisional Triumvirate and/or Clinical Lead for Governance and identifies any support required for staff involved in the event, and immediate safety concerns. T

- **Learning from Patient Safety Events** - this meeting will be held weekly to review incidents that have occurred that may require an investigation. The multidisciplinary members of the meeting discuss the incidents and agree the level of impact to the patient, and what kind of investigation should be undertaken. It will also hear the initial findings from incident reports and provide an opportunity for additional aspects to be considered and potential actions to be decided.
- **Learning from Excellence Group** - occurs monthly with the Medical Directos, patient safety team (PST), Legal team, safeguarding team, assurance team, complaints department to triangulate patient safety information and share learning and provide assurances.
- **Corporate Patient Safety Group -** receives AAA reports from these groups describing the issues and risks that have been identified or discussed during the above meetings.

## 5. Medical Examiners

5.1 The purpose of the Medical Examiner (ME) system is to provide greater safeguards for the public by ensuring proper scrutiny of all non-Coronial deaths, ensure appropriate direction of deaths to a Coroner, provide a better service for the bereaved, provide an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased, improve the quality of death certification, and improve the quality of mortality data. Medical Examiner Service has been in place at WWL since March 2020.

5.2 Two thirds of deaths are reviewed at WWL weekly (acute) and monthly(community). This has recently been expanded to scrutinise deaths of paediatric patients from the 1 October 2023.,

5.3 The Trust Board receives quarterly mortality report as part of the regular Learning from Deaths reviews. In addition, WWL produce an annual learning from deaths report.

5.4 Alerts and triggers from death via Dr Foster and HED are discussed at the monthly Mortality Group

## 6. Other Systems/Processes reviewing deaths at WWL

6.1 Two thirds of deaths are reviewed at WWL weekly (acute) and monthly(community) and learning from these deaths are shared widely with the clinical (and wider) groups. This has recently been expanded to scrutinise deaths of non-coronial paediatric patients starting from the 1 October 2023.

6.2 The Trust Board receives quarterly mortality report as part of the regular Learning from Deaths reviews. In addition, the Trust Board receives an annual learning from deaths report.

6.3 The Medical Director chairs Monthly mortality group, which is multidisciplinary, including external bodies (AQuA, Dr Fosters, HED) where any deaths/disease conditions which alert the organisation are discussed.

6.4 In addition, the Medical Director also chairs a Quarterly mortality group which is also multidisciplinary, including external bodies where audits/patient pathways/learnings are presented following alerts raised from the monthly mortality group.

## 7. Conclusion

TheTrust has reviewed the correspondence from NHS England. This paper provides assurance to the Trust Board that there are policies and processes in place at WWL that enable staff to raise concerns without detriment, and which have Board oversight through regular reporting.

# Committee report

| | |
|---|---|
| **Report from:** | People Committee |
| **Date of meeting:** | 12 September 2023 |
| **Chair:** | Lynne Lobley |

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

| **ALERT** |
|---|
| ▪ The committee were alerted to the slight decline in the GMC survey results, but noted that WWL is still well placed within GM.<br>▪ The committee were concerned that ED&I lead position still only funded as a temporary position for 12 months. It was acknowledged that further work needs to be done to develop a plan to address this, the Committee were however assured that a recent appointment had been made to the role of EDI Lead which, in the short term, provides capacity and capability to lead the work required.<br>▪ The committee are concerned about the upcoming industrial action taking place with Junior Doctors and Consultants striking in the same 24-hour period. They recognised that 'Christmas Day' cover would be in place but were worried about the backlog in care that this is contributing to and patient safety. |
| **ASSURE** |
| ▪ The Staff Story was provided by Joseph Usher, Chair of the True Colours Staff Network. The committee were assured by how well the networks are running and are keen to hear from some of the different networks also.<br>▪ Following the committee effectiveness review the committee were assured that the outcomes have been reviewed and the appropriate actions have been implemented to address the feedback.<br>▪ The committee expressed concern over the joint action of Junior Doctors and Consultants. Especially as it may increase the possibility of patient harm and impact on Trust finances. However, the committee were assured that robust planning is being put into place to mitigate these and other challenges.<br>▪ The committee were assured that there has been a new appointment for the Guardian for Safe Working and were pleased to be introduced to her at the meeting.<br>▪ The Guardian Service will no longer be providing the FTSU service for the Trust. The Committee were assured that a robust interim appointment has been made and a substantive appointment for the role is being actioned.<br>▪ The committee were provided with good assurance around the Trust's library service, recognising how vital this is for staff across the Trust. The committee want to place on record the excellent report received and the hard work of the library team and leadership. |

| ADVISE |
| --- |
| ▪ The committee wish to advise the Board that following the 'limited assurance' from the Medical E-Rostering audit the service is now on an improvement trajectory and this is starting to come through.<br>▪ Staff across the Trust have previously had difficulty in accessing CPD funding but some of these barriers have been removed and plans are in place to improve this.<br>▪ There has been difficulty in utilising the apprenticeship levy but the teams are working together to develop plans to improve this and this will be driven by the Education Governance Group.<br>▪ Th BAF has been refined further since Juliette Tait began in post and she has plans in place to monitor the delivery of the objectives.<br>▪ The NHS Long Term Workforce Plan and the WWL People Strategy will be aligned<br>▪ Upon establishment of new governance arrangements to support the GM workforce efficiency programme, the People committee and the Executive team will receive reports form the new 'Pay Control Group' and associated vacancy control groups.<br>▪ Work is beginning to analyse the data of those staff who take up a post at WWL and then leave within the first 12 months of starting. This will assist the team when looking at the recruitment and retention of staff.<br>▪ With the appointment of the new Chief People Officer, the workplan will be reviewed accordingly to ensure the Committee is receiving appropriate assurance in relation to recruitment and retention plans, amongst other key strategic items. |
| **RISKS DISCUSSED AND NEW RISKS IDENTIFIED** |
| ▪ Industrial Action may be further escalated by middle grade doctors joining the strikes. |

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

# Committee report

| | |
|---|---|
| **Report from:** | Research Committee |
| **Date of meeting:** | 5 September 2023 |
| **Chair:** | Clare Austin |

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

| **ALERT** |
|---|
| ▪ The funding requirement to enable WWL to meet University Hospital status is yet to be met<br>▪ WWL's service level agreement with the Christie Hospital (around research trials) is not yet in place although meetings have been scheduled to discuss this with their team.<br>▪ The surgery divisional presentation showed that the 'time for research' is still an issue for clinicians and is something that additional support is required for to ensure that their programmes activity does account for this properly. |
| **ASSURE** |
| ▪ The Committee noted good progress made with embedding equality and diversity considerations in WWL's research work and maximising the potential for inclusion, however it was acknowledged that new national systems will be put in place in the near future, which will allow WWL to ascertain a better picture of its own position and effect that these positive steps have had.<br>▪ The message conveyed by the RAPSODI echoed what was contained within the equality, diversity and inclusion report and the Committee was keen that this be shared as widely as possible (once approved by the National Institute of Health and Care Research).<br>▪ The Committee now has an approved workplan in place. |
| **ADVISE** |
| ▪ The Committee has requested that a forum is set up to better facilitate engagement with external partner organisations at various levels, this action is assigned to the Director of Strategy and Planning.<br>▪ The Committee noted good assurance around the synergies between clinical audit and research.<br>▪ A report on research activity and outputs from the surgery division was received.<br>▪ Work is underway to capture the dissertations of MCh postgraduate qualification programme students recruited through the Global Training and Education Centre as research projects. It was noted that this could be considered more widely with Edge Hill students.<br>▪ The recommendations from the Committee's effectiveness review findings were approved for action. It was agreed that external partnership membership is not required but that |

consideration will be given to inviting partners to attend meetings, in line with each agenda.

- Minutes of the reporting committees were noted.
- The O'Shaughnessy Report was noted to identify similar challenges in conducting commercial clinical trials as WWL have identified.
- Clinical academic appointments were noted to be increasing.

**RISKS DISCUSSED AND NEW RISKS IDENTIFIED**

- None noted

# Committee report

| | |
|---|---|
| **Report from:** | Audit Committee |
| **Date of meeting:** | 20 September 2023 |
| **Chair:** | Ian Haythornthwaite |

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

**ALERT**

- A number of limited assurance internal audit reports were presented to the committee:
  - Global Training and Education Centre
  - Medical e-rostering
  - Escalation of a deteriorating patient and sepsis

  The committee noted that these audits had been proactively commissioned by management to identify issues and that focused work is now ongoing to address the recommendations made. The executive lead for each of these audits attended the meeting to provide an update to the committee.
- The committee noted that Freedom to Speak Up arrangements have now transferred from an external company to an in-house provision. This is currently being undertaken via an interim Guardian whilst substantive arrangements are confirmed. Work is ongoing to determine whether a collaborative approach with NHS Greater Manchester may be beneficial, noting the benefits of independence whilst ensuring the Guardian is visible and embedded in WWL. A report will be provided to the next committee meeting to provide assurance around the transfer of cases following the end of the external contract.
- The committee received a report on a risk relating to pharmacy staffing. Note was made of the fact that this is a national issue which is affecting many NHS organisations, but the committee noted the need for robust mitigation at local level.

**ASSURE**

- The committee received 1 internal audit report with high assurance (safeguarding) and 1 with substantial assurance (Data Security and Protection Toolkit 2022/23). The committee passed on its thanks to all involved in both of these audits.
- The internal audit follow-up report showed significant progress in closing off outstanding recommendations, and the committee noted that where extensions to deadlines are requested, this is subject to scrutiny and often based on external factors.

- Continuing strong performance in counter-fraud was noted, and the committee was pleased to hear that WWL has been selected for visit by the national team due to high levels of good practice having been observed.
- The committee received a report which provided an analysis of the foundation trust's compliance with the new Code of Governance for NHS Provider Trusts and confirmed the actions that will be completed in order to ensure compliance by year-end. A follow-up report will be presented to the committee in February 2024.
- The committee reviewed the corporate risk register and confirmed that it was confident in the arrangements for management oversight of risk via Risk Management Group which is chaired by the Chief Executive and attended by a number of executive directors.

**ADVISE**

- The committee recommends that the Council of Governors extends the external audit contract for a further two years, in line with its option to do so after the initial two-year period. An increased fee was noted, which was partly due to inflation and partly due to increased regulatory requirements on auditors. This recommendation will be presented to the Council of Governors at its meeting on 24 October 2023.
- The committee reviewed the draft annual report and accounts of the Three Wishes charity and recommended their approval by the Charitable Trust Committee.
- The committee reviewed the proposed changes to Standing Financial Instructions and recommended their approval by the Board of Directors.

**RISKS DISCUSSED AND NEW RISKS IDENTIFIED**

- The committee discussed the pharmacy staffing risk in detail. An update to the next committee meeting would be provided by the Medical Director and Chief People Officer.

# Committee report

| | |
|---|---|
| **Report from:** | Quality and Safety Committee |
| **Date of meeting:** | 9th August 2023 |
| **Chair:** | Francine Thorpe |

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

**ALERT**

- The committee received a AAA report from the Deteriorating Patients Group outlining a range of actions being taken to address issues identified. Further information was requested in relation to the measures being used to track improvement. This will be presented at the next meeting.
- The surgical divisional deep dive report highlighted an increase in discharge delays from critical care beds, leading to an increased risk of patient harm and higher numbers of mixed sex accommodation (MSA) breaches. This has been flagged as a divisional risk and actions are in place to mitigate the impact as far as possible.
- The committee received a thematic review of cancer treatment delays that outlined a number of actions taken as a result of issues identified. However, the quarter one serious incident report highlighted a continued theme in relation to treatment delays. A separate Lost to Follow Up Working Group has been established to address this issue. The committee will receive regular reports on progress.

**ASSURE**

- The surgical divisional deep dive provided assurance on a range of improvement programmes contributing to achievement of the Trust's objectives including:
  - Regular audit of compliance with the Sepsis 6 care bundle
  - Actions to improve the delivery of harm free care.
  - Significant numbers of staff trained in human factors.
  - Actions taken to address issues raised within the staff survey.
  - Thematic analysis of incidents to inform improvement plans.
  - Achievement of 85% in complaint response times as well as a range of actions taken in response to patient feedback
- The CQC inspection report for maternity services was received which highlighted that the service has retained its' overall rating as 'good'. The 'safe' Domain has been rated as 'requires improvement' largely due to the timing of staff mandatory training. Actions are in place to address this.

- Maternity services provided a thematic analysis in relation to incidents reported on cardiotocography (CTG) monitoring. The report provided assurance that actions identified had been completed and that there were no recurring sub-themes.
- It was noted that the work undertaken by the organisation in Human Factors Training has been shortlisted for a Health Service Journal Patient Safety award.
- The Aspire Accreditation report provided assurance that steady progress is being made to ensure that we meet the Trust objective for 2023/24. weekly quality assurance audits have been introduced which sit alongside the monthly quality assurance audits. The measures within both these audits aim to drive continuous improvement in patient outcomes, increase patient satisfaction and staff experience at ward and unit level.
- The AAA report from the Patient Safety Group provided assurance we are on track to meet the transition to the patient safety incident response framework (PSIRF) in the autumn.
- The AAA report from the Patient Experience Group highlighted that:
    - In-house patient satisfaction surveys are showing an overall trend of increased satisfaction over the last 6 months.
    - Quality improvement projects are underway focussing on the reduction of noise at night and the implementation of self-administration of medicines. These directly address areas of patient feedback

**ADVISE**

- The quarter one harm free care report highlighted that there has been an increase in harms this quarter: specifically, within the month of May. It was noted that there has been a reduction in moderate and severe harm hospital acquired pressure ulcers and although falls have increased in quarter one serious falls have decreased. Improvement work continues to address the harm free care initiatives.
- The Patient Safety Group AAA report highlighted that a themed SIRI Panel focussing on lost to follow-up, treatment delays, delay in diagnosis and never events took place on the 26 June 2023. This event was well attended with good feedback received from attendees.
- The quarter one safe staffing report highlighted the following key points:
    - Overall nursing and midwifery vacancies continue to reduce.
    - Trust matrons continue to undertake a minimum of twice daily staffing huddles to collectively review staffing and the acuity of patients. This proactively addresses staffing shortfalls and mitigates the risk of harm to patients.
    - There has been a 27% decrease in temporary spend within the first quarter of the year, largely attributable to increased scrutiny at divisional level and corporate oversight.
    - Specialist Services have maintained production and approval processes for roster production for 12 months which is to be celebrated.
    - Three midwifery red flags were raised relating to staffing shortfalls, 1 of which related to the unit going on divert. No harms were reported as a result of these.
    - In this reporting period a total of 92 nursing red flags were raised, a 59% reduction from the Q4 position (number 78).

**RISKS DISCUSSED AND NEW RISKS IDENTIFIED**

- The risks relating to the board assurance framework were reviewed.
- No new risks were identified

| | |
|---|---|
| **Title of report:** | Board Assurance Framework (BAF) |
| **Presented to:** | Board of Directors |
| **On:** | 4 October 2023 |
| **Presented by:** | Director of Corporate Affairs |
| **Prepared by:** | Head of Risk<br>Director of Corporate Affairs |
| **Contact details:** | E: paul.howard@wwl.nhs.uk |

**Executive summary**

The latest assessment of the trust's fourteen 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 is one people risk 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:** The four patient focussed BAF risks were presented at the Quality and Safety Committee meeting on 9 August 2023. The next review of the patient related BAF risks is scheduled for the Quality and Safety Committee meeting on 11 October 2023. There have been no changes to the scoring since the last Board meeting in August 2023.

2.3 **People:** One people focussed BAF risk was reviewed, updated and presented at the People Committee on 12 September 2023. There have been no changes to the scoring since the last Board meeting in August 2023.

2.4 **Performance:** The five performance focussed BAF risks were reviewed, updated and presented at the Finance and Performance Committee meeting on 27 September 2023. There have been no changes to the scoring since the last Board meeting in August 2023.

2.5 **Partnership:** The four partnership focussed BAF risks have been reviewed and updated for presentation at the Board meeting. One new risk has been identified and added to the BAF. The current risk score for ID 3300 Partnership working - CCG changes has increased from 8 to 12 due to disrupted partnership working having a much more material impact on managing patient flow and on our system finances.

## 3. New Risks Recommended for Inclusion in the BAF

3.1 ID 3582 - Supporting widening access to employment for local residents – current risk score 8.

## 4. Risks Accepted and De-escalated from the BAF

4.1 No BAF risks have been accepted and de-escalated since the last Board meeting in August 2023.

## 5. Review Date

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

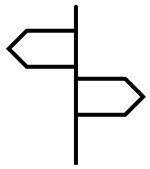
2023/24

The content of this report was last reviewed as follows:

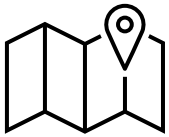
| | |
|---|---|
| Board of Directors | August 2023 |
| Quality and Safety Committee: | August 2023 |
| Finance and Performance Committee: | September 2023 |
| People Committee: | September 2023 |
| Executive Team: | September 2023 |

> **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

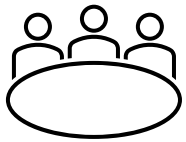


**Strategy:** Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and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

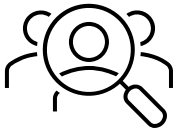


**Corporate objectives:** Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives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

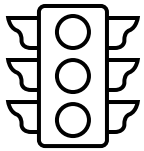
**Board Assurance Framework:** The board assurance framework provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains risks which are most likely to materialise and those which are likely to have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

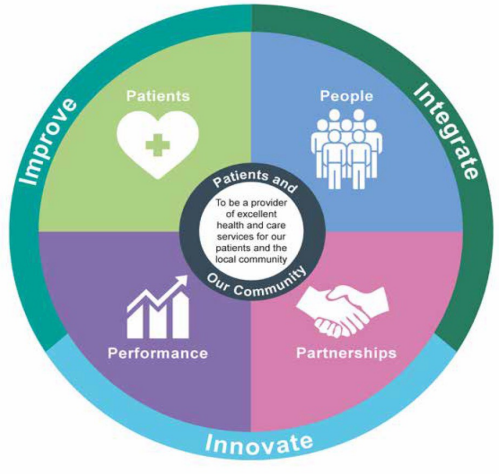
**DIRECTOR LEADS**

| | | | |
|---|---|---|---|
| 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 which the corporate objective has been aligned to – one of the 4 Ps (patients, people, performance or partnerships) |
| **Strategic risk:** | Principal risks which 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 which 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.<br>1st Line functions which own and manage the risks, 2nd line functions which oversee or specialise in compliance or management of risk,<br>3rd line function which provide 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.<br>Five T's - Terminate, Transfer, Tolerate, Treat, Take the Opportunity. |
| **Monitoring:** | The forum which 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

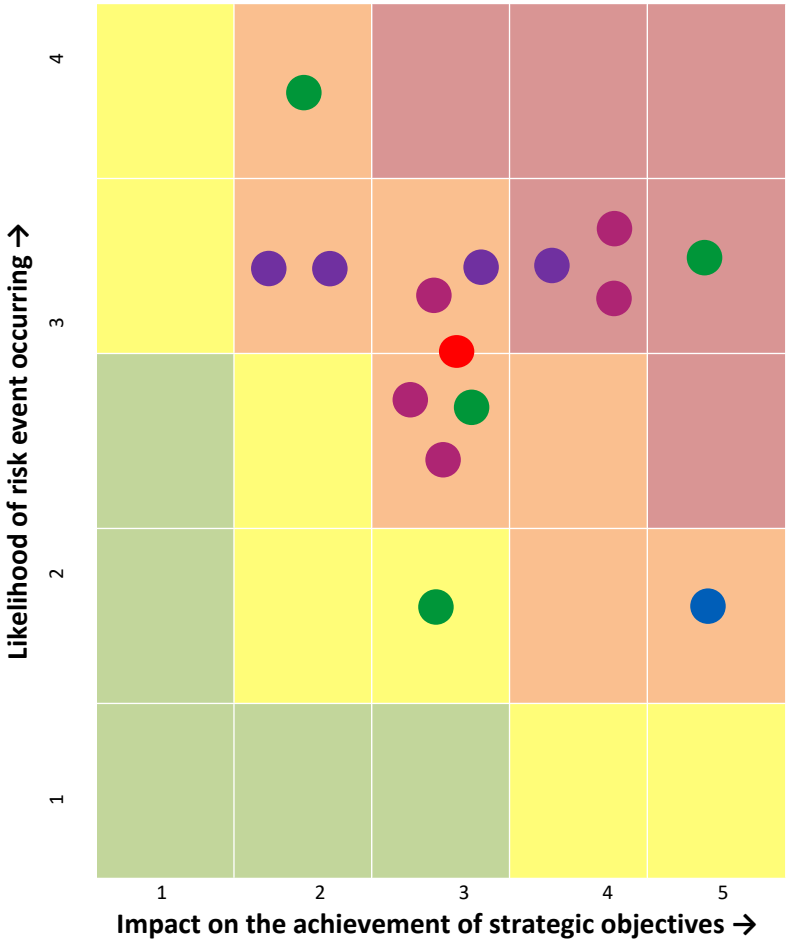
**We will…**
- Improve the health and wellbeing of the population we serve
- Develop effective partnerships within the new statutory environment
- Make progress towards becoming a Net Zero healthcare provider
- To increase research capacity and capability at WWL and in collaboration with EHU plan to 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 14 strategic risks based on their current scores:




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

# Patients

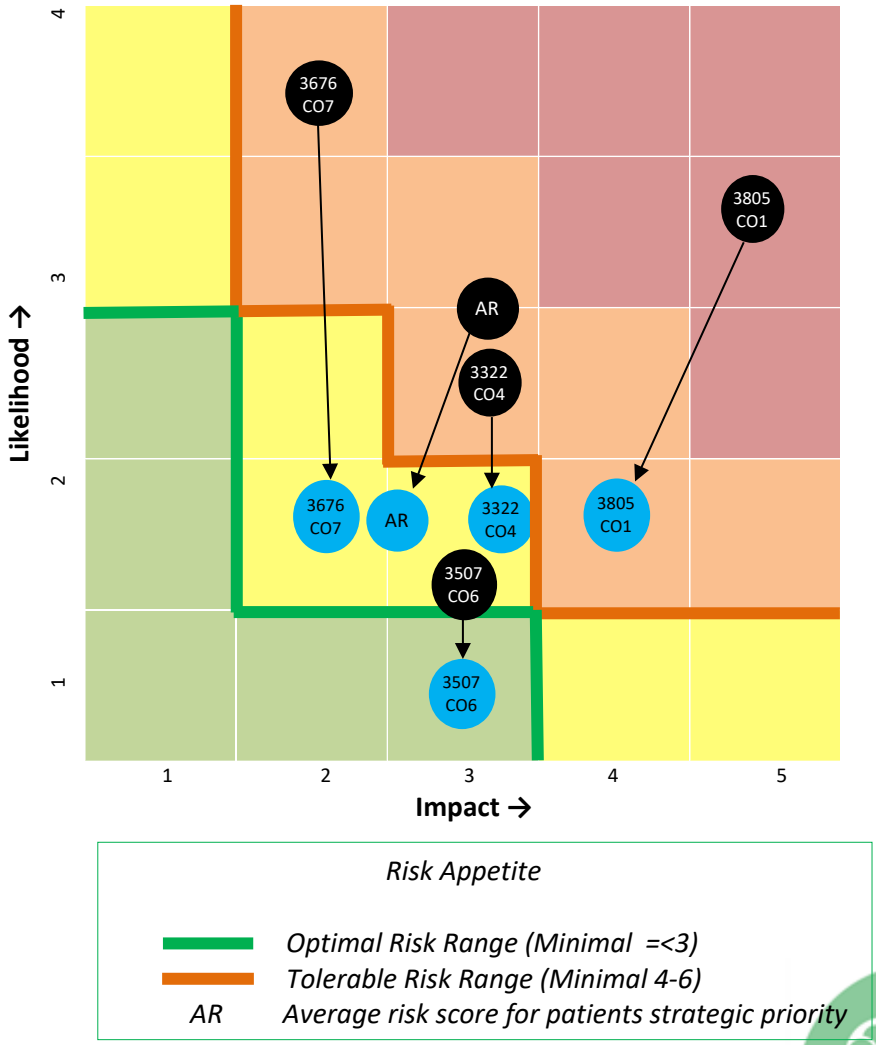
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

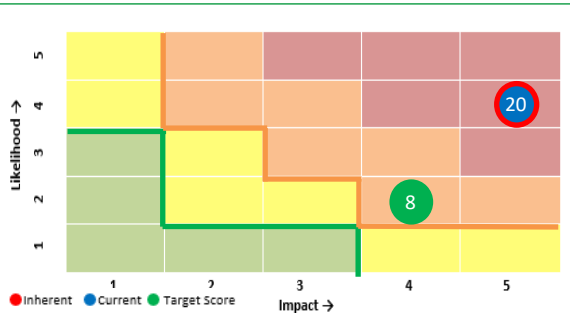
Monitoring: Quality and Safety Committee

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

| Ref. | 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.<br>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.<br>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. |

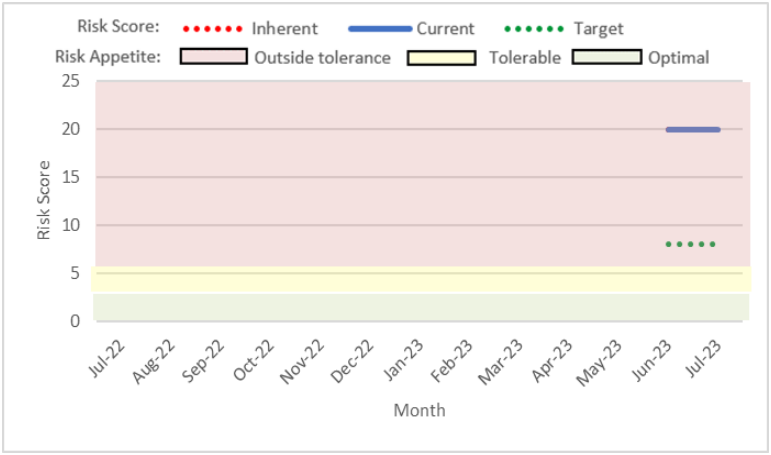
The heat map below sets out the current risk score (black shading) and the target risk score (blue shading) for these risks:



| **Corporate Objective**: **CO1** To improve the safety and quality of clinical services | | | | | **Overall Assurance level** | **Medium** |
|---|---|---|---|---|---|---|
| **Principal risk** What could prevent us achieving our strategic objective? | **Risk Title:** | **PR 1: Sepsis Recognition, Screening and Management** | | | | |
| | **Risk Statement:** | There is a risk of the under diagnosing of patients with Sepsis, due to Health Care Professionals failing to recognise Sepsis in the deteriorating patient, which may result in patients not receiving Sepsis 6 treatment within one hour of triggering for Sepsis. | | | | |
| **Lead Committee** | **Quality and Safety** |  | **Risk Appetite** | Minimal | | |
| **Lead Director** | **MD** | | **Risk category** | Safety, quality of services & patient exp. | | |
| **Date risk opened** | **19.07.23** | | **Linked risks** | - | | |
| **Date of last review** | **19.07.23** | | **Risk treatment** | Treat | | |

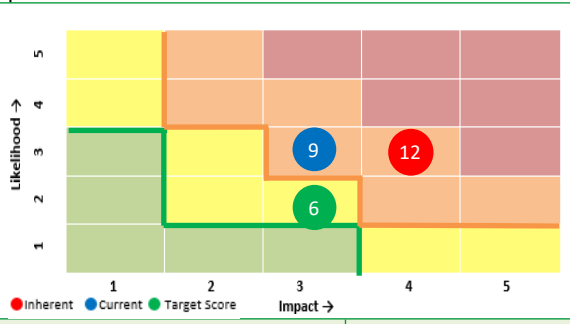


Risk Score Timeline

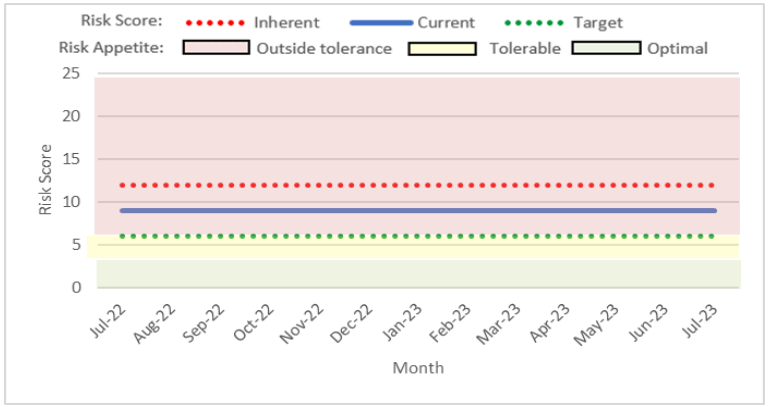




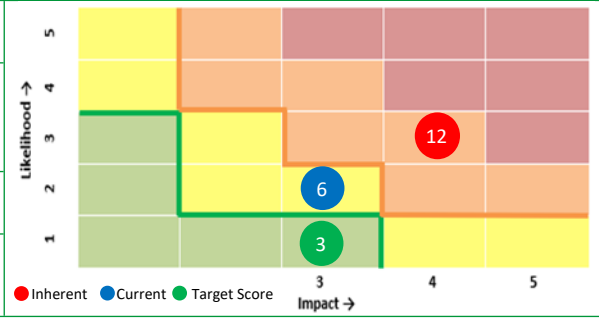
| Strategic Opportunity / Threat Linked risk | Existing controls | Gaps in existing controls | Assurances (and date) | Gap in assurances | Risk Treatment | Due Date / By Whom |
|---|---|---|---|---|---|---|
| **Threat:**<br>**(ID 3805)** | • Ward walk rounds recommenced by current Sepsis Lead Nurse.<br>• Link Nursing in all wards and department have been reinstated.<br>• Training and Education - Corporate Induction, E-learning Sepsis, Sepsis in HIS.<br>• Health Care Professionals - All staff are encouraged to maintain high standards of nursing care.<br>• Sepsis nurse has recommenced reviewing Sepsis incidents on Datix.<br>• Single Nurse Led Service<br>• Sepsis Lead Nurse has reviewed and updated current Sepsis Recognition and Management in Adults SOP - undergoing review and ratification process. This document is supported by NICE NG51 and UK Sepsis Trust.<br>• AQ (Advancing Quality as per Trust objectives) has now recommenced and we have data from January to May.<br>• AMAT auditing for the Ward/Clinical areas. | • In process of recruiting band 6 Sepsis/AKI specialist nurse<br>• A third party has not delivered a full Sepsis in HIS programme that would detail at a point in time a Clinical Performance Management Report that would identify how many patients are currently under our care with having been treated as Sepsis or currently deteriorating with Sepsis. | **2nd Line:**<br>• Quality & Safety Committee June 2023 | **2nd Line:**<br>• Sepsis Group to be established reporting into Deteriorating Patient Group. | 1. Review Sepsis SOP<br>2. To recommence Sepsis training<br>3. Sepsis E-Learning review | Aug 2023 Sepsis Lead<br>July 2023 Complete<br>Sep 2023 Sepsis Lead |

| **Corporate Objective: CO4** To improve the delivery of harm-free care | | | | | **Overall Assurance level** | **Medium** |
|---|---|---|---|---|---|---|
| **Principal risk** | **Risk Title:** | **PR 2: Harm Free Care - Avoidable Pressure ulcers** | | | | |
| | **Risk Statement:** | There is a risk that our systems and processes, coupled with challenged staffing, may not facilitate the swift identification of potentially avoidable pressure ulcers resulting in harm to our patients. | | | | |
| **Lead Committee** | **Quality and Safety** |  | **Risk Appetite** | Minimal | | |
| **Lead Director** | **CN** | | **Risk category** | Safety, quality of services & patient exp. | | |
| **Date risk opened** | **19.10.21** | | **Linked risks** | 3323 | | |
| **Date of last review** | **20.07.23** | | **Risk treatment** | Treat | | |

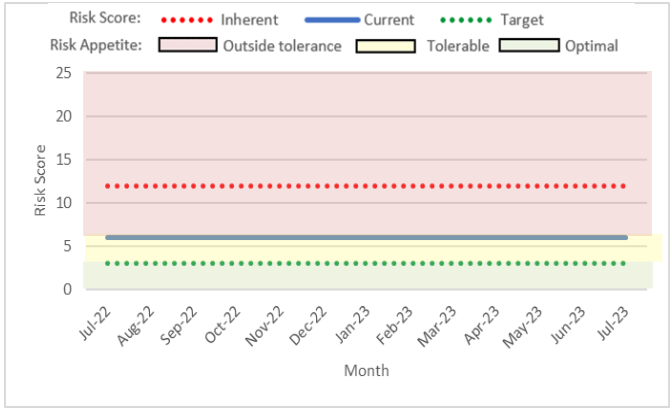
Risk Score Timeline



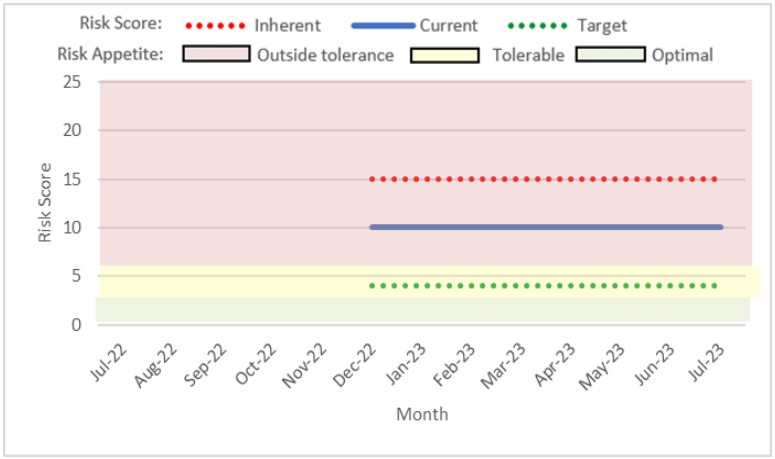
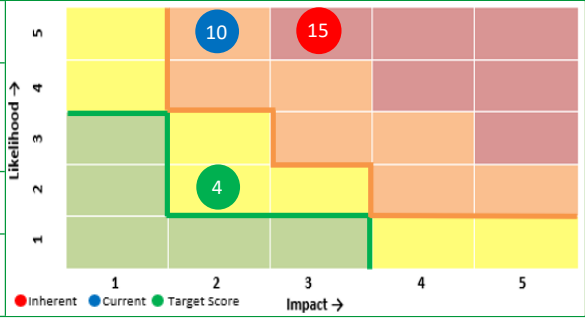

| Strategic Threat | Existing controls | Gaps in existing controls | Assurances (and date) | Gap in assurances | Risk Treatment | Due Date / By Whom |
|---|---|---|---|---|---|---|
| **Threat:**<br>**(ID 3322)**<br><br>**Linked risk:**<br>3323 – Tissue viability team capacity | • Pressure ulcer link nurses trained within all areas and extended to community care homes.<br>• Human factors training to continue to be embedded within the organisation building on success of 2022/23.<br>• Category 2/DTI Pressure Ulcer Low Harm Review Panels (PURP) in place.<br>• Category 3/4 & Unstageable Pressure ulcer panels Moderate& Severe Review Panels (PURP) in place.<br>• Pressure ulcer policy and SOPs embedded.<br>• PU prevention training in place and monitored via the Learning Hub.<br>• Quarterly reports submitted to HFC group, Patient Safety group, NMAHP body and Q&S committee to provide assurance.<br>• Data captured re incidence of moisture associated skin damage (MASD)<br>• 2022/23 MIAA PU audit report evidenced substantial assurance and all actions required where completed by Q4.<br>• ED improvement plan in plan and monitored by PU steering group.<br>• Use of AAR to create opportunities for learning cross divisions.<br>• First contact data now captured. | • Staff being able to be released to undergo training.<br>• Junior workforce.<br>• High use of bank and agency staff.<br>• Escalated areas continue beyond winter.<br>• Number of increased ED attendances, with the capacity demands continuing beyond its current footprint<br>• Large number of patients on the no right to reside list contribute to compromised patient flow which results in continued long waits to be seen and delays in patients being admitted to an inpatient area.<br>• Ongoing Industrial action (IA)<br>• Equipment issues.<br>• Beds owned by individual Divisions.<br>• Under resourcing of Tissue Viability Team.<br>• Due to the Trust financial situation, further investment into patient safety and the HFC Business case (BC) is on hold. | **2nd Line:**<br>• Quality & Safety Committee June 2023 | • No gaps currently identified. | • Continue the roll out of human factor training.<br>• Implement governance changes in managing the low-level harm panels to align to the Patient Safety Incident Response Framework (PSIRF framework).<br>• Implement the utilisation of the revised Datix PU reporting form.<br>• Further work and interrogation of data to be undertaken regarding relationship between end of life skin changes and pressure damage.<br>• Explore a system wide response to pressure ulcer development utilising 'on first contact" data.<br>• Commence Pioneer pilot in 3 clinical areas: Pemberton ward, Shevington ward and BWN.<br>• Implementation of the Repose Wedges.<br>• Roll of out the revised MASD pathway to acute and community services.<br>• Commence differential diagnosis training as part of the verification training to enhance the verification process.<br>• Review the Purpose T training package to prepare for implementation in the Trust as an alternative to using the waterlow risk assessment tool.<br>• Total bed management project progressing to BC stage. | PU steering group<br><br>March 2024 |

| **Corporate Objective**: **CO6** To improve the quality of care for our patients | | | | | **Overall Assurance level** | **Medium** |
|---|---|---|---|---|---|---|
| **Principal risk** | **Risk Title:** | **PR 3: 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 Appetite** | Minimal | |
| **Lead Director** | **CN** | | | **Risk category** | Safety, quality of services & patient exp. | |
| **Date risk opened** | **20.07.22** | | | **Linked risks** | - | |
| **Date of last review** | **29.06.23** | | | **Risk treatment** | Treat | |

Risk Score Timeline




| Strategic Opportunity / Threat | Existing controls | Gaps in existing controls | Assurances (and date) | Gap in assurances | Risk Treatment | Due Date / By Whom |
|---|---|---|---|---|---|---|
| **Threat:**<br>**(ID 3507)** | • Introduced the ASPIRE ward accreditation programme and have accredited 6 wards as silver status.<br>• Weekly QA audits which have a greater focus on the quality/accuracy of clinical documentation, not just the timeliness.<br>• Using coaching/Talk Safe conversations to understand any noncompliance and support improvement work | • 8 wards to achieve silver, 6 achieved Silver, 14 bronze and 4 double whites during 2022/23.<br>• At least one ward to achieve gold: SAL is pending their gold application.<br>• Go live with scoped areas within ED to achieve bronze: Framework being developed. Interim measure bespoke Monthly QA audits developed for use and generic weekly QA audits in use (bespoke in development).<br>• Expand scope of programme to paediatrics and maternity: Framework being developed. Interim measure bespoke Monthly QA audits developed for use and generic weekly QA audits in use (bespoke in development). | **2nd Line:**<br>• Quality & Safety Committee June 2023<br>• Monthly ASPIRE QSSG | **2nd Line:**<br>• Project plan to go to NMAHP, NMALT and new Quality Assurance Group. | 1. The QA audits and ASPIRE results/themes are being reviewed at the monthly ASPIRE QSSG where we have also started to ask the areas which are doing well to share their work to ensure that learning is shared across every area. | Monthly CN |

| **Corporate Objective**: **CO7** Listening to our patients to improve their experience | | | | | **Overall Assurance level** | **Low** |
|---|---|---|---|---|---|---|
| **Principal risk** | **Risk Title:** | **PR 4: Complaint response rates** | | | Risk Score Timeline | |
| | **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 Appetite** | Minimal | | |
| **Lead Director** | **CN** | | **Risk category** | Safety, quality of services & patient exp. | | |
| **Date risk opened** | **24.01.23** | | **Linked risks** | - | | |
| **Date of last review** | **17.07.23** | | **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:**<br>**(ID 3676)** | • Complaints SOP in place with defined roles, processes and timescales.<br>• How to respond to a complaint training is being delivered with further sessions planned.<br>• Patient relations team provide support and guidance. | • Releasing staff to attend training. | **2nd Line:**<br>• Quality & Safety Committee June 2023 | **2nd Line:**<br>• No gaps currently identified. | 1. Complaints backlog to be addressed.<br>2. Further training for staff to be arranged with staff given time to attend the training. | March 2024<br>CN<br>March 2024<br>CN |

# People

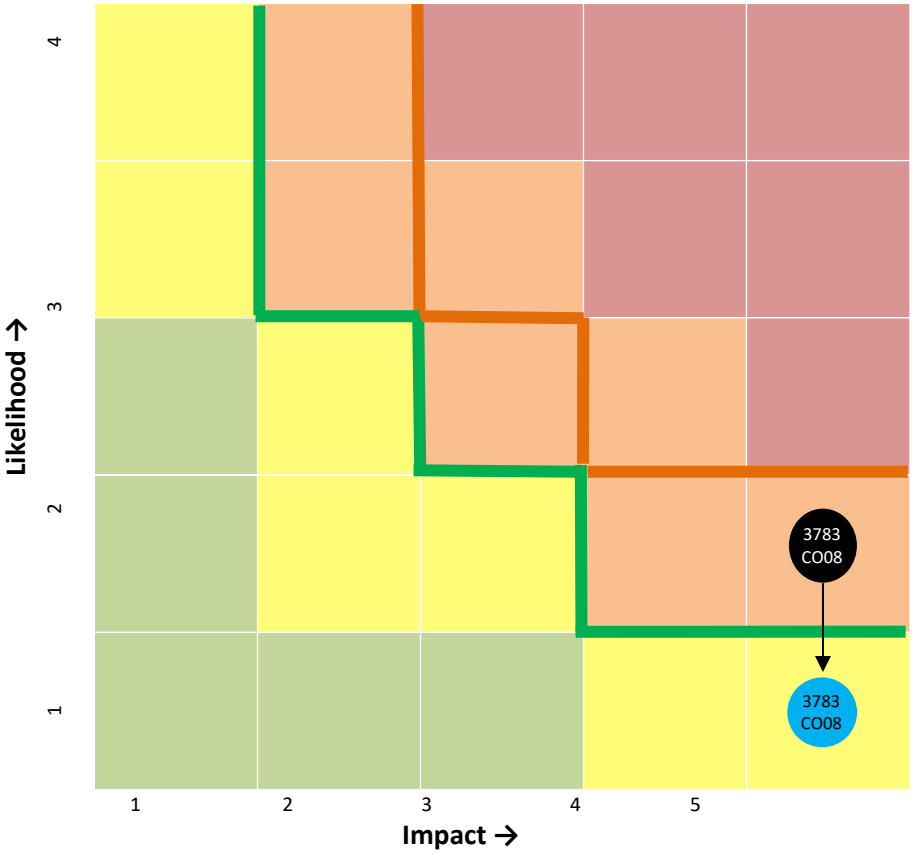
To ensure wellbeing and motivation at work and to minimise workplace stress.

Monitoring: People Committee

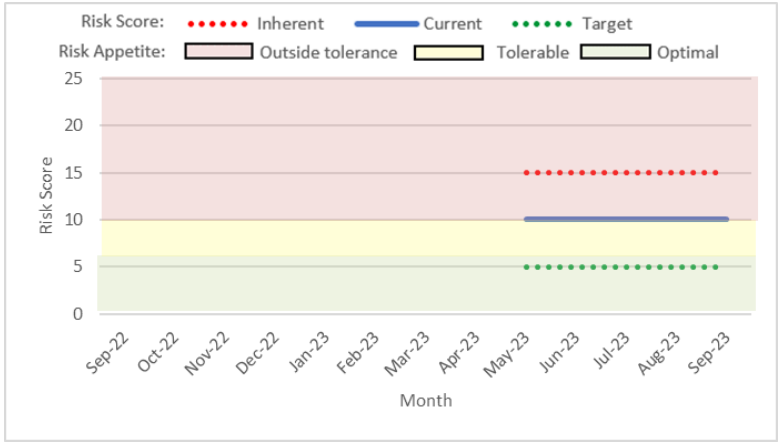
The following corporate objectives are aligned to the **people** strategic priority:

| 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:<br>✓ Reduce sickness absence from 6.58% to 5%<br>✓ Reduce vacancy rate from 6.85%<br>✓ Improve time to hire.<br>✓ Reduce employee relations cases.<br>✓ 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:<br>✓ Continue to prioritise our staff voice.<br>✓ Co design our just and learning culture.<br>✓ Improve the quality of meaningful conversations with our people.<br>✓ Create an inclusive, person centred experience.<br>✓ 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:<br>We will regularly participate in leadership development events so that we:<br>✓ Continue to develop inclusive and compassionate leadership capability.<br>✓ Achieve higher levels of mutual trust and respect.<br>✓ 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 the people strategic risk:



| **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** | **Medium** |
|---|---|---|---|---|---|---|---|---|
| **Principal risk** What could prevent us achieving our strategic objective? | **Risk Title:** | **PR 5 : Workforce Sustainability** | | | | | | |
| | **Risk Statement:** | There is a risk that we may not deliver the workforce sustainability agenda objective, due to issues with staff retention and keeping colleagues well in work, that may result in an increase in sickness absence, vacancies, time to hire challenges and an increase in employee relations cases. | | | | | | |
| **Lead Committee** | **People** | **Risk rating** | **Inherent Risk** | **Current Risk** | **Target Risk** | **Risk Appetite** | Cautious | |
| **Lead Director** | **CPO** | **Likelihood** | 3. Possible | 2. Unlikely | 1. Rare | **Risk category** | Staff Capacity & Capability, Staff Engagement Staff Wellbeing. | |
| **Date risk opened** | **19.06.23** | **Impact** | 5. Critical | 5. Critical | 5. Critical | **Linked risks** | 3572, 3229, 3227 | |
| **Date of last review** | **04.09.23** | **Risk Rating** | 15. Significant | 10. High | 5. Moderate | **Risk treatment** | Treat / Tolerate | |




| Strategic Opportunity / Threat | Existing controls | Gaps in existing controls | Assurances (and date) | Gap in assurances | Risk Treatment | Due Date / By Whom |
|---|---|---|---|---|---|---|
| **Threat:**<br>**ID 3783**<br><br>Linked risks to corporate risk register:<br>**ID 3572** Industrial action<br>**ID 3229** Staff absence wellbeing<br>**ID 3227** Maintaining safe staffing levels | • Workforce planning 2023/24<br>• Empactis relaunch<br>• Civility Programme (just & learning culture)<br>• People Dashboard refresh<br>• Newton Europe Commission (pending)<br>• National Staff Survey (October 2023 go live)<br>• Launched start of year events – new appraisal season and route plan appraisal approach. | • Lead for people dashboard refresh and reporting mechanisms | **2nd Line:**<br>• The sustainable workforce programme aims to implement robust trust wide workforce planning methodology and plans.<br>• Empactis relaunch reports to Transformation Board monthly under sustainable workforce workstream<br>• Civility Programme reports to Our Family, Our Future, Our Focus under the culture and leadership workstream.<br>• Newton Europe Commission updates via ETM<br>• Our Family, Our Future, Our Focus oversees National Staff Survey.<br>• First start of year event 28th June. Assurance reporting regarding compliance and quality improvements will be to People Committee. | • No gaps in assurances currently identified. | 1. Identify lead for people dashboard refresh and reporting mechanisms | 1. September 2023 - CPO |

# Performance

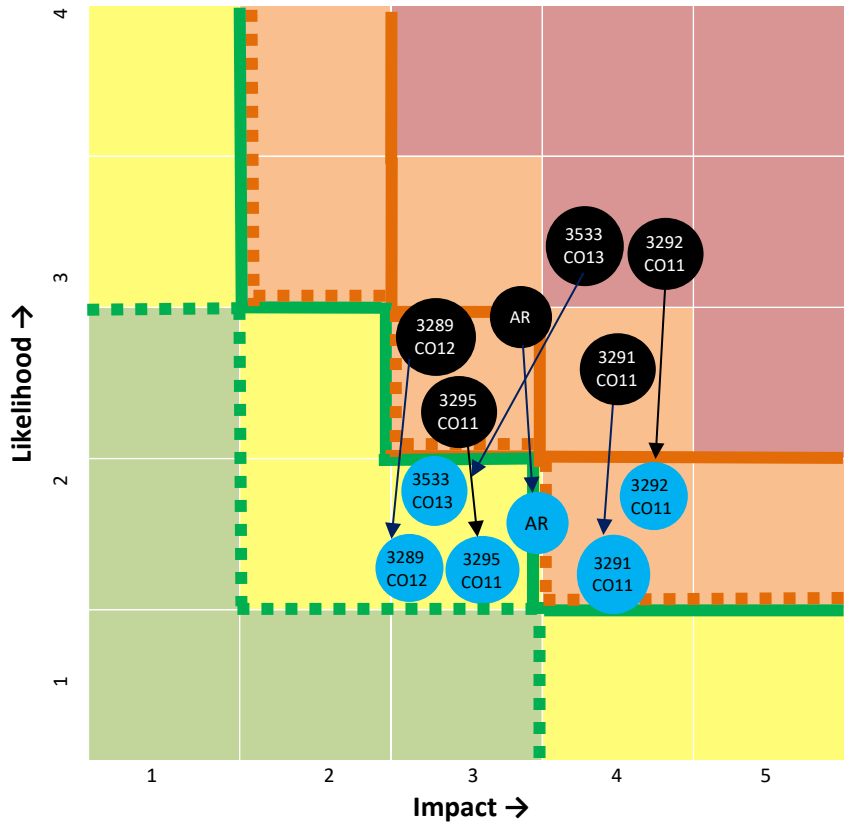
Our ambition is to consistently deliver efficient, effective and equitable patient care

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.<br><br>✓ 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.<br><br>✓ 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*

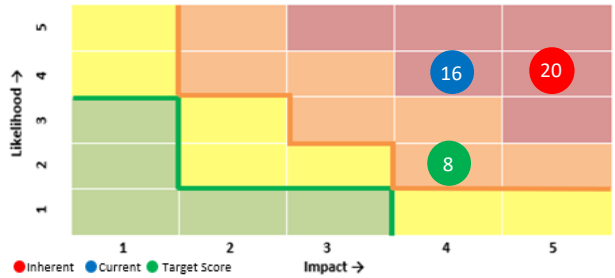
*Optimal Risk Range (Financial Duties: Minimal ≤ 3)*

*(Other: Cautious ≤ 6)*

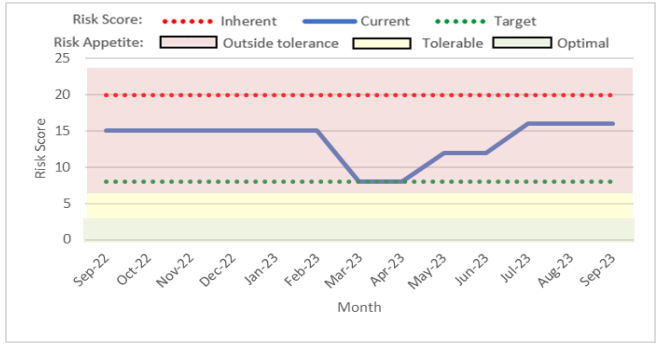
*Tolerable Risk Range (Financial Duties: Minimal 4-6)*

*(Other: Cautious 8-10)*

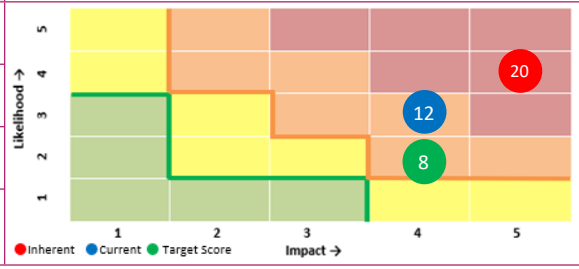
*AR* *Average risk score for performance strategic priority*

| **Corporate Objective**: **C11** Deliver our financial plan, providing value for money services | | | | **Overall Assurance level** | **Medium** |
|---|---|---|---|---|---|
| **Principal risk** | **Risk Title:** | **PR 6: 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 Appetite** | Minimal | |
| **Lead Director** | **CFO** | | **Risk category** | Financial Duties | |
| **Date risk opened** | **19.10.21** | | **Linked risks** | - | |
| **Date of last review** | **19.09.23** | | **Risk treatment** | Treat | |

Risk Score Timeline

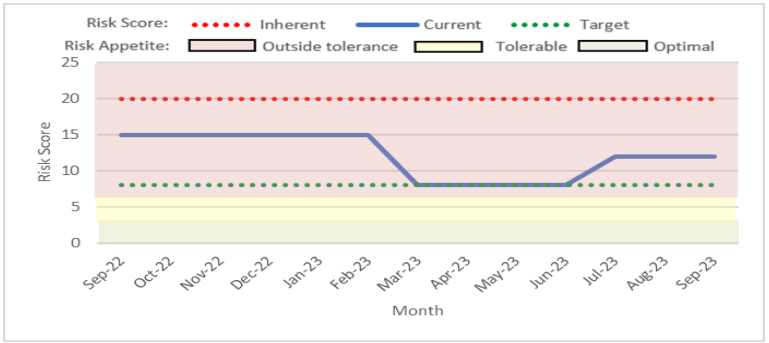



| Strategic Opportunity / Threat | Existing controls | Gaps in existing controls | Assurances (and date) | Gap in assurances | Risk Treatment | Due Date / By Whom |
|---|---|---|---|---|---|---|
| **Threat:**<br><br>**(ID 3292)** | • Final plan signed off by Board and submitted to NHSEI – 4th May 23<br>• Work is ongoing with NHSE GM ICB and locality to manage the £11.9m funding gap from the withdrawal of locality support. Shortlist of options identified, although in year gap remains.<br>• All divisions accepted budgets in April 23<br>• CIP target agreed with programme for delivery and actions.<br>• Continued lobbying via Greater Manchester in respect of additional funding which is appropriate for current clinical capacity and operational and inflationary pressures (Ext.)<br>• Robust forecasting including scenario planning for worst, most likely and best case.<br>• Executive oversight and challenge of CIP & Financial performance through RAPID, Transformation Board & Divisional Assurance Meeting<br>• Pay control group established with scrutiny and rigour over agency spend in line with national agency controls.<br>• Stringent business case criteria to ensure only business critical investments are approved.<br>• Escalation meeting held with NHSE in April 23 to review financial plan.<br>• Full review of financial position by locality partners<br>• RAPID meetings held for all divisions monthly in Q1 and as per RAPID metrics in Q2.<br>• Escalation reduction plan agreed through ETM.<br>• PWC concluded diagnostic into the drivers of financial and operational performance and key actions being progressed.<br>• GM standardised financial controls has been shared by GM and are being implemented across WWL.<br>• NHSE has authorised additional external support to GM ICS to support in rapidly improving the financial position across the system (Ext)<br>• GM ICS appointed a Turnaround Director to oversee and support the turnaround, including supporting monthly Finance Recovery Meetings (FRM).<br>• ERF baseline adjustment of 2% to reflect industrial action in April only | • System and locality financial support withdrawn.<br>• Current plans to mitigate do not cover the gap currently.<br><br>• No additional funding available for NRTR, additional beds and escalation costs.<br><br>• No clarity on additional funding to cover increased costs associated with industrial action.<br><br>• No medium to long term resource confirmation or financial planning<br><br>• Limited guidance on ERF arrangements. | **1st Line:**<br><br>Monthly RAPID meetings for applicable divisions<br><br>**2nd Line:**<br><br>Finance & Performance Committee Sept 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<br><br>2. GM System PMO established to support delivery of I&E position (Ext) | Sept 23/ CFO<br><br>Mar 24/ CFO |

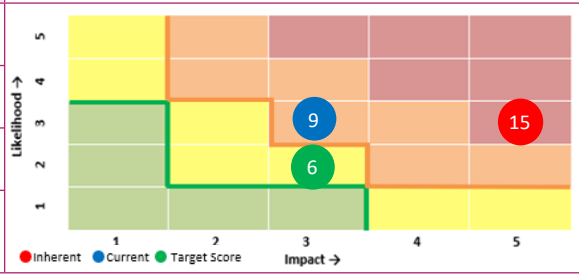
| **Corporate Objective**: **C11** Deliver our financial plan, providing value for money services | | | | **Overall Assurance level** | **High** |
|---|---|---|---|---|---|
| **Principal risk** | **Risk Title:** | **PR 7: Financial Sustainability: Efficiency targets & Balance Sheet** | | | |
| | **Risk 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 Appetite** | Minimal | |
| **Lead Director** | **CFO** | | **Risk category** | Financial Duties | |
| **Date risk opened** | **19.10.21** | | **Linked risks** | - | |
| **Date of last review** | **19.09.23** | | **Risk treatment** | Treat | |



Risk Score Timeline

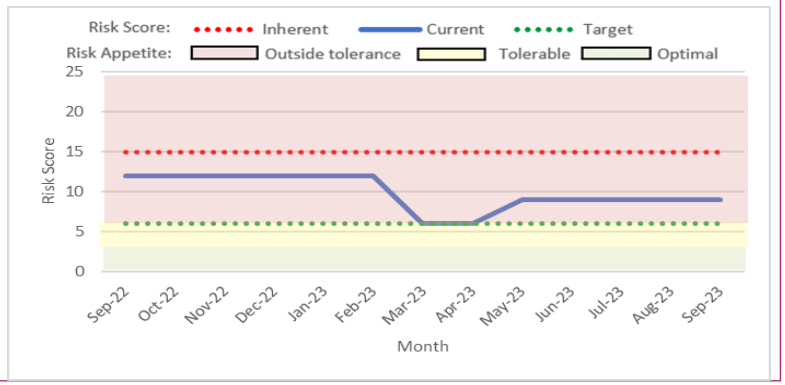



| Strategic Opportunity / Threat | Existing controls | Gaps in existing controls | Assurances (and date) | Gap in assurances | Risk Treatment | Due Date / By Whom |
|---|---|---|---|---|---|---|
| **Threat:**<br>**(ID 3291)** | • Robust CIP divisional delivery approach and governance.<br>• Work is ongoing to identify a bridge for the locality funding included in CIP.<br>• Monitored via Divisional Assurance Meetings, with additional escalation through RAPID if Divisional delivery is off plan.<br>• Further oversight at Executive Team, Transformation Board, F&P Committee and Board of Directors.<br>• Work is ongoing across the GM system on developing a joint approach to productivity and cross cutting efficiency (Ext).<br>• Transformation Board input & oversight of strategic programmes.<br>• Effective credit control including monitoring debtor and creditor days and liquidity with oversight through SFT.<br>• Effective monthly cash flow forecasting reviewed through SFT.<br>• RAPID recovery metrics include recurrent CIP delivery.<br>• Release of potential balance sheet flexibility included within 2023/24 financial plan.<br>• Enhanced balance sheet reporting including cash metrics to SFT and within monthly finance report.<br>• Clinical leadership established reviewing benchmarking opportunities for quality improvements through model hospital and GIRFT and reported through CAB, ETM and Divisional Assurance Meetings.<br>• GM Cash management group being established from Q2 with WWL representation (Ext)<br>• Internal cash management strategy being developed.<br>• Cash forecast reviewed with no support required in Q2.<br>• Cash position assessment, risks and mechanisms for accessing cash support shared with Finance and Performance Committee (July 23)<br>• Current and forecast cash position and an update on the development of the cash and treasury management strategy and action plan shared with Finance and Performance Committee (Sept 23).<br>• GM cash planning ongoing as part of Trust Provider Collaborative. | • Limited mechanisms to facilitate delivery of system wide savings.<br>• GM system efficiency requirement with no plan<br>• Unidentified CIP 11%% in year<br>• GM Cash Management Strategy not yet developed (Ext) | **1st Line:**<br>Monthly RAPID meetings for applicable divisions<br>**2nd Line:**<br>Finance & Performance Committee Sept2023 | • 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.<br>2. GM PMO established leading on system efficiency target £130m (Ext)<br>3. Cash management strategy developed. | Throughout 2023/24 CFO/DCEO<br>Throughout 2023/24 CFO/DCEO<br>Q2 CFO |

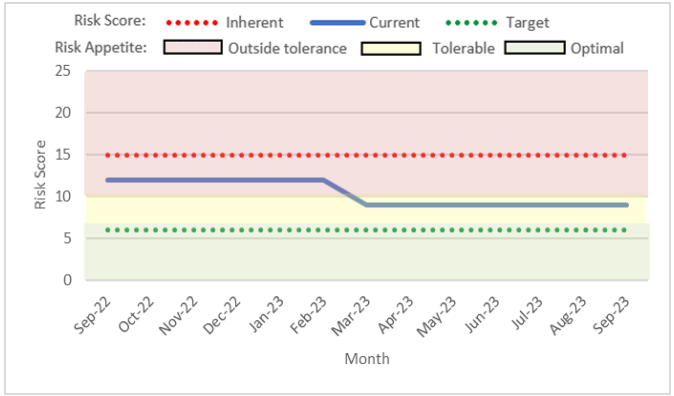
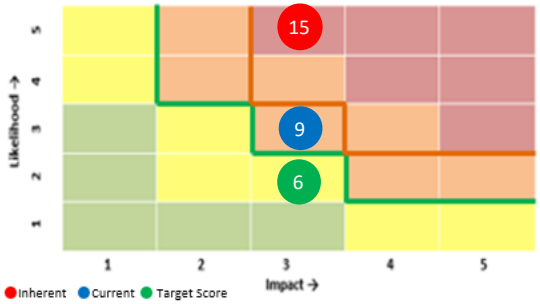
| **Corporate Objective: C11** Deliver our financial plan, providing value for money services | | | | | **Overall Assurance level** | **High** |
|---|---|---|---|---|---|---|
| **Principal risk** | **Risk Title:** | **PR 8: Estates Strategy - Capital Funding** | | | | |
| | **Risk Statement:** | There 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 Appetite** | Minimal | | |
| **Lead Director** | **CFO** | | **Risk category** | Financial Duties | | |
| **Date risk opened** | **19.10.21** | | **Linked risks** | - | | |
| **Date of last review** | **19.09.23** | | **Risk treatment** | Treat | | |



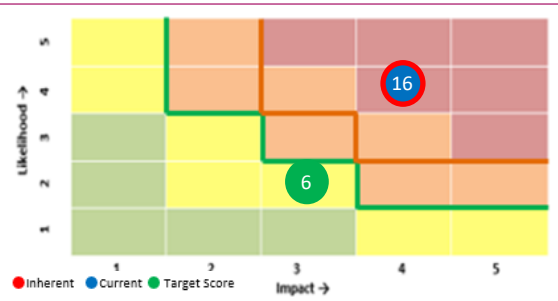
Risk Score Timeline



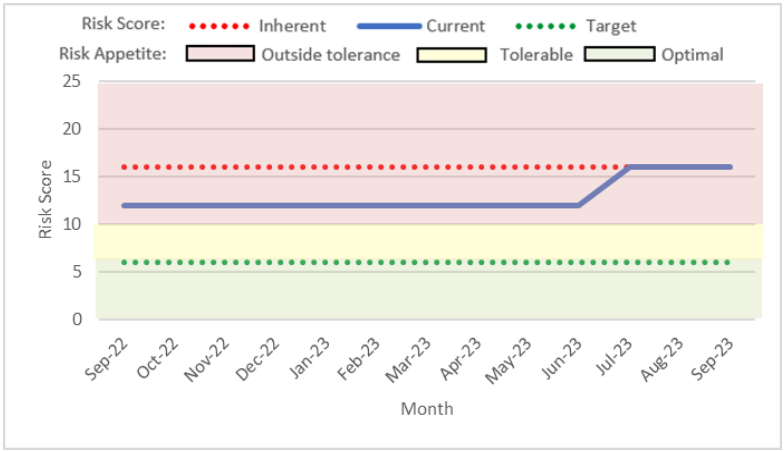

| Strategic Opportunity / Threat | Existing controls | Gaps in existing controls | Assurances (and date) | Gap in assurances | Risk Treatment | Due Date / By Whom |
|---|---|---|---|---|---|---|
| **Threat:**<br><br>**(ID 3295)** | •Lobbying via Greater Manchester (Ext)<br>•Capital Priorities agreed by Executive Team & Trust Board.<br>•Cash for Capital investments identified within plan.<br>•Reprioritisation of additional capital schemes to ensure the capital programme is reflective of organisational priorities (Sep 2023 ETM/F&P)<br>•3 year capital allocations available to inform more longer term system planning.<br>•Strategic capital group established with oversight of full capital programme.<br>•Operational capital group established to manage the detailed programme.<br>•Attendance at GM capital leads group (Ext)<br>•Programme Boards established for major capital schemes.<br>•Work ongoing to bid for additional PDC funding.<br>•Proportionate reduction accepted via majority of GM providers with a proposal to increase the contingency beyond allowable value to ensure GM CDEL plans are within envelope (excluding pre-committed bespoke transaction impacting NCA and MFT £40m).<br>•Accelerated timescale for endoscopy required to secure national PDC funding – approved at national panel.<br>•Theatre 11 PDC funding approved at national panel (July 23) in line with WWL capital strategy.<br>•Exploring options with commercial partners to facilitate capital investments outside of CDEL in line with strategy.<br>•Identified opportunities to lease rather than purchase in line with IFRS 16 | • Impact of inflation in terms of project costs and timescales<br><br>• GM overcommitment on CDEL plan with agreement not yet reached with NHSE – potential further reductions to CDEL limit expected, including for IFRS16 leases.<br><br>• Cash for capital investments identified is subject to achievement of I&E position including CIP delivery.<br><br>• IFRS 16 | **1st Line:**<br><br>Monthly Capital Strategy Group<br><br>**2nd Line:**<br><br>Finance & Performance Committee - Sept 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.<br><br>2. Development of capital reporting through the refreshed DFM App<br><br>3. Discussions ongoing with national team re. additional capital funding to support the £40m GM bespoke transaction and contingency (Ext) | Throughout 2023 CFO<br><br>Q42023/24 CFO<br><br>Q4 CFO |

| **Corporate Objective**: **CO12** To minimise harm to patients through delivery of our elective recovery plan | | | | | **Overall Assurance level** | **Medium** |
|---|---|---|---|---|---|---|
| **Principal risk** | **Risk Title:** | **PR 9: Elective services** | | | Risk Score Timeline | |
| | **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 industrial action, demand management schemes not resulting in a reduction in demand 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 Appetite** | Cautious | | |
| **Lead Director** | **DCE** | | **Risk category** | Performance Targets | | |
| **Date risk opened** | **19.10.21** | | **Linked risks IDs** | 3572, 3718 | | |
| **Date of last review** | **19.09.23** | | **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)**<br><br>Linked risks on corporate risk register:<br><br>**3572** Industrial action<br><br>**3718** Elective Recovery | • Patients waiting over 78 weeks who were impacted by the e-referral drop off issue have now been booked, except for patient choice.<br>• Received 2% reduction in activity from the National team for the first month of industrial action for activity lost.<br>• Divisions have re-evaluated activity plans due to National choose and book system and capacity reducing from the Junior Doctors and Consultants industrial action.<br>• On track to eliminate waits over 65 weeks.<br>• Continue to exceed the trajectory for the cancer faster diagnosis standard.<br>• Implementation of Community Diagnostic Centres which will provide more capacity without waiting list initiatives.<br>• Monitor through divisional assurance meetings with clear escalation protocols to exec team meetings and F&P Committee - developed into an app.<br>• Transformation Plan - elective productivity and capacity aims to increase diagnostics and support delivery of electives and develop elective capacity.<br>• Providing and receiving mutual support from GM and region for high volume high complexity work. | • Elective activity below planned levels year to date primarily attributed to lost activity due to industrial action.<br>• Continued industrial action this year.<br>• Yet to hear from National Team how subsequent industrial action is going to be mitigated.<br>• Demand for patients on cancer pathways exceeds capacity and impacts on delivery of non-cancer elective work.<br>• Diagnostic capacity insufficient to deliver elective waiting times in some modalities.<br>• Follow up waiting list is increasing.<br>• Further work is required on DNAs linked to the paper on deprivation.<br>• Increase productivity to meet organisational targets | **2nd Line:**<br>• Integrated performance report through Finance & Performance Committee – July 2023 | •No gaps in assurance currently identified. | 1. Implementation of Transformation Programme<br><br>2. Funding from national team and reprofiling of activity plan. | March 2024<br>DCE<br><br>March 2024<br>DCE |

| **Corporate Objective: CO13** Improve the responsiveness of urgent and emergency care | | | | **Overall Assurance level** | **Medium** |
|---|---|---|---|---|---|
| **Principal risk** | **Risk Title:** | **PR 10: Urgent and Emergency Care** | | | |
| | **Risk Statement:** | There is a risk to urgent and emergency care delivery as we are consistently operating above 92% occupancy levels, due to insufficient capacity and ongoing industrial action, resulting in lack of capacity, longer waits, delayed ambulances, no right to reside patients, reduced patient flow and more scrutiny through NHS England. | | | |
| **Lead Committee** | **Finance & Performance** |  | **Risk Appetite** | Cautious | |
| **Lead Director** | **DCE** | | **Risk category** | Performance Targets | |
| **Date risk opened** | **05.09.22** | | **Linked risks IDs** | 3423 | |
| **Date of last review** | **19.09.23** | | **Risk treatment** | Treat | |

Risk Score Timeline




| Strategic Opportunity / Threat | Existing controls | Gaps in existing controls | Assurances (and date) | Gap in assurances | Risk Treatment | Due Date / By Whom |
|---|---|---|---|---|---|---|
| **Threat:**<br>**(ID 3533)**<br><br>Linked risk on corporate risk register:<br><br>**3423**<br>ED – Increase in attendances and insufficient patient flow | • National team due to visit in October as part of GM Tier 1 allocation to experience challenges first hand and discuss flow with system partners.<br>• As part of Tier 1 allocation, the Wigan locality has been offered support through a number of national incentives.<br>• Emergency Care Intensive Support Team (ECIST) visited the trust on 6th September 2023, following which they have offered us a programme of works commencing on 1st October 2023 for 4 months to support the existing hospital transformation programme.<br>• Newton Europe working with Better Care Fund to support the Director of Integration with the Home First and Integration programme.<br>• A&E performance at month 5 is at risk given ongoing pressures.<br>• 2 hour urgent care performance on track.<br>• Delay in ambulance handovers within 60 minutes continues to improve.<br>• Hospital Discharge and Flow Programme led by DCE.<br>• The urgent and emergency care transformation board supports system wide change.<br>• Incident response team in place to manage ongoing industrial action risk. | • Insufficient capacity with 99% occupancy rate.<br>• Corridor care<br>• 12 hour waits have reduced slightly but remain a concern.<br>• Number of no rights to reside patients.<br>• Work required further upstream regarding higher acuity of patients in borough. | **2nd Line:**<br>• Integrated performance report through Finance & Performance Committee – July 2023 | **3rd Line:**<br>• Visit from NHS England National Team - due October 2023. | 1. Work closely with colleagues in Wigan locality to progress WWL Transformation Plan and Hospital Discharge and flow programme. | March 2024<br>DCE |

# Partnerships

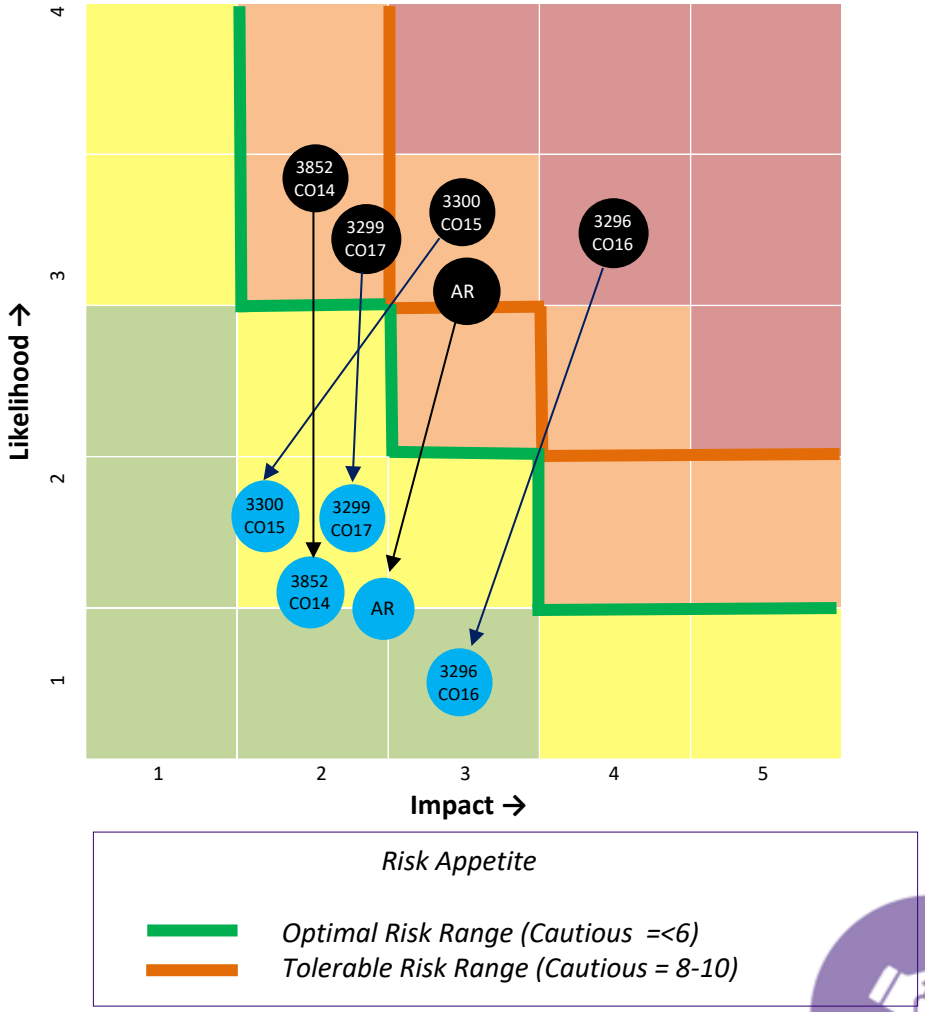
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

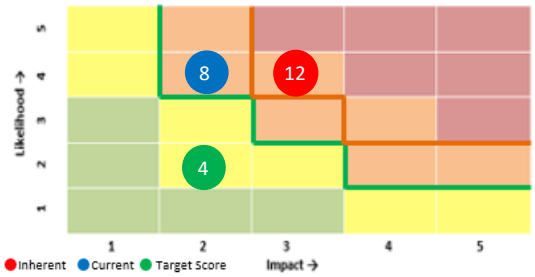
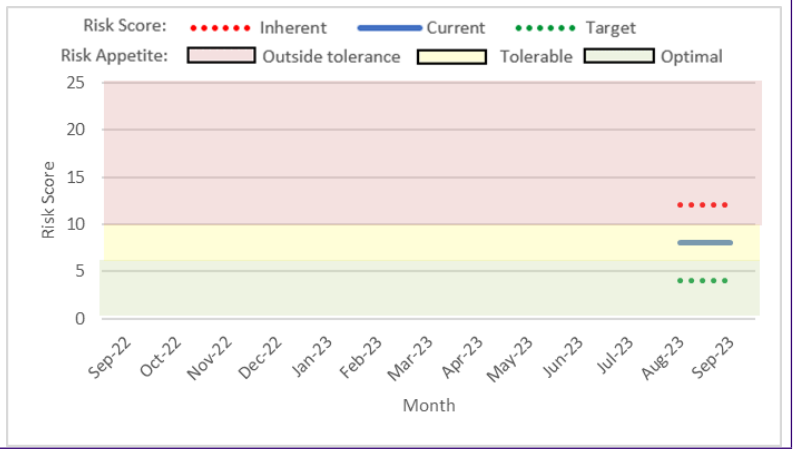
Monitoring: Board of Directors

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.<br>✓ 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:<br>✓ Increase the NIHR Research Capability Funding to achieve an average of £200k/annum over 2 years in Year 4 and Year 5.<br>✓ 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:

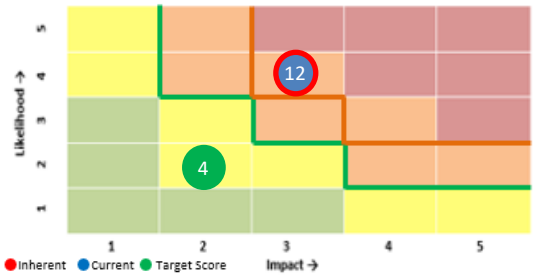


| **Corporate Objective**: **CO14** To improve the health and wellbeing of the population we serve | | | | | **Overall Assurance level** | **Medium** |
|---|---|---|---|---|---|---|
| **Principal risk** What could prevent us achieving our strategic objective? | **Risk Title:** | **PR 11: Supporting widening access to employment for local residents** | | | Risk Score Timeline | |
| | **Risk Statement:** | There is a risk that access to funding for support initiatives which support widening access to employment for local residents is less certain, due to pressures on the Trust's financial position, which may impact on delivery of the objective. | | | | |
| **Lead Committee** | **Board of Directors** |  | **Risk Appetite** | Cautious |  | |
| **Lead Director** | **DSP** | | **Risk category** | Strategy | | |
| **Date risk opened** | **25.09.23** | | **Linked risks** | - | | |
| **Date of last review** | **25.09.23** | | **Risk treatment** | Treat | | |



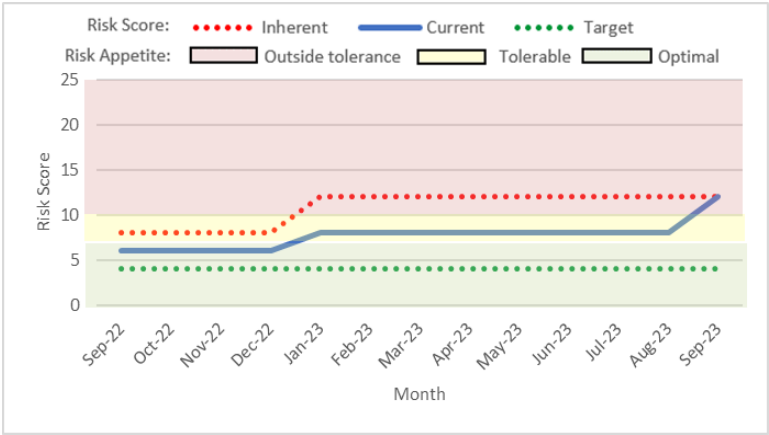


| Strategic Opportunity / Threat | Existing controls | Gaps in existing controls | Assurances (and date) | Gap in assurances | Risk Treatment | Due Date / By Whom |
|---|---|---|---|---|---|---|
| **Threat:** **(ID 3852)** | • Progress reviewed through Anchor Institution Steering Group. | •Recurrent funding to support ongoing development and delivery of widening access to employment schemes. | **2nd Line:** • Bimonthly Anchor Institution Steering Group • Biannual report to Trust Board | •None currently identified | 1. Review current and potential widening access to employment schemes through the Anchor Institution Steering Group 2. Consider development of approach to business cases which take into account quantifiable social benefits. | March 2024 - DSP |

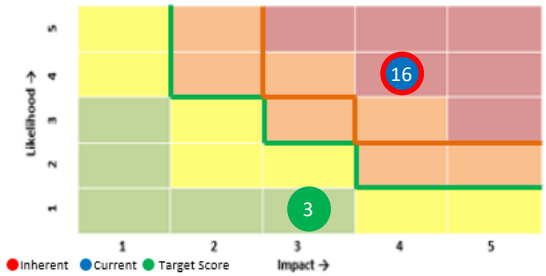
| **Corporate Objective**: **CO15** To develop effective partnerships within the new statutory environment | | | | | **Overall Assurance level** | **Medium** |
|---|---|---|---|---|---|---|
| **Principal risk** What could prevent us achieving our strategic objective? | **Risk Title:** | **PR 12: Partnership 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 Appetite** | Cautious | | |
| **Lead Director** | **DSP** | | **Risk category** | Strategy | | |
| **Date risk opened** | **19.10.21** | | **Linked risks** | - | | |
| **Date of last review** | **25.09.23** | | **Risk treatment** | Treat | | |



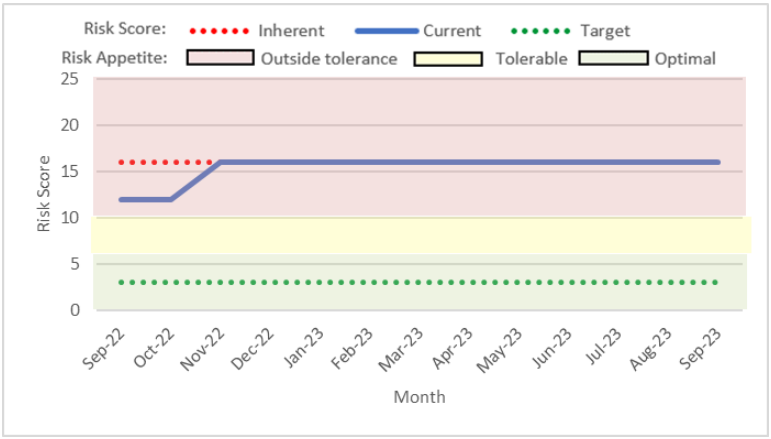
Risk Score Timeline



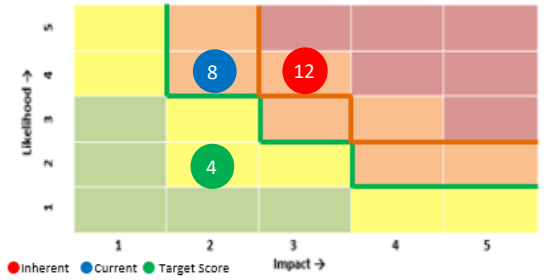

| Strategic Opportunity / Threat | Existing controls | Gaps in existing controls | Assurances (and date) | Gap in assurances | Risk Treatment | Due Date / By Whom |
|---|---|---|---|---|---|---|
| **Threat:** **(ID 3300)** | • Locality meeting structures in place to support lasting corporate knowledge. | Despite bringing people from the ICB and other system partners together through specific fora, there is still huge uncertainty about how we deploy our limited capacity to best effect and further resignations have exacerbated that.<br>The disrupted partnership working is having a much more material impact on managing patient flow and on our system finances. | **2nd Line:**<br>• Board of Directors June 2023<br>• **External:** System Board meetings – monthly | • Uncertainty around CCG changes. | 1. Attendance at System Board meetings with Partners. | DPS - Monthly |

| **Corporate Objective: C16** Progress towards becoming a Net Zero healthcare provider | | | | | **Overall Assurance level** | **Medium** |
|---|---|---|---|---|---|---|
| **Principal risk** | **Risk Title:** | **PR 13: Estate Strategy - net carbon zero requirements** | | | | |
| | **Risk Statement:** | There is a risk that the Trust will not meet its net zero commitments and Climate Change will have an impact on the Trust delivering services, that cannot be mitigated. | | | | |
| **Lead Committee** | **Finance & Performance** |  | **Risk Appetite** | Cautious | | |
| **Lead Director** | **DSP** | | **Risk category** | Sustainability /Net Zero | | |
| **Date risk opened** | **19.10.21** | | **Linked risks** | - | | |
| **Date of last review** | **19.09.23** | | **Risk treatment** | Treat | | |

Risk Score Timeline

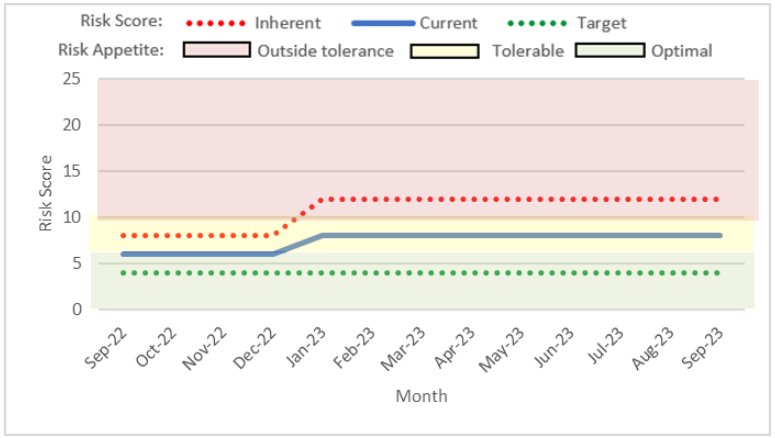



| Strategic Opportunity /Threat | Existing controls | Gaps in existing controls | Assurances (and date) | Gap in assurances | Risk Treatment | Due Date / By Whom |
|---|---|---|---|---|---|---|
| **Threat:**<br>**(ID 3296)** | • Sustainability Manager in post.<br>• Band 7 Energy Manager approved.<br>• Climate Change Adaptation Plan is in development.<br>• Heat Decarbonisation Plan has been approved for funding at ETM.<br>• Prioritised investment plan, Net Zero Strategy and Green Plan have been produced to outline how the trust will address its impact on climate change.<br>• Net Zero and sustainability e-learning programme rolled out.<br>• Governance structures set up to address divisional sustainability issues.<br>• Sustainability and Net zero included in corporate objectives process for 2023-24. | • Recurrent baseline emissions assessment (funded for 2019-2023)<br>• Climate Change Adaptation Plan (in development)<br>• Sustainable Travel Plan (in development)<br>• Sustainability Impact Assessment (developed not integrated into QIA)<br>• Capital funds required to fund adaptation measures.<br>• Sustainability Assurance Framework<br>• Lack of functioning sub meters to monitor energy use | • Bimonthly Finance & Performance Committee AAA reporting<br>• Bimonthly Greener WWL Steering Group<br>• Annual Sustainability report<br>• Annual Carbon Footprint<br>• Response plans for business continuity, critical and major incidents<br>• Annual self-assessment against the NHS EPRR framework | • EPRR Self assessments reflecting climate change risk assessments (in development) | • Climate change adaptation plan to be produced, approved, and implemented.<br>• Complete carbon footprint assessment annually.<br>• Map annual progress towards net zero against net zero trajectory<br>• Net Zero Investment Plan and Climate Change Adaptation Plan to be integrated into Capital planning.<br>• Climate Change Adaptation to be incorporated into Estates Strategy and site masterplans.<br>• Heat Decarbonisation strategy to be integrated into Estates Strategy and site masterplans.<br>• Sustainable Travel Plan to be produced and incorporated into Estates strategy and site masterplans.<br>• Incorporate Sustainability Impact Assessment into Quality Improvement Assessment<br>• Further develop governance structures to ensure all areas captured. | March 2024 / DSP |

| **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** | **Risk Title:** | **PR 14: University Teaching Hospital - University Hospital Association criteria** | | | |
| | **Risk Statement:** | There is a risk that all the criteria that the University Hospital Association have specified may not be met, due to two key areas which we may find difficult to achieve, resulting in a potential obstacle towards our ambition to be a University Teaching Hospital. | | | |
| **Lead Committee** | **Board of Directors** |  | **Risk Appetite** | Cautious | |
| **Lead Director** | **MD** | | **Risk category** | Strategy | |
| **Date risk opened** | **19.10.21** | | **Linked risks** | - | |
| **Date of last review** | **25.09.23** | | **Risk treatment** | Treat | |



Risk Score Timeline





| Strategic Opportunity / Threat | Existing controls | Gaps in existing controls | Assurances (and date) | Gap in assurances | Risk Treatment | Due Date / By Whom |
|---|---|---|---|---|---|---|
| **Threat:**<br>**(ID 3299)** | • Project documentation including action log in place.<br>• Research Committee assurance (Sept23)<br>• 1 colleague confirmed as meeting the substantive employment to EHU. | •A core number of university Principal 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.<br>•No new NIHR grants have been awarded. We are not achieving the criteria currently (2 years' average of £200k/annum Research Capacity Funding awarded). | **2nd Line:**<br>• Board of Directors – Aug 2023 | • None currently identified. | The key actions for increasing University employed research Principal Investigators:<br>✓ 1 substantive EHU clinician with Honorary Consultant status in WWL, exists since October 2021<br>✓ 2 substantive EHU Clinical Academics offered Honorary Clinical Contracts with WWL (n progress)<br>✓ The CD for Research offered a substantive appointment at EHU with HCC at WWL (in progress)<br>The Research Finance Investment Group will meet from mid-November following observation of the first 6 months income/expenditure run rate of 2023-24 financial year, according to the Research Financial Investment Strategy and incorporating the principles within the Joint Clinical Academic Workforce (JCAW) paper.<br>✓ 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. | AR/AW March 2024<br><br>AR/AW March 2024 |

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# M5 Balanced Scorecard

## 4 October 2023

# M5 Scorecard

| | |
|---|---|
| **Title of report:** | WWL M5 23/24 Balanced Scorecard |
| **Presented to:** | Board of Directors |
| **On:** | 4 October 2023 |
| **Presented by:** | Director of Strategy & Planning |
| **Prepared by:** | Data Analytics and Assurance Team |
| **Contact details:** | DAASupport@wwl.nhs.uk |

# M5 Scorecard

## Quality and Safety (Chief Nurse & Medical Director)

| KPI Title | Period Covered | Total | Target | On Target | Trend | YTD |
|---|---|---|---|---|---|---|
| SHMI Rolling 12 Months | May-23 | 107.81 | 100 | ● | ▼ | 107.81 |
| HSMR Rolling 12 months | May-23 | 92.83 | 100 | ● | ▼ | 92.83 |
| Never Events | Aug-23 | 0 | 0 | ● | ↔ | 2 |
| Number of Serious Incidents | Aug-23 | 6 | 0 | ● | ▼ | 39 |
| STEIS Reportable Category 3, 4 & Unstageable Pressure Ulcers | Aug-23 | 2 | 0 | ● | ▲ | 4 |
| STEIS Reportable Serious Falls | Aug-23 | 0 | 0 | ● | ↔ | 0 |
| Methicillin-Resistant Staphylococcus Aureus (MRSA) | Aug-23 | 0 | 0 | ● | ↔ | 0 |
| Methicillin-Susceptible Staphylococcus Aureus (MSSA) | Aug-23 | 5 | 0 | ● | ▲ | 16 |
| Clostridium Difficile (CDT) | Aug-23 | 5 | 0 | ● | ▼ | 26 |
| Complaints Responses | Aug-23 | 83.3% | 85% | ● | ▲ | 69.57% |
| Patient Experience (FFT) | Aug-23 | 89.6% | N/A | N/A | ▼ | 90.98% |

## People (Chief People Officer)

| KPI Title | Period Covered | Total | Target | On Target | Trend | YTD |
|---|---|---|---|---|---|---|
| Leaders Forum reach (Number of Leaders attending the Forum) | Aug-23 | 136 | 110 | ● | ▼ | 768 |
| FTSU contacts | Aug-23 | 1 | N/A | | ▼ | 31 |
| Number of outputs per month (LF, ASTB, Executive Vlogs, CEO Vlog / Blog) | Aug-23 | 8 | 6 | ● | ▲ | 33 |
| Your Voice Score (QTR) - Engagement score | Jun-22 | 3.94 | 4.0 | ● | ↔ | |
| Your Voice Score (QTR) - Psychological Safety | Jun-22 | 3.71 | 3.75 | ● | ↔ | |
| Your Voice Score (QTR) - Well-being score | Jun-22 | 3.35 | 3.5 | ● | ↔ | |
| Mandatory training compliance | Aug-23 | 96.26% | 95% | ● | ▲ | 95.96% |
| Rostering timeliness | Aug-23 | 64.86% | 75% | ● | ▼ | 76.22% |
| Appraisal | Aug-23 | 81.91% | 90% | ● | ▲ | 80.92% |
| Usefulness of Trust wide communication | Nov-22 | 81.00% | 70% | ● | ▲ | N/A |
| Rate card adherence (Medical) | Aug-23 | 47.60% | 80% | ● | ▲ | 48.09% |
| % Turnover Rate | Aug-23 | 9.18% | 10% | ● | ▼ | 9.49% |
| Vacancy rate | Aug-23 | 5.37% | 5% | ● | ▼ | 5.98% |
| Sickness - %age time lost | Aug-23 | 4.79% | 5% | ● | ▲ | 4.71% |

## Performance (Deputy Chief Executive)

| KPI Title | Period Covered | Total | Target | On Target | Trend | YTD |
|---|---|---|---|---|---|---|
| Ambulance handovers 60+ minutes delay | Aug-23 | 46 | 0 | ● | ▼ | 394 |
| Reduce 12-hour waits in EDs | Aug-23 | 15.0% | 10% | ● | ▲ | 14.46% |
| A&E waiting times : patients seen within 4 hours | Aug-23 | 69.35% | 74.01% | ● | ▼ | 69.85% |
| G&A Bed Occupancy - Acute Adult Inpatient Wards | Aug-23 | 98.50% | 95% | ● | ▲ | 98.81% |
| 85% Paediatric Bed Occupancy | Aug-23 | 41.94% | 85% | ● | ▼ | 47.52% |
| 85% Critical Care Bed occupancy for Adults and Children | Aug-23 | 57.83% | 85% | ● | ▼ | 61.49% |
| Virtual ward patients | In Dev. | | | | | |
| No Right to Reside Patients (excluding Discharges) | Aug-23 | 129 | 50 | ● | ▼ | 129 |
| Cancer - waits longer than 62 days | Aug-23 | 58 | 68 | ● | ▼ | 58 |
| Patients waiting over 78 weeks (except patient choice and clinically complex) | Aug-23 | 0 | 0 | ● | ▼ | - |
| Total patients waiting over 65 weeks (except patient choice and clinically complex) | Aug-23 | 955 | 302 | ● | ▲ | 955 |
| Reduce waits of over 52 weeks by 50% by March 2024 | Aug-23 | 4,162 | 2060 | ● | ▲ | 4,162 |
| Number of diagnostics received completed within 6 weeks | Aug-23 | 67.51% | 87% | ● | ▼ | 77.81% |
| Diagnostic activity compared to 19/20 levels | Aug-23 | 14,525 | 13,822 | ● | ▼ | 74,521 |
| Meet the cancer faster diagnosis standard by March 2024 | Jul-23 | 79.70% | 67.5% | ● | ▼ | 77.58% |
| Reduction in outpatient follow-ups | Aug-23 | 15,878 | 16,963 | ● | ▲ | 15,878 |
| Day case rate | Aug-23 | 83.56% | 84% | ● | ▲ | 84.02% |
| Elective Theatre Utilisation | Aug-23 | 85.40% | 85% | ● | ▲ | 82.33% |
| Elective Recovery Plan | Aug-23 | 89.85% | 100% | ● | ▼ | 93.01% |
| 2-hour urgent community response | Jul-23 | 77.14% | 70% | ● | ▲ | 72.89% |

## Finance (Chief Finance Officer)

| KPI Title | Period Covered | Total | Target | On Target | Trend | YTD |
|---|---|---|---|---|---|---|
| Cash (£'000s) | Aug-23 | 27,989 | 32,347 | ● | ▲ | 157,306 |
| Cost Improvement Programme (CIP) (£'000s) | Aug-23 | 2,610 | 2,033 | ● | ▲ | 9,700 |
| Capital Expenditure (£'000s) | Aug-23 | 1,140 | 2,014 | ● | ▼ | 7,418 |
| Agency Expenditure (£'000s) | Aug-23 | 716 | 1,138 | ● | ▼ | 4,151 |
| Better Payment Practice Code (BPPC) | Aug-23 | 90.81% | 95% | ● | ▼ | 93.76% |
| Agency % of Total Pay | Aug-23 | 2.23% | 3.7% | ● | ▼ | 2.73% |
| Adjusted Financial Performance (£'000s) | Aug-23 | (2,610) | 88 | ● | ▼ | (5,170) |
| Surplus /Deficit (£'000s) | Aug-23 | (2,626) | 72 | ● | ▼ | (5,194) |

# M5 Commentary (Page 1 of 3)

## Quality and Safety (Chief Nurse & Medical Director)

**Patient Safety**

During the month of August there were 6 incidents escalated to StEIS; these included x1 neonatal death, 1x delay in diagnosis of endometrial cancer, 1x alleged abuse of a patient, 1x delayed in diagnosis of breast cancer, x2 unstageable pressure ulcers. It is important to note that there has been a run of incidents reported over past months relating to alleged abuse of patients by security staff, there is an ongoing piece of work around least restrictive practice. The policy TW13-026 "Therapeutic Management of Vulnerable Adults with Challenging Behaviour (including Control & Restraint Management)" will be replaced with TW23-047 "Least Restrictive Interventions Policy" this will require all staff performing physical restraint to complete a relevant trust approved course and to have valid registration. In addition, the Trust has also seen an increase in the number of incidents reported relating to diagnostic delays, this was specifically around a failure to act on test results resulting in harm to patients. This was escalated to the Medical Director and further updates have been requested around the progress with the implementation of COMPASS on HIS, this project will assist in mitigating this risk across the Trust.

**Complaints**

The complaints response rate for June 56%, July 74%, and August 83%, this means cumulative response rate for the year so far is up to 70%, which is the highest this has been post pandemic. August showed the significant improvement with 6 of the 7 divisions achieving 100%. In order to continue improved compliance a complaints ideation workshop was held during the month of August. We looked at what went well, what our barriers were and shared good practice. Every participant took away an individual action that would be followed up by the continuous improvement team, actions were very specific to own areas of work and were measurable. It was agreed that further meetings would not be beneficial until we constantly achieved an overall compliance of 85% to the 60-day response time, when this achievement met then a similar meeting would reconvene to review the process in order to drive down the 60-day response time.

How to respond to a complaint training – July took place, with 16 out of 23 places attended, September is planned (20 places), with a further date given in November. Venues are being sourced for ongoing dates beyond November; and the session has adapted and changed following completion of feedback forms with more examples and practical work on writing a complaint. Furthermore, to ensure that staff are given time from work to attend we have reduced the allocated session from 6.5 hours to 4 hours.

## Performance (Deputy Chief Executive)

WWL remains the second highest performing Trust in Greater Manchester against the 4-hour standard but still below the National Average. The 2-hour urgent community response performance achieved with performance at 77.14%, above the 70% target. Positive progress also continues to be made against the target of eliminating all ambulance handover delays greater than 60 minutes. However, the percentage of patients waiting over 12 hours in the A&E department remains high and the care of patients on the corridor continues to feature on most days. One of the key drivers is occupancy levels on General & Acute inpatient wards which remains well above the 95% target. The number of medically optimised patient remains static, circa 100 which is the lowest level since September 2022. The length of stay for non-elective patients staying over 1 day in General and Acute beds has continued to increase since January 2022, in order to eradicate corridor care, close unfunded areas and maintain 92% occupancy a reduction in non-elective length of stay is required. A focused piece of work is currently underway to identify opportunities to positively influence Urgent and Emergency Care demand across wigan systems, this work is supported by Emergency Care and Intensive Support Team (ECIST) and Newton Europe who are working with the Wigan Borough as part of the National tiering allocation.

Cancer referral rates remain higher than planning assumptions, despite this the 2-week standard was achieved in July (the last validated position.) 68 patients waited over 62 days or longer for treatment at the end of August against a plan of 58, this was primarily due to difficulty in obtaining step down decisions and reduced core capacity due to annual leave, the Trust expects to be back on track by October. The cancer faster diagnosis standard of 67.5% was exceeded with a performance of 79.7%. The Trust continues to make good progress with clearance of long waits for elective care. All patients who were initially waiting beyond 78 weeks when impacted by the e-referral drop off issue have been treated, other than patient choice. There are no patients remaining in the 104 weeks wait cohort. Diagnostic activity was 125% above the pre covid levels, however only 68% of patients received their test within 6 weeks. Elective activity was again below planned levels predominantly due to lost activity as a direct result of junior doctor and consultant strike action. The Trust received notice of a reduction in elective income target to account for the impact on Industrial Action in April, we await further notification to mitigate for later strikes.

# M5 Commentary (Page 2 of 3)

## People (Chief People Officer)

**Sickness & Wellbeing :**
The Trust continues to offer a broad range of wellbeing support for staff via the Steps for Wellness and Staff Experience Team. During the month of August 46 referrals were received into the Staff Psychological Service and a specific Benefits Realisation review is underway to assess the benefits that this service brings to the Trust and Staff. Whilst sickness continually reports below the average of 5% at 4.79% the Trust provides a high level of scrutiny to cases and themes to ensure there is compassionate, yet effective management of cases. The Divisional Assurance process provides an opportunity for Divisions to present hot spot areas and confirm where additional support is required. Empactis Absence Management will commence roll out in October 2024, commencing with the Specialist Services Division. This will bring greater visibility of real time data and improved reporting functionality.

**Retention**
Under Our Focus, Our Family, Our Future, WWL has launched the Team Culture programme. Over 40 applications have been received from teams who proactively want to access the support that this offers to support the development of positive cultures. Active follow up will be provided to those wards featuring as "white" on the ASPIRE accreditation programme. Further work is required to learn from those who leave our organisation, and the People Services Team will be developing a process to enable feedback via an exit process, and ensure this learning is embedded into Divisional leadership groups and themes presented to the People Committee. The turnover figure for those who chose to leave WWL within one year of commencing is reporting at an average of 25%, a specific review is being undertaken during the month of October to understand the reasons for this and develop appropriate actions to address. The Staff Experience Team and Nursing, Midwifery and AHP Professional Practice Team are working in partnership to develop a new and improved induction programme.

**Goal Setting and Appraisal**
28.2% of staff have completed goal setting declaration, an increase since last month which was 17.3%. Surgery have the lowest completion rate. Route plan appraisal completions show a small increase at 81.9% since last month at 80.3%, Medicine division have lowest completion rate of Route Plan Appraisals. The Learning and Development Team are actively evaluating the new scheme and feedback will be provided to support the design of the next wave of the appraisal programme.

**Equality, Diversity & Inclusion**
Workforce Disability Equality Standard (WDES) data received, and the high-level summary indicates areas for improvement for WWL particularly around declaration rates, recruitment/formal capability processes, disabled representation on the board, reporting of bullying and harassment, career progression, feeling valued and reasonable adjustments. The Chief People Officer is hosting a listening event on 27th September to engage with our disabled workforce and create meaningful actions for improvement. Workforce Race Equality Standard (WRES) data is not yet available, however, a similar approach will be taken to ensure our Black, Asian and Minority Ethnic Staff feel valued and are not discriminated against. An extraordinary People Committee will be established before the end of October 2023 to ensure Board can be suitably sighted on the published action plan.

**Personal development:**
Mandatory training – nationally mandated training 96.3% an increase of 0.1% since previous month. Locally mandated training 91.7% an increase of 0.2% since last month. Both showing steady improvements.
Moving & Handling L2 compliance is 80.3% performing below Trust target of 95%. 54 staff compliance expired August & only 4 of these staff booked onto an event. Staff contacted directly along with their leaders to encourage attendance. Also escalated via H&S Manager.
Oliver McGowan Mandatory eLearning 42.3% completion. 2922 staff completed so far which is aligned with average completion rates at other GM trusts
57 staff did not attend Mandatory training events in August, 46 staff did not attend Resus L2 ABLS impacting compliance. Other events not attended - Resus L3 PILS, Resus L3 EILS & Information Asset Owner Training. Non-attendance contributes to cost of running additional courses & trainer's time.
Forecasting, typically see sharp increase in non-compliance over Nov/Dec across divisions - suggest staff seek to complete any Mandatory Training ahead of this busy winter period.

# M5 Commentary (Page 3 of 3)

## Finance (Chief Finance Officer)

**Surplus/Deficit**
The Trust reported an actual deficit of £2.6m in month 5 (August 2023), which is an adverse variance of £2.7m to the plan. Year to date, the Trust is reporting an actual deficit of £5.2m which is £6.0m adverse to plan.

**Adjusted Financial Performance**
The adjusted financial performance is a deficit of £2.6m which is £2.7m adverse to the plan of £0.1m surplus.

**Agency Expenditure**
Agency expenditure is £0.7m in month 5, a decrease from last month. Year to date, agency spend is £4.1m which is £1.4 favourable to plan.

**Agency % of Total Pay**
The Trust is operating within the agency ceiling with agency representing 2.8% of the total pay bill year to date (compared to the ceiling of 3.7%).

**Capital Expenditure**
Capital expenditure against internal CDEL was £0.3m in month 5 against a plan of £1.2m, which is £0.9m below plan. Year to date, capital expenditure is £3.6m below the internal CDEL plan. This is primarily due to Community Diagnostic Centre (CDC) and Leigh Laminar Flow, which is expected to be recovered during the year.

**Cash**
Cash is £28.0m at the end of month 5 which is £4.3m below plan. This has increased by £1.7m from the previous month. The variance to plan relates to the loss of assumed council income which was included in plan and other timing differences. The operating cash days metric is 21 days at the end of August.

**Cost Improvement Programme (CIP)**
In month 5, £2.6m CIP has been delivered which is above plan. Year to date, CIP delivery is £0.5m below plan due to slippage in the first two months.

**Better Payment Practice Code (BPPC)**
BPPC for month 5 is 93.7% by volume and 92.9% by value. Performance by volume has deteriorated marginally from the previous month (94.3%) and improved by value (93.2%). An action plan is in place to improve the BPPC to the target of 95.0%.

# Change Log

| Ref | Metric | Change | Date | Requested by: |
|---|---|---|---|---|
| 23/24 01 | Sickness Absence | Change target from 4% to 5% | 22/05/2023 | Deputy Chief People Officer |
| 23/24 02 | Ambulance Handovers under 30 minutes | Remove metric | 13/04/2023 | Deputy Chief Executive |
| 23/24 03 | Ambulance Handovers under 15 minutes | Remove metric | 13/04/2023 | Deputy Chief Executive |
| 23/24 04 | Cancer referrals - 115& of pre-covid average | Remove metric | 13/04/2023 | Deputy Chief Executive |
| 23/24 05 | Patients waiting over 104+ weeks (except patient choice or clinically complex) | Remove metric | 13/04/2023 | Deputy Chief Executive |
| 23/24 06 | Outpatient utilisation (In Dev) | Remove metric | 13/04/2023 | Deputy Chief Executive |
| 23/24 07 | Outpatient DNA rates | Remove metric | 13/04/2023 | Deputy Chief Executive |
| 23/24 08 | Virtual Outpatient Consultations | Remove metric | 13/04/2023 | Deputy Chief Executive |
| 23/24 09 | Total Waiting List - RTT position | Remove metric | 13/04/2023 | Deputy Chief Executive |
| 23/24 10 | A&E waiting times : patients seen within 4 hours | Add metric | 13/04/2023 | Deputy Chief Executive |
| 23/24 11 | 85% Paediatric Bed Occupancy | Metric added | 13/04/2023 | Deputy Chief Executive |
| 23/24 12 | 85% Critical Care bed occupancy for Adults and Children | Metric added | 13/04/2023 | Deputy Chief Executive |
| 23/24 13 | Patients waiting over 65+ weeks (except patient choice or clinically complex) | Add metric | 13/04/2023 | Deputy Chief Executive |
| 23/24 14 | Patients waiting over 52+ weeks by 50% by Mar 24 | Add metric | 13/04/2023 | Deputy Chief Executive |
| 23/24 15 | Virtual ward patients - add placeholder whilst metric under development | Add metric | 13/04/2023 | Deputy Chief Executive |
| 23/24 16 | Number of diagnostics received completed within 6 weeks | Add metric | 13/04/2023 | Deputy Chief Executive |
| 23/24 17 | Diagnostic activity compared to 19/20 levels | Add metric | 13/04/2023 | Deputy Chief Executive |
| 23/24 18 | Meet the cancer faster diagnosis standard | Add metric | 13/04/2023 | Deputy Chief Executive |
| 23/24 19 | Reduction in outpatient follow - ups | Add metric | 13/04/2023 | Deputy Chief Executive |
| 23/24 20 | Day case rate | Add metric | 13/04/2023 | Deputy Chief Executive |
| 23/24 21 | 2-hour urgent community response | Metric added | 13/04/2023 | Deputy Chief Executive |
| 23/24 22 | Sepsis - Screening and Antibiotic Treatment (In Dev.) | Remove metric | 03/07/2023 | Medical Director |
| 23/24 23 | Change order of Quality & Safety metrics | Re-order metrics | 03/07/2023 | Medical Director |
| 23/24 24 | All | Improve the visualisation of the report | 19/07/2023 | Executives |
| 23/24 25 | All | Change the format of the report from Word to PowerPoint | 18/09/2023 | DAA |
| 23/24 26 | All | Added sparklines for 6 months to show trends | 18/09/2023 | Executives |

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# Thank you

Agenda item: 19

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| | |
|---|---|
| **Title of report:** | Monthly Trust Financial Report – Month 5 (August 2023) |
| **Presented to:** | Board of Directors |
| **On:** | 4 October 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 Trust is reporting a deficit of £5.2m YTD, which is £6.0m adverse to plan.<br><br>As per the NHSE guidance, we have included our assessment of ERF underperformance YTD within the month 5 position (but not within forecast). Our current assessment is an underperformance of £2.2m, which is driven by reduced activity during industrial action. Our assessment is based on the GM calculator for month 3 YTD position and current actuals for month 4 & 5. This includes the 2% reduction for the industrial action in April. Of the underperformance, an estimated £1.6m is outside of the GM ICB.<br><br>There is £1.1m of expenditure associated with the industrial action within the YTD position. This is not reflected within the NHSE full year forecast as it is assumed that these will be funded to negate the financial impact above plan. Escalation expenditure of £4.6m has been incurred YTD. Work continues to safely de-escalate the main hospital site. So far there have been some reductions in the use of escalated areas, with work ongoing with external agencies (Newton Europe and ECIST) and the locality to reduce non elective length of stay.<br><br>CIP delivery has been above plan for month 3 to 5, with the YTD underperformance of £0.5m reflecting slippage in month 1 to 2. This is expected to be recovered with forecast delivery of the CIP target of £24.4m in full (a saving of c.5%).<br><br>The Trust has planned for non-recurrent balance sheet support of £8.9m within the 2032/24 plan. Year to date, £5.6m has been released through a full review of payables and deferred income. This is £2.9m above the planned release of £2.8m. This has been utilised to mitigate the underlying run rate whilst work continues to reduce this. |

| | | | |
|---|---|---|---|
| | | | The final plan for 2023/24 included an income assumption of £11.9m from Wigan Council, which included £7.0m to support escalation and £4.9m for unfunded bed capacity, with a plan of £7.9m YTD. On the 19th June, Wigan Council notified the Trust that they are now unable to provide funding in 2023/24 due to their own financial position. The Trust continues to work with locality colleagues to develop an action plan to try and address or mitigate the issues that have arisen subsequently to the original agreed 2023/24 financial plan. Each of the actions are being progressed through the relevant governance including full consideration from an operational, quality and safety perspective alongside the financial impact. As at month 5, £5.0m has been bridged against the £11.9m. This includes £1.5m funding from GMICB for the Jean Hayes Reablement Unit, of which £0.6m has been recognised YTD.<br><br>The medical pay award has been applied to the plan (income and expenditure net neutral) and the plan adjusted, with no impact to the bottom line pending further guidance and confirmation of the income uplift expected in month 6.<br><br>At present, the Trust is forecasting to deliver the full year planned deficit of £6.5m.<br><br>There are significant risks to achievement of the financial plan including delivery of CIP (£24.4m), mitigations to the loss of council income (£11.9m), the impact of further industrial action, de-escalation and delivery of the elective activity plan. Further detail is included in the risks tab. |
| Activity | Achieve the elective activity plan for 2023/24. | Red | The month 5 activity data highlights that the Trust has not achieved the year to date elective activity plan that was submitted to NHSE. This has been impacted by industrial action in April, June, July, and August with further action planned for September and October. The month 5 position includes an under performance of £2.2m YTD but this only includes the notified target reduction of 2% for April's industrial action. |

| | | | |
|---|---|---|---|
| Cash & liquidity | Effective cash management ensuring financial obligations can be met as they become due. | Amber | Cash is £28.0m at the end of month 5 which is £4.3m below plan. This has increased by £1.7m from the previous month. The variance to plan relates to the loss of assumed council income which was included in plan and other timing differences. The operating cash days metric is 21 days at the end of August. |
| Capital expenditure (CDEL) | Achieve CDEL for 2023/24. | Amber | Capital expenditure against internal CDEL was £0.3m in month 5 against a plan of £1.2m, which is £0.9m below plan. Year to date, capital expenditure is £3.6m below the internal CDEL plan. This is primarily due to Community Diagnostic Centre (CDC) and Leigh Laminar Flow, which is expected to be recovered during the year. It is anticipated that the CDEL limit will reduce for 2023/24 by c.£1.2m for the GM ICS to remain within the overall system allocation. This would reduce the allocation to £10.4m which represents a highly constrained capital envelope. |
| Cost Improvement Programme (CIP) | Deliver the planned CIP of £24.4m, of which £19.7m is recurrent. | Amber | In month 5, £2.6m CIP has been delivered which is above plan. Year to date, CIP delivery is £0.5m below plan due to slippage in the first two months.<br><br>As at month 5, the in year unidentified gap is £0.5m (4%). The recurrent CIP target is now fully identified, although a significant proportion remains high risk. The unidentified gap relates predominantly to the centralised CIP. An update on the divisional CIP can be found in appendix 7. |
| Temporary expenditure | To remain within the agency ceiling set by NHSE and reduce bank expenditure. | Amber | Divisional agency expenditure is £0.7m in month 5, a decrease from last month. The Trust is operating within the agency ceiling with agency representing 2.8% of the total pay bill year to date (compared to the ceiling of 3.7%). However, bank expenditure within the divisions was £2.7m in month 5, an increase of £0.4m from last month. |
| Business conduct | Comply with the Better Payments Practices Code (BPPC) of paying 95% of invoices within 30 days. | Amber | BPPC for month 5 is 93.7% by volume and 92.9% by value. Performance by volume has deteriorated marginally from the previous month (94.3%) and improved by value (93.2%). An action plan is in place to improve the BPPC to the target of 95.0%. |

| | | | |
|---|---|---|---|
| Financial risk | Report the financial risks through the Board Assurance Framework. | Red | The financial environment for 2023/24 for both revenue and capital is extremely challenging and is likely to impact on the ability of the Trust to deliver its strategic objectives.<br><br>Due to the collective financial position of the GM system, NHSE have authorised additional external support as part of a financial recovery programme. A turnaround director has been appointed with PMO support provided by PWC. Monthly finance recovery meetings will take place with all providers.<br><br>There are a range of risks which are driving an underlying deficit, including continued escalation into unfunded areas, high volumes of no right to reside patients and sustained levels of high length of stay. Other risks include bridging the loss of the Wigan Council income, delivery of the activity plan, likely further industrial action, temporary staffing spend, delivery of the CIP plan and cost 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.**

There is a significant financial challenge associated with delivery of the planed deficit of £6.5m, as well as the sustainability risk of operating at a deficit. The Trust is currently £6.0m adverse to plan at the end of month 5, which will need to be recovered before the end of the financial year.

The Trust has been working with locality colleagues to develop an action plan to mitigate the financial plan income assumption of £11.9m from Wigan Council. £5.0m has been identified to date, including a further £1.5m for the Jean Heyes Reablement Unit, meaning this unit is now fully funded. Each of the actions are being progressed through the relevant governance including full consideration from an operational, quality and safety perspective alongside the financial impact.

There is a risk to delivery of the activity plan, primarily due to the loss of activity during industrial action. Year to date, the estimated impact against the NHSE plan is an underperformance of £2.2m and further strikes are planned in the coming months. Discussions are continuing at a national level about potential funding adjustments to the API regime to reflect the impact of industrial action.

Other issues presenting material risks to delivery of the revenue plan are delivery of the planned CIP of £24.4m, the impact of further industrial action and the safe reduction of expenditure associated with escalation for the second half of the year. Further work is ongoing within the Trust transformation programmes as well as the ICB and the locality to address escalation. Fortnightly updates on CIP are provided to either the Transformation Board or Executive Team. A number of transformation programmes have been established, all of which are executive led. Schemes are also being scoped across the Wigan system and are being progressed via the Wigan Investment Group.

The Trust has planned for non-recurrent balance sheet support of £8.9m within the 2032/24 plan. Year to date, £5.6m has been released through a full review of payables and deferred income. This is £2.9m above the planned release of £2.8m. This has been utilised to mitigate the underlying run rate whilst work continues to reduce this. Further opportunities to release balance sheet above plan are now exhausted.

Three scenarios have been modelled to consider the year end deficit in a best case, mid case and worst case. These range from the best case scenario being delivery of plan to the worst case scenario being a deficit of £22.4m (£15.9m worse than plan). The current mid case scenario is a £12.1m deficit (£5.6m worse than plan). The Trust is committed to delivering the plan and is working to continue to mitigate the financial gap.

At present the Trust's cash balance is below plan, but there remains sufficient cash to service the planned deficit and the planned capital program. However, that assumes that the full value of the efficiency programme is cash releasing and that costs do not exceed the plan. The loss of the Council income had a direct impact on cashflow and will need to be mitigated to preserve cash. A cash management strategy is under development both locally and across Greater Manchester, with cash expected to become an issue for several providers across GM this financial year based on current trajectories.

**Financial implications**

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

**Legal implications**

There are no direct legal implications in this report.

**People implications**

There are no direct people implications in this report.

**Wider implications**

There are no wider implications in this report.

**Recommendation(s)**

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

# Financial Performance

## Key Messages

In month 5, The Trust has reported an actual deficit of £2.6m, which is an adverse variance of £2.7m to plan. The position includes the reduction in income for under performance on the activity plan.

Year to date, the Trust has reported an actual deficit of £5.2m, which is £6.0m adverse to the planned surplus of £0.8m.

The Trust is forecasting to deliver the financial plan to NHSE, which is an annual deficit of £6.5m.

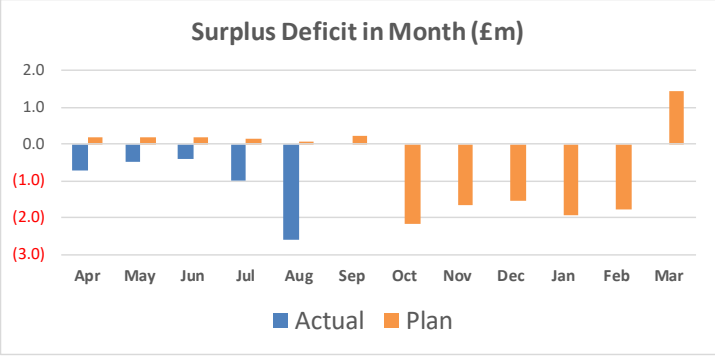
The Trust reported an actual deficit of £2.6m in month 5 (August 2023), which is an adverse variance of £2.7m to the plan. Year to date, the Trust is reporting an actual deficit of £5.2m which is £6.0m adverse to plan.

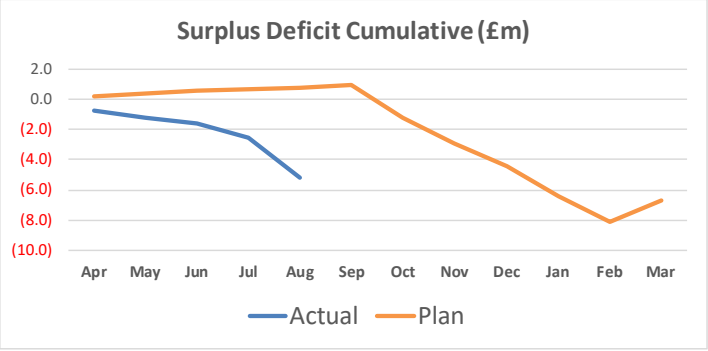
The draft year to date position for the GM ICS is an actual deficit of £149.9m, which is an adverse variance of £129.7m to plan. GM providers are collectively reporting a deficit of £141.0m, which is £70.0m adverse to plan (see appendix 1). Due to increasing regional and national scrutiny on the financial performance NHSE has authorised additional external support to the system which includes the appointment of a turnaround director with support from PWC.

From month 5, NHSE have advised to include the performance against the aligned payment incentive (API) within the year to date position, but not the forecast. Our current assessment is an underperformance of £2.2m, which is driven by reduced activity during industrial action.

Escalation expenditure of £4.6m above plan has been incurred YTD and there is £1.1m of expenditure associated with the industrial action within the YTD position.

The Trust has planned for non-recurrent balance sheet support of £8.9m within the 2032/24 plan. Year to date, £5.6m has been released through a full review of payables and deferred income. This is £2.9m above the planned release of £2.8m. This has been utilised to mitigate the underlying run rate whilst work continues to reduce this.



# 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 | 40,320 | 43,703 | (3,383) | 207,725 | 212,804 | (5,079) | 506,768 |
| Pay | (30,764) | (29,991) | (773) | (148,875) | (145,102) | (3,773) | (351,791) |
| Non Pay | (10,315) | (11,865) | 1,550 | (55,290) | (58,014) | 2,724 | (139,842) |
| Financing / Technical | (1,866) | (1,775) | (91) | (8,754) | (8,949) | 195 | (21,829) |
| Surplus / Deficit | (2,626) | 72 | (2,698) | (5,194) | 738 | (5,933) | (6,693) |
| Adjusted Financial Performance * | (2,610) | 88 | (2,698) | (5,170) | 819 | (5,989) | (6,500) |
| **Memo Items** | | | | | | | |
| CIP | 2,610 | 2,033 | 577 | 9,700 | 10,160 | (460) | 24,404 |
| Bank Expenditure | 2,718 | 858 | (1,861) | 13,084 | 4,289 | (8,795) | 12,136 |
| Agency Expenditure | 716 | 1,049 | 333 | 4,151 | 5,508 | 1,357 | 5,508 |
| Cash Balance | 27,989 | 32,347 | (4,358) | 27,989 | 32,347 | (4,358) | 30,403 |
| Capital Spend - CDEL | 306 | 1,193 | 887 | 3,300 | 6,942 | 3,642 | 11,640 |
| Capital Spend - PDC | 834 | 821 | (13) | 4,118 | 4,107 | (11) | 13,150 |

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

## Financial Performance

- Income is £3.4m adverse to plan in month and £5.1m adverse to plan year to date (see appendix 2). From month 5, this includes £2.2m of activity underperformance YTD.
- Operating expenditure is £0.7m favourable to plan in month 5 (see appendix 4). Year to date, operating expenditure is £1.0m adverse to plan.

## Temporary Spend

- Bank spend £2.7m in month and £13.1m year to date.
- Agency Spend for the Trust is £0.7m in month and £4.1m year to date (see appendix 5). Currently below the agency ceiling at 2.7% of total pay bill (ceiling 3.7%).

## CIP

- £2.6m transacted in month, which is above plan.
- £9.7m transacted year to date, £0.5m adverse year to date due to slippage in earlier months.
- Split in month: Divisional £1.8m; Centralised CIP £0.8m (see appendix 7).

## Cash

- £28.0m cash balance.
- £4.3m worse than plan (see appendix 9).

## Capital

- Capital spend of £1.1m against a plan of £2.0m in month. (see appendix 10).
- CDEL exependiture £0.3m which is £0.9m below plan.
- PDC expenditure £0.8m which is on plan.

# Divisional Performance

## Medicine

- (£1.2m) Adverse to plan in month (an improvement of £0.4m on last month)
- (£0.9m) Escalation (see appendix 6)
- (£0.2m) Unachieved CIP
- (£0.1m) Supernumerary staff and unfunded nurses
- (£0.1m) Industrial action
- £0.1m Clinical supplies and drugs

## Surgery

- (£0.3m) Adverse to plan in month
- (£0.1m) Industrial action
- (£0.1m) Supernumerary staff and unfunded nurses
- (£0.1m) Clinical supplies and drugs

## Specialist Services

- £0.3m Favourable to plan in month
- £0.2m CIP - Private patient income
- £0.1m Vacancies

## Community

- On plan in month
- £0.1m virtual hub
- £0.2m vacant posts
- (£0.1m) Non pay pressures
- (£0.2m) Temporary staffing spend – vacancy cover (CAU, JHRU)

## Estates & Facilities

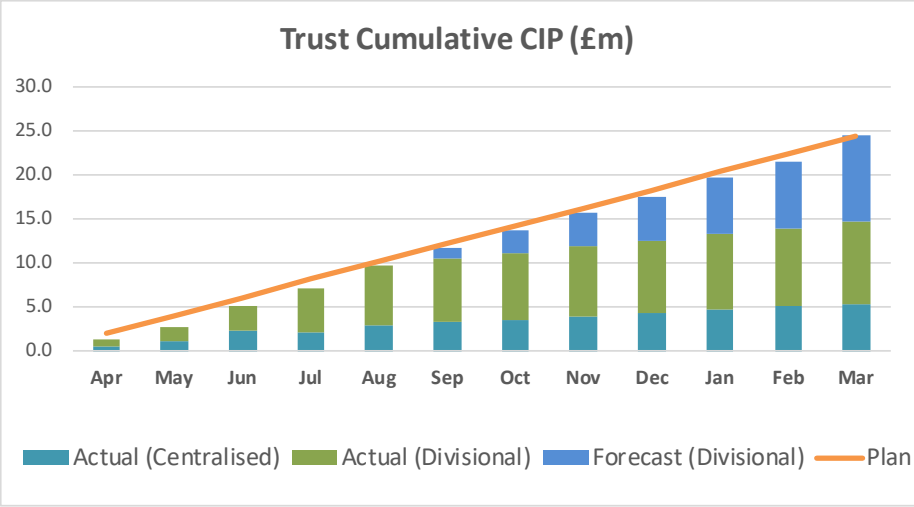
- On plan in month
- (£0.1m) Unachieved CIP
- (£0.1m) Lease costs
- £0.1m SSDU one off credit
- £0.1m Sustainability

## Corporate Divisions

- On plan in month
- (£0.4m) GTEC hosted nurses income
- £0.1m Centralised CIP
- £0.1m Interest received
- £0.2m IM&T MS licences (contract reduction reversed by NHSE)

Further detail on operating expenditure can be found in appendix 4, and the divisional RAPID metrics in appendix 8. Following a review of the flash metrics by the Executive Team, all divisions with the exception of specialist services will be escalated to RAPID for month 5.

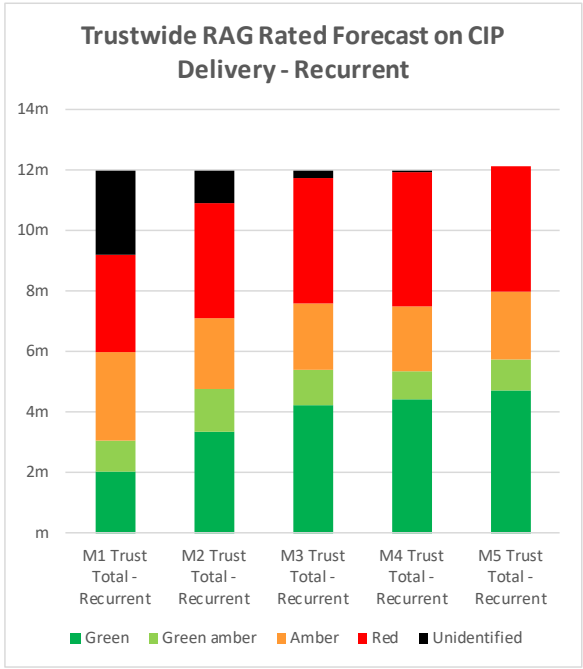
# Cost Improvement Programme




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 5, actual CIP of £2.6m has been transacted which is on plan. £1.8m has been transacted against the divisional CIP target (including the divisional stretch).

In month 5, the Divisional CIP transacted is split £1.5m for transactional schemes and £0.3m for transformational schemes.



## Forward Look

£12.0m. As at month 5, the in year unidentified gap is £0.5m (4%). The recurrent CIP target is now fully identified, although a significant proportion remains high risk.

n transacted recurrently in year for divisional CIP, an increase of £0.4m from
s comprises of £1.1m private patient income, £2.5m are non-pay savings, the
combination of smaller schemes.

Transformational schemes make up £2.6m of the in-year forecast which includes income from private patients and a reduction in Endoscopy weekend working. Further information on the divisional CIP delivery and forecasts can be found in appendix 7.

The CIP position is reported at the Transformation Board for scrutiny and to support divisions with more focussed approach on delivering their plans.

ssued. At the end of August, a revised set of
n status. A number of additional pay controls were
with these measures will be monitored as part of
operationalisation and communication of these
ed.

meetings are being established. These will be
e in September with the first WWL meeting
n place for the remainder of the financial year. The
orce movement.

sultants during the months of September and
urther unplanned costs as various staff groups step in to support essential patient services. This industrial action will see both consultants and junior doctors strike simultaneously in both months.


The ICB have approved £0.9m recurrent investment in the IMC at Home model for the Wigan locality. Implementation of IMC at Home will have a direct impact on the onward care of Wigan patients discharged through WWL, with the focus being on the Home First Approach. This should improve patient flow through WWL supporting de-escalation in the immediate and providing resilience in the medium term.

# Appendix 1 – Greater Manchester financial position (draft month 5)

The below shows the draft YTD month 5 position for all GM providers based on the working day 6 key returns. Collectively, GM providers are reporting a deficit of £141.0m year to date, which is £70.0m adverse to the planned deficit of £71.0m. All providers are currently forecasting to NHSE delivery of their plan in year. Local scenarios have been developed across GM to describe the risks to delivery against plan.

The Trust continues to have the sixth largest absolute deficit across providers, ranging from MFT with a deficit of £52.5m to GMMH with a deficit of £1.9m.

When comparing the variance to plan year to date, WWL has the third highest adverse variance, ranging from NCA with an adverse variance of £34.2m to the Christie, with a favourable variance of £1.5m.

When comparing the variance to plan to contract income, WWL is now second highest (third in month 4) at -1.4%, following NCA (-2.5%).

| Provider | Annual | | YTD Month 5 | | | View 1. Absolute Deficit | | | View 2. Absolute Variance to Plan | | | View 3. Proportionate variance to contract income | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Annual Plan £m | Contract Income £m | YTD Plan | YTD Actual | YTD Variance | YTD Actual | Graphic | Rank | YTD Variance | Graphic | Rank | YTD Actual / Contract Income | Graphic | Rank |
| MFT | £0.0 | £2,202.8 | -£26.3 | -£52.5 | -£26.2 | -£52.5 | | 1 | -£26.2 | | 2 | -1.2% | | 3 |
| Christie | -£8.0 | £354.7 | -£3.4 | -£1.9 | £1.5 | -£1.9 | | 8 | £1.5 | | 9 | 0.4% | | 9 |
| NCA | -£32.2 | £1,354.9 | -£7.5 | -£41.7 | -£34.2 | -£41.7 | | 2 | -£34.2 | | 1 | -2.5% | | 1 |
| BFT | -£12.4 | £399.4 | -£5.2 | -£6.6 | -£1.4 | -£6.6 | | 5 | -£1.4 | | 5 | -0.4% | | 6 |
| TGICFT | -£31.5 | £231.2 | -£13.7 | -£14.4 | -£0.7 | -£14.4 | | 4 | -£0.7 | | 7 | -0.3% | | 7 |
| WWLFT | -£6.5 | £434.2 | £0.8 | -£5.2 | -£6.0 | -£5.2 | | 6 | -£6.0 | | 3 | -1.4% | | 2 |
| PCFT | £0.0 | £249.5 | -£2.1 | -£2.0 | £0.1 | -£2.0 | | 7 | £0.1 | | 8 | 0.0% | | 8 |
| SFT | -£31.5 | £363.5 | -£13.5 | -£14.8 | -£1.3 | -£14.8 | | 3 | -£1.3 | | 6 | -0.4% | | 5 |
| GMMHFT | £0.0 | £441.2 | £0.0 | -£1.9 | -£1.9 | -£1.9 | | 8 | -£1.9 | | 4 | -0.4% | | 4 |
| Total - Provider | -£122.0 | £6,031.4 | -£71.0 | -£141.0 | -£70.0 | -£141.0 | | | -£70.0 | | | -1.2% | | |

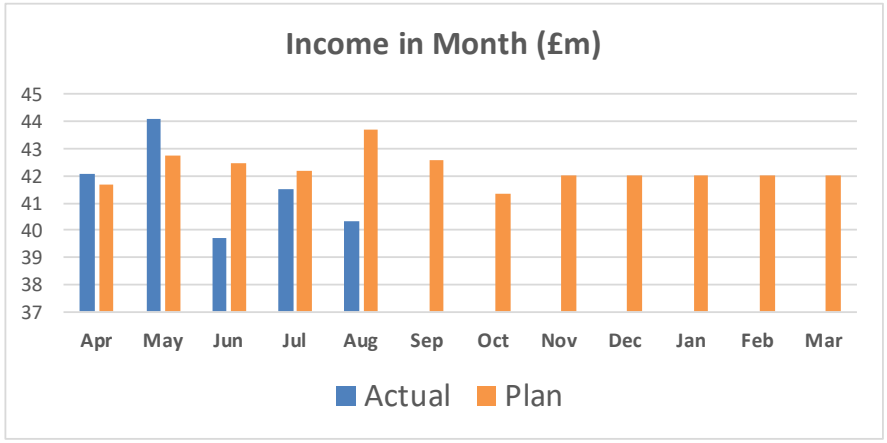
The draft position of the ICS at month 5 is a deficit of £149.9m, which is £129.7m adverse to plan. This includes an adverse variance of £51m associated with the system risk savings.

# Appendix 2 – Income by Source

The Trust has under-performed against the income plan by £3.4m in month.

Patient care income is £3.3m adverse in month which includes an under performance of £2.2m against the Aligned Payment and Incentive contract (API). NHSE have instructed providers to report the actual YTD ERF/API performance in month 5 but they have only notified Trusts of a 2% target adjustment for the industrial action in April. The Trust is expecting a further reduction for all the strikes but as this has not been communicated and therefore no further adjustment has been made to the target.

Local authority income is £1.4m adverse in month due to the reduction in Local Authority income support from Wigan Borough Council.




| Source | In Month (£000) | | | Year to Date (£000) | | |
|---|---|---|---|---|---|---|
| | Actual | Plan | Variance | Actual | Plan | Variance |
| **Income from Patient Care Activities** | | | | | | |
| NHS England - Block | 1,841 | 1,928 | (87) | 9,282 | 9,454 | (173) |
| NHS England - ERF Base | 19 | 19 | 0 | 94 | 94 | 0 |
| NHS England - Other | (24) | (17) | (7) | (67) | (85) | 18 |
| ICB - Block/API | 34,867 | 34,868 | (1) | 168,849 | 168,856 | (7) |
| ICB - ERF Base | (780) | 1,440 | (2,220) | 4,980 | 7,200 | (2,220) |
| ICB - Other | 860 | 673 | 187 | 4,162 | 3,364 | 798 |
| Local Authorities | 625 | 2,045 | (1,419) | 2,744 | 10,223 | (7,479) |
| Private Patient Income | 627 | 371 | 256 | 2,709 | 1,853 | 856 |
| Other NHS Clinical Income | 403 | 368 | 35 | 1,964 | 1,840 | 125 |
| Other Clinical Income | 101 | 160 | (59) | 727 | 802 | (75) |
| **Total Income from Patient Care Activities** | **38,539** | **41,855** | **(3,316)** | **195,445** | **203,601** | **(8,156)** |
| **Other Operating Income** | | | | | | |
| Research and Development | 210 | 127 | 83 | 631 | 636 | (5) |
| Education and Training | 787 | 1,062 | (275) | 7,677 | 5,311 | 2,367 |
| Car Parking Income | 99 | 86 | 12 | 470 | 431 | 40 |
| Catering Income | 268 | 260 | 9 | 1,324 | 1,288 | 36 |
| Other | 418 | 313 | 105 | 2,178 | 1,538 | 640 |
| **Total Other Operating Income** | **1,781** | **1,848** | **(67)** | **12,280** | **9,203** | **3,078** |
| **Total Income** | **40,320** | **43,703** | **(3,383)** | **207,725** | **212,804** | **(5,079)** |

This reflects the council's communication in June that they were unable to support the escalation and unfunded bed capacity which are within plan. Discussions have been carried out within the locality about the potential redirection of other funding, and GM ICB have agreed to allocate £1.5m to fund the Jean Heyes Reablement Unit and this accounts for £0.1m of the favourable variance against ICB – other income in month.

Private patient income is £0.3m favourable in month due to over performance within Trauma and Orthopaedics and Assisted Conception.

Other operating income is £0.1m adverse in month due to an under performance on Education income of £0.3m relating to GTEC income.

# Appendix 3 – Divisional Activity v Internal ERF/API Plan

As per appendix 2 the Trust has reported an adverse position relating to ERF/API of £2.2m in the month end position, this is based on the performance against the NHSE plan and only includes an adjustment for April's industrial action. The table below details the Trusts performance against the internal plan and includes an estimate of lost income for all strike days.

The table below highlights that the Trust is £1.4m behind the internal ERF/API plan in month 5 and £3.8m YTD. Activity has been impacted by industrial action and this has been estimated at £2.6m YTD. Therefore, the variance to plan excluding the industrial action days is estimated at £1.1m adverse to plan YTD. Please note that the values below are indicative values as a large portion of data is still uncoded and therefore an average tariff

| | | In Month Activity | | | In Month (£000) | | | Year to Date Activity | | | Year to Date (£000) | | | (£000) | (£000) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Division | POD | Actual | Plan | Variance | Actual | Plan | Variance | Actual | Plan | Variance | Actual | Plan | Variance | Estimate income lost due to Strike YTD | Revised income Variance |
| Medicine | Day Cases | 1,395 | 1,263 | 132 | 767 | 704 | 64 | 6,968 | 6,492 | 476 | 3,950 | 3,681 | 269 | 121 | 389 |
| Medicine | Electives | 32 | 16 | 16 | 38 | 27 | 11 | 111 | 81 | 30 | 154 | 135 | 19 | 12 | 32 |
| Medicine | OP Proc | 505 | 902 | (397) | 113 | 180 | (68) | 2,809 | 4,221 | (1,412) | 620 | 844 | (224) | 34 | (190) |
| Medicine | OPA New | 1,890 | 2,025 | (135) | 425 | 456 | (31) | 9,820 | 10,421 | (601) | 2,202 | 2,348 | (146) | 117 | (29) |
| **Medicine Total** | | **3,822** | **4,206** | **(384)** | **1,343** | **1,367** | **(24)** | **19,708** | **21,215** | **(1,507)** | **6,925** | **7,007** | **(82)** | **284** | **202** |
| Specialist Services | Day Cases | 640 | 761 | (121) | 918 | 1,184 | (265) | 3,277 | 3,686 | (409) | 4,754 | 5,618 | (865) | 444 | (421) |
| Specialist Services | Electives | 292 | 404 | (112) | 1,923 | 2,595 | (672) | 1,580 | 1,894 | (314) | 10,280 | 12,167 | (1,887) | 1,175 | (713) |
| Specialist Services | OP Proc | 1,920 | 2,410 | (490) | 260 | 341 | (81) | 8,981 | 11,484 | (2,503) | 1,221 | 1,620 | (399) | 62 | (337) |
| Specialist Services | OPA New | 2,824 | 3,445 | (621) | 537 | 653 | (116) | 14,351 | 17,002 | (2,651) | 2,684 | 3,226 | (541) | 106 | (435) |
| **Specialist Services Total** | | **5,676** | **7,020** | **(1,344)** | **3,638** | **4,772** | **(1,134)** | **28,189** | **34,066** | **(5,877)** | **18,939** | **22,631** | **(3,692)** | **1,787** | **(1,905)** |
| Surgery | Day Cases | 664 | 789 | (125) | 796 | 919 | (123) | 3,360 | 3,710 | (350) | 3,904 | 4,329 | (426) | 205 | (221) |
| Surgery | Electives | 139 | 137 | 2 | 480 | 469 | 11 | 611 | 646 | (35) | 1,980 | 2,185 | (206) | 118 | (88) |
| Surgery | OP Proc | 4,408 | 5,313 | (905) | 762 | 864 | (102) | 21,893 | 24,871 | (2,978) | 3,804 | 4,046 | (242) | 102 | (140) |
| Surgery | OPA New | 3,421 | 3,263 | 158 | 615 | 605 | 10 | 17,767 | 15,281 | 2,486 | 3,184 | 2,832 | 352 | 144 | 495 |
| **Surgery Total** | | **8,632** | **9,502** | **(870)** | **2,654** | **2,858** | **(204)** | **43,631** | **44,508** | **(877)** | **12,871** | **13,393** | **(521)** | **568** | **47** |
| **Grand Total ERF Activity** | | **18,130** | **20,727** | **(2,597)** | **7,635** | **8,997** | **(1,362)** | **91,528** | **99,788** | **(8,260)** | **38,736** | **43,031** | **(4,296)** | **2,639** | **(1,657)** |
| **Low Value Activity - removal from API** | | | | | **(78)** | **(151)** | **72** | | | | **(521)** | **(720)** | **198** | | **198** |
| **Unbundled Activity - All Divisions** | | | | | **2,131** | **2,242** | **(111)** | | | | **10,975** | **10,643** | **332** | | **332** |
| **Grand Total ERF Activity excluding LVA** | | **18,130** | **20,727** | **(2,597)** | **9,687** | **11,088** | **(1,401)** | **91,528** | **99,788** | **(8,260)** | **49,189** | **52,954** | **(3,766)** | **2,639** | **(1,127)** |

has been used. The detailed speciality analysis is being reviewed at Elective Transformation Board monthly.

# Appendix 4 – Operating Expenditure

| Division | In Month (£000) | | | Year to Date (£000) | | | Full Year (£000) |
|---|---|---|---|---|---|---|---|
| | Actual | Plan | Variance | Actual | Plan | Variance | Plan |
| **Clinical Divisions** | | | | | | | |
| Medicine | 10,896 | 9,716 | (1,180) | 53,311 | 46,274 | (7,038) | 113,604 |
| Surgery | 9,199 | 8,835 | (364) | 43,559 | 41,764 | (1,795) | 100,585 |
| Specialist Services | 9,583 | 9,582 | (0) | 45,713 | 45,747 | 34 | 111,930 |
| Community Services | 3,994 | 3,649 | (344) | 19,890 | 19,849 | (42) | 47,541 |
| **Sub Total** | **33,672** | **31,782** | **(1,890)** | **162,474** | **153,633** | **(8,841)** | **373,661** |
| **Corporate Divisions** | | | | | | | |
| Director of Strategy & Planning | 626 | 656 | 30 | 3,327 | 3,252 | (75) | 7,799 |
| IM & T | 1,076 | 1,288 | 212 | 5,438 | 5,757 | 319 | 13,817 |
| Finance | 370 | 372 | 2 | 1,813 | 1,860 | 47 | 4,464 |
| Dir of Operations | 54 | 55 | 1 | 259 | 275 | 16 | 660 |
| Human Resources | 338 | 342 | 5 | 1,665 | 1,704 | 40 | 4,100 |
| Medical Director | 218 | 232 | 15 | 992 | 1,049 | 57 | 2,518 |
| Estates & Facilities | 3,989 | 4,123 | 134 | 20,211 | 20,716 | 504 | 50,431 |
| Nurse Director | 769 | 688 | (81) | 3,833 | 3,483 | (350) | 8,822 |
| Trust Executive | 143 | 168 | 25 | 752 | 848 | 96 | 2,066 |
| GTEC | 291 | 256 | (35) | 2,503 | 1,260 | (1,244) | 3,017 |
| **Sub Total** | **7,874** | **8,181** | **308** | **40,794** | **40,204** | **(590)** | **97,695** |
| **Other** | | | | | | | |
| Reserves | 0 | 714 | 714 | 0 | 4,437 | 4,437 | 10,549 |
| Corporate | (466) | 1,178 | 1,645 | 898 | 4,843 | 3,944 | 9,728 |
| **Sub Total** | **(466)** | **1,893** | **2,359** | **898** | **9,279** | **8,381** | **20,277** |
| **Total** | **41,079** | **41,856** | **777** | **204,166** | **203,117** | **(1,049)** | **491,633** |

In month 5, the Trust is £0.8m favourable to the planned operating expenditure (pay and non-pay) of £41.9m. Year to date, operating expenditure is £1.0m adverse to plan.

The clinical divisions are £2.0m adverse to plan in month, which is driven by Medicine (£1.2m adverse) and Surgery (£0.4m adverse). This is due to escalation costs (see appendix 6) and unachieved CIP.

The Corporate Divisions are £0.3m favourable to plan. This is due to the reversal of the NHSE decision to adjust contract for Microsoft licences, where these savings are not accessible.

GTEC and nurse director are incurring expenditure more than their plan, however there is income overperformance to offset this expenditure.

Trust reserves are supporting the Trust position by £0.7m in month and £4.4m year to date.

The favourable variance within Corporate relates to the centralised CIP and review of balance sheet items, which has also supported the overall position by £2.0m in month and £5.6m year to date.

# Appendix 5 – Workforce

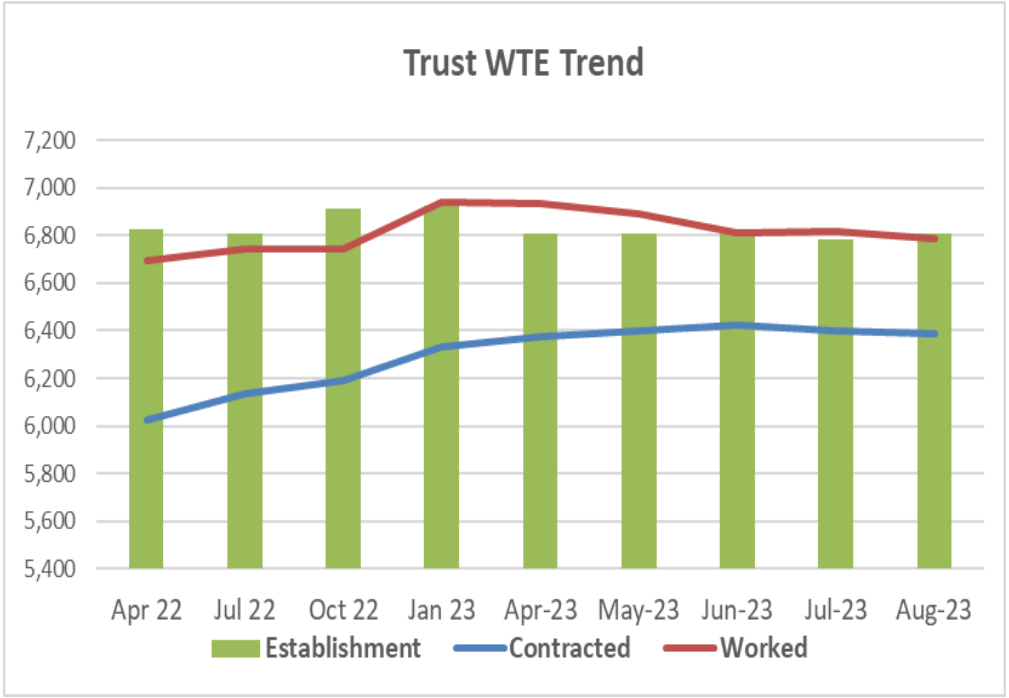
| In Month Pay Expenditure | Actual | Plan | Variance |
|---|---|---|---|
| **Division** | **(£000)** | **(£000)** | **(£000)** |
| Medicine | 8,791 | 7,536 | (1,255) |
| Specialist Services | 6,105 | 6,195 | 90 |
| Surgery | 7,737 | 7,472 | (265) |
| Community Services | 3,511 | 3,274 | (237) |
| Estates & Facilities | 2,076 | 2,047 | (29) |
| Corporate Divisions | 2,545 | 3,468 | 923 |
| **Total** | **30,764** | **29,991** | **(773)** |

| Division | Contracted WTE | | | Worked WTE | | |
|---|---|---|---|---|---|---|
| | Jul-23 | Aug-23 | Increase/ (Decrease) | Jul-23 | Aug-23 | Increase/ (Decrease) |
| Medicine | 1,462 | 1,447 | (15) | 1,756 | 1,718 | (38) |
| Specialist Services | 1,273 | 1,281 | 9 | 1,311 | 1,305 | (6) |
| Surgery | 1,422 | 1,422 | (0) | 1,472 | 1,495 | 23 |
| Community Services | 886 | 885 | (1) | 904 | 900 | (4) |
| Estates & Facilities | 704 | 704 | 0 | 727 | 729 | 2 |
| Corporate Divisions | 653 | 649 | (3) | 645 | 639 | (5) |
| **Total** | **6,399** | **6,388** | **(11)** | **6,815** | **6,786** | **(29)** |

The in-month pay expenditure for the Trust is £30.8m, which is £0.8m adverse to the £30m plan. Medicine has the largest overspend on pay, £1.3m, mainly due to escalation costs. Surgery is £0.3m adverse to budget due to supernumerary staff and international nurses outside of funded posts. Industrial action continues to increase pay costs outside of plan.

There is a decrease of 29 WTE worked since last month, as shown in the table above right. This is largely in Medicine (38 WTE), offset by Surgery 23 WTE. Other divisions have remained relatively static. There is an decrease in contracted WTE of 11 WTE since last month mainly in Medicine and Corporate Divisions, offset by Specialist Services.

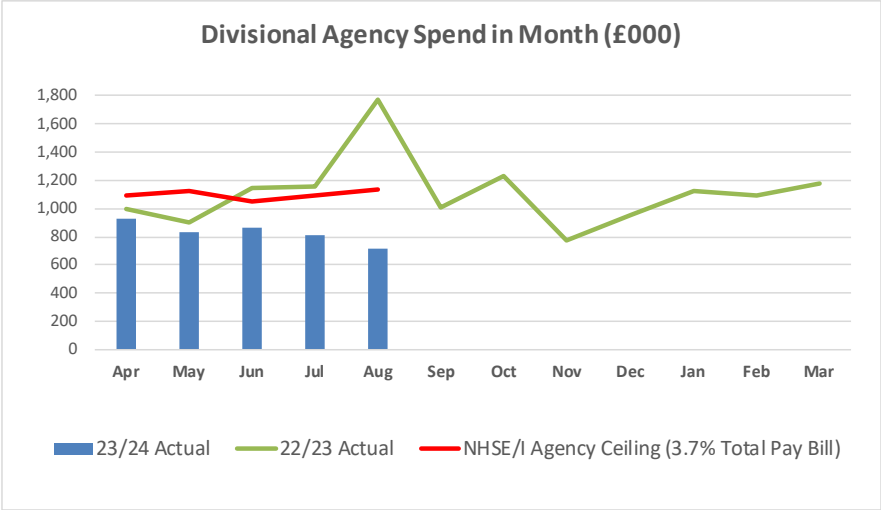
Scrutiny is intensifying on analysing WTE movements across GM ICS, with additional requests for information being received through both the CPO and CFO routes. There remains a significant increase in WTE growth across all providers in GM with a perception that this hasn't contributed to increased productivity.

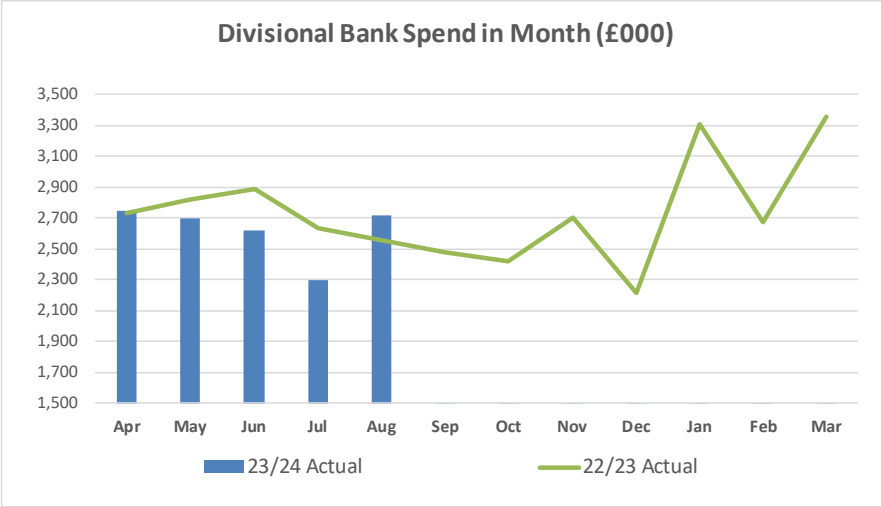



A vacancy scrutiny group has been established to provide oversight and assurance around allocation of international nurses across the Trust.
Agency spend for the Trust in month 5 is £0.7m, which is £0.1m reduction from the same time last year last year. The NHSE agency ceiling for 2023/24 is 3.7% of the Trust's total pay bill. Year to date, agency expenditure is 2.7% of the total pay bill, which is 1% below the ceiling.

The divisions with the highest levels of agency spend are Medicine £0.5m and Specialist Services £0.1m. Agency spend within the divisions is predominantly associated with medical locum cover to support escalation and cover vacant posts and rota gaps.

The Trust bank expenditure in month 5 is £2.7m, which is £0.6m increase compared to the same time last year. The divisions with the highest spend in month 5 are Medicine £1.7m, Surgery £0.5m and Specialist Services £0.3m. Bank usage within the divisions is predominantly related to nursing spend covering summer leave, escalation and 1:1 enhanced care.




## Appendix 6 – Escalation

The Trust needs to deliver its escalation cost reduction plan this year. The division of medicine are currently working on various streams to evaluate and plan to safely de-escalate the main hospital site. The Trust incurred costs estimated at £14m in 2022/23 associated with escalation and the level of no right to reside patients within the hospital.

Escalation costs noted in the division of Medicine amounted to £0.9m in month 5 and £4.6m year to date, with little movement overall in costs since July.

The escalation cost should start to reduce in September as the new staffing models are implemented and the use of temporary staffing reduces. There has been successful appointment of nurses into the new emergency department posts and the benefit of having these nurses in post will

support the delivery of care in the department. This is part of the reallocation of budgets described in the Emergency Village business case bundle that will help with patient care and flow as well as reducing the expenditure run rate on escalation costs going forwards.

| Escalation Costs – Division of Medicine | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Area** | **Monthly cost (£000)** | **Annual cost (£000)** | **M1 Actual (£000)** | **M2 Actual (£000)** | **M3 Actual (£000)** | **M4 Actual (£000)** | **M5 Actual (£000)** | **Full year Forecast (£000)** |
| A&E Rota Issues | 338 | 4,054 | 338 | 338 | 338 | 338 | 338 | 2,614 |
| Paeds rota issues | 90 | 1,077 | 89 | 89 | 89 | 89 | 89 | 926 |
| Acute Rota Issues | 167 | 2,002 | 107 | 79 | 79 | 75 | 79 | 969 |
| Acute Outliers | 52 | 630 | 52 | 52 | 52 | 52 | 76 | 490 |
| AAA | 87 | 1,045 | 64 | 37 | 0 | 0 | 0 | 101 |
| Corridor | 181 | 2,177 | 171 | 124 | 37 | 153 | 130 | 744 |
| Waiting room | 31 | 368 | 31 | 31 | 31 | 31 | 31 | 372 |
| 1:1 Enhanced Care | 235 | 2,820 | 235 | 178 | 170 | 173 | 167 | 1,468 |
| **Total** | **1,181** | **14,173** | **1,087** | **928** | **796** | **910** | **910** | **7,684** |
| Winter Business Cases | | | 0 | 0 | 0 | 0 | 0 | 1,047 |
| **Grand Total** | | | **1,087** | **928** | **796** | **910** | **910** | **8,731** |

## Appendix 7 – Divisional Cost Improvement Programme

| Divisional CIP | In Month (£000) | | | Year to Date (£000) | | | In Year (£000) | | |
|---|---|---|---|---|---|---|---|---|---|
| | Actual | Plan | Variance | Actual | Plan | Variance | Forecast Actual | Plan | Forecast Variance |
| Community | 67 | 102 | (34) | 258 | 509 | (250) | 1,221 | 1,221 | 0 |
| Dir Of Operations | 0 | 1 | (1) | 0 | 7 | (7) | 10 | 16 | (6) |
| Dir Of Strategy & Planning | 9 | 17 | (7) | 51 | 83 | (33) | 215 | 200 | 15 |
| Estates & Facilities | 50 | 102 | (52) | 192 | 509 | (317) | 1,221 | 1,221 | 0 |
| Finance | 9 | 9 | 0 | 44 | 44 | 0 | 105 | 105 | 0 |
| GTEC | 0 | 8 | (8) | 4 | 42 | (38) | 62 | 100 | (38) |
| HR | 6 | 9 | (2) | 28 | 44 | (16) | 105 | 105 | 0 |
| IM&T | 23 | 25 | (2) | 214 | 125 | 89 | 354 | 299 | 55 |
| Medical Director | 0 | 5 | (5) | 0 | 25 | (25) | 53 | 61 | (7) |
| Medicine | 86 | 266 | (180) | 496 | 1,327 | (830) | 2,466 | 3,190 | (724) |
| Nurse Director | 0 | 19 | (19) | 253 | 96 | 158 | 253 | 230 | 24 |
| Specialist Services | 385 | 222 | 163 | 898 | 1,055 | (157) | 2,742 | 2,612 | 130 |
| Surgery | 184 | 159 | 25 | 1,171 | 876 | 294 | 2,677 | 2,595 | 82 |
| Trust Executive | 4 | 4 | (0) | 20 | 21 | (1) | 50 | 50 | (0) |
| **Subtotal** | **823** | **948** | **(125)** | **3,629** | **4,761** | **(1,132)** | **11,536** | **12,004** | **(469)** |
| Non Recurrent Stretch | 495 | 392 | 103 | 2,036 | 1,958 | 78 | 4,816 | 4,696 | 121 |
| Non Recurrent Vacancies | 468 | 0 | 468 | 1,130 | 0 | 1,130 | 1,130 | 0 | 1,130 |
| **Total** | **1,786** | **1,340** | **446** | **6,795** | **6,719** | **77** | **17,482** | **16,700** | **782** |
| **Memo: Scheme Type** | | | | | | | | | |
| Transformational | 275 | | | 976 | | | 2,617 | | |
| Transactional | 1,511 | | | 5,820 | | | 14,865 | | |
| **Total** | **1,786** | **1,340** | **446** | **6,795** | **6,719** | **77** | **17,482** | **16,700** | **782** |

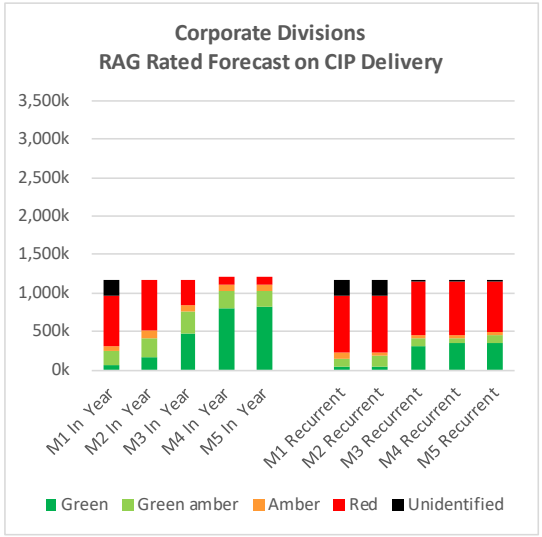
The Divisional CIP Target for 2023/24 is £12.0m plus an additional £4.7m stretch for non-recurrent vacancies.

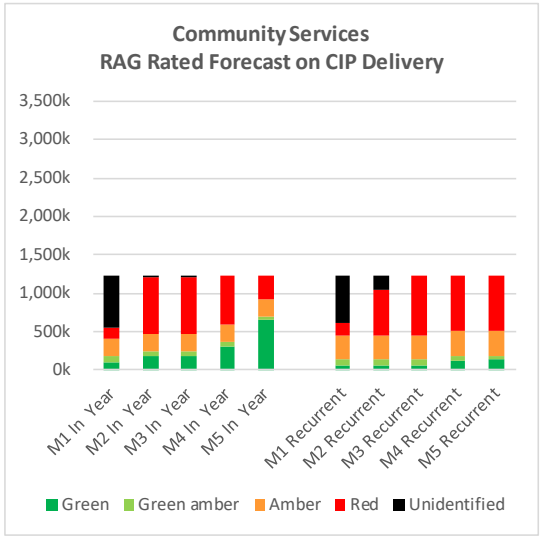
In month 5, the Divisional CIP transacted was 1.8m, which is £0.4m favourable against a plan of £1.3m. The amount transacted in month includes £0.5m for non-recurrent vacancies towards achievement of the £4.7m stretch included in the plan. An additional £0.5m vacancy factor was transacted to bridge the in-year gap.

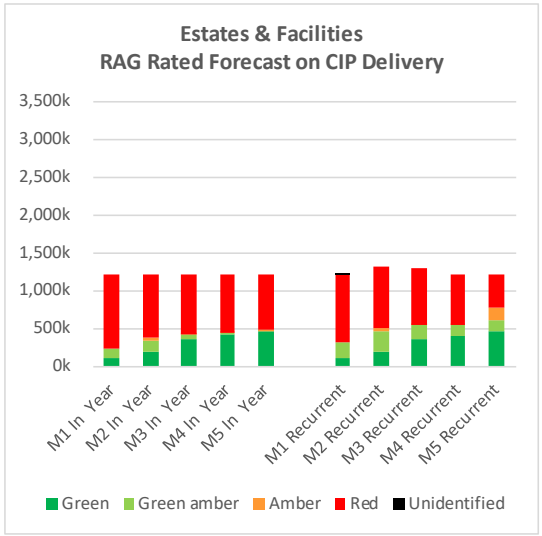
To date, £1.0m has been delivered through the Transformational schemes which relates to Private Patient income.

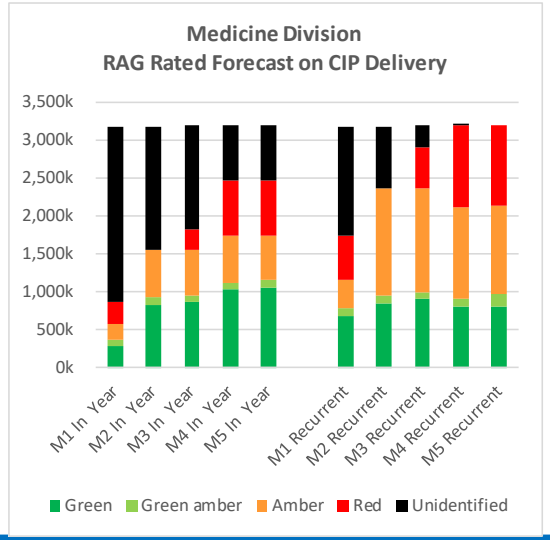
Excluding the non-recurrent vacancies, the divisions have forecasted £11.5m of CIP delivery, an increase of £0.3m from last month. This is £0.5m below the 23/24 target of 12.0m.

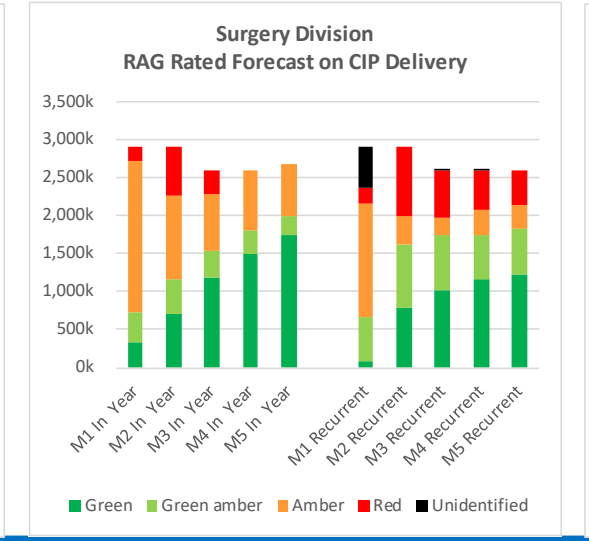
The tables below show the RAG rated forecast for CIP delivery for each Division. Overall, the Divisions have improved against both in year and recurrent targets, however it should be noted that a significant proportion of the schemes are categorised as high risk.

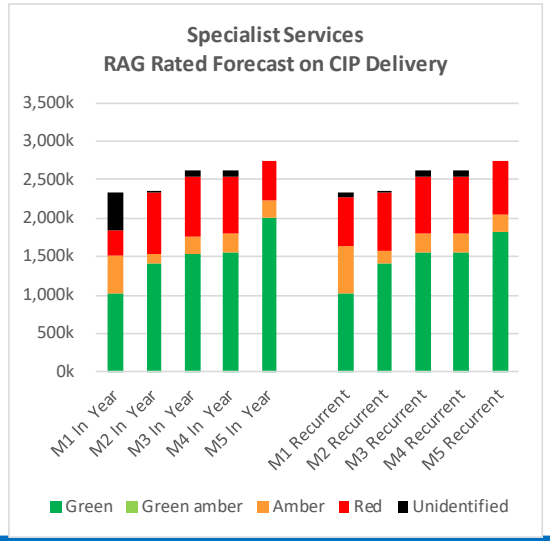



# Appendix 8 – RAPID Triggers

| | Financial Position | Operational Variances | | CIP | | | Outcome |
|---|---|---|---|---|---|---|---|
| **RAPID Metric** | **Overall variance to plan** | **Operational pressures** | **Agency ceiling** | **CIP Variance Year to Date** | **CIP Forecast** | **Recurrent Delivery** | **Based on Metrics** |
| *Trigger criteria* | *Adverse variance > 3% in month* | *Adverse variance excluding 22/23 CIP > 3% in month* | *Exceeding NHSE agency celing > 25% in month* | *CIP Variance to Plan > 25% adverse* | *Risk adjusted forecast > 25% adverse to plan in year* | *Recurrent delivery < 70% of plan* | *One or more metrics triggered* |
| **Division** | | | | | | | |
| Medicine | (12.1%) | (10.0%) | (41%) | (63%) | (48%) | 25% | Yes |
| Surgery | (3.5%) | (3.8%) | 67% | 34% | (8%) | 47% | Yes |
| Specialist | 3.0% | 1.1% | 28% | (13%) | (16%) | 75% | No |
| Community | (11.1%) | (9.7%) | 40% | (48%) | (31%) | 9% | Yes |
| E&F | 0.7% | 2.0% | 16% | (62%) | (49%) | 38% | Yes |

All divisions except Specialist Services have triggered based on the metrics. All other divisions will have a RAPID meeting in September. Whilst not reported within the divisions, the expectation is that divisions will closely monitor their API performance via the ERF app.

## Appendix 9 - Statement of Financial Position & Cash

## Cash

- The closing cash balance at the end of the month was £28.0m.
- This is an increase of £1.7m from the previous month, this is due to capital PDC funding £3.2m received in month ahead of the timing of the corresponding payments out. Therefore the underlying balance would be a £1.5m reduction due to timings of payments, receipts and YTD deficit.
- The Trust has established a monthly cash monitoring group, to ensure effective cash management for the remainder of the financial year.

## Better Payments Practice Code (BPPC)

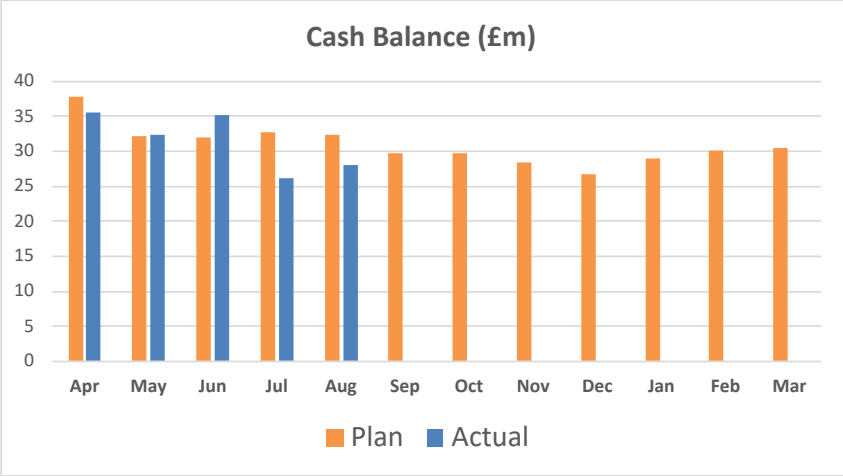
- 93.7% by volume and a deterioration from prior month (94.4%).
- An action plan is in place to improve this and reach the target of 95.0%.

## Debtor Days

- This ratio represents the average number of days to collect debtor payments.
- This has remained at 21 days in July.

## Operational Cash Days and Liquidity

- Operational cash days ratio represents the number of days the Trust can continue to pay its operating expenses with the current cash available. This has increased from 20 days in July to 21 days in August due to the increase in the cash balance at the end of August.
- Liquidity is a working capital ratio that indicates the Trusts ability to pay short term liabilities that are payable within 12 months. There has been a slight deterioration in month due to an increase in liabilities.




**Balance sheet metrics**

| | Jul-23 | Aug-23 |
|---|---|---|
| Cash balance (£m) | £26.2 | £28.0 |
| BPPC (volume) cumulative | 94.4% | 93.7% |
| Debtor days | 21 | 21 |
| Operational cash days | 20 | 21 |
| Liquidity (Current ratio) | -0.65 | -0.66 |
| Quick ratio | -0.61 | -0.62 |
| Cash ratio | -0.30 | -0.32 |

# Appendix 10 - Capital

## Summary

- £1.1m spend in month 5 against plan of £2.0m.
- £7.4m spend year to date against plan of £11.0m.
- Capital expenditure is £3.6m below plan at month 5, which relates to the CDC and Leigh theatre 4 combined build. This is due to the timing of the construction payments and optimism bias.

## Core Elements

- Includes back log maintenance, capital medical equipment, IM&T and Pathology.
- £0.3m below plan in month and £0.4m above plan year to date.

## Committed developments

- Includes Leigh theatre committment above PDC and agreed slippage from 2022/23 for Leigh Laminar Flow and CDC.
- Other schemes inlcude electrical infrasture improvements, contingency and agreed slippage on schemes from 2022/23.
- £0.6m below plan in month, and £4.1m below plan year to date.

## PDC funded schemes

- This includes year 2 of the approved PDC funding for the CDC and Leigh Laminar Flow schemes which are due to complete this year. These are £0.9m below plan in month.
- NHSE has approved the Endoscopy and Theatre 11 at Wrightington schemes to proceed in 2023/24.

| | In Month (£000) | | | Year to Date (£000) | | | Draft Revised Full Year (£000) |
|---|---|---|---|---|---|---|---|
| **Scheme** | **Actual** | **Plan** | **Var** | **Actual** | **Plan** | **Var** | **Plan** |
| Internally funded schemes | | | | | | | |
| Core Elements | (8) | 285 | 293 | 1,663 | 1,232 | (431) | 4,735 |
| Committed developments | 314 | 908 | 595 | 1,637 | 5,710 | 4,073 | 6,905 |
| **Total Internally funded** | **306** | **1,193** | **887** | **3,300** | **6,942** | **3,642** | **11,640** |
| | | | | | | | |
| PDC funded schemes | | | | | | | |
| CDC | 700 | 709 | 9 | 3,490 | 3,546 | 56 | 4,965 |
| Leigh Laminar Flow | 14 | 112 | 98 | 457 | 561 | 104 | 785 |
| Theatre 11, Wrightington | 0 | 0 | 0 | 0 | 0 | 0 | 4,800 |
| Endoscopy | 120 | 0 | (120) | 171 | 0 | (171) | 5,002 |
| **Total PDC funded schemes** | **834** | **821** | **(13)** | **4,118** | **4,107** | **(11)** | **15,552** |
| **Total exxcluding IFRS16** | **1,140** | **2,014** | **875** | **7,418** | **11,049** | **3,631** | **27,192** |
| | | | | | | | |
| IFRS16 Impact | | | | | | | |
| Lease Remeasurements | 0 | 0 | 0 | 519 | 3,214 | 2,695 | 3,214 |
| Parr Bridge | 0 | 0 | 0 | 1,640 | 2,173 | 533 | 2,173 |
| Equipment | 0 | 0 | 0 | 0 | 0 | 0 | 1,000 |
| **IFRS16 Total** | **0** | **0** | **0** | **2,159** | **5,387** | **3,228** | **6,387** |
| **Total including IFRS 16** | **1,140** | **2,014** | **875** | **9,577** | **16,436** | **6,859** | **33,579** |

## Capital plan 2023/24

- The GM capital plan submitted to NHSE in May 2023 includes an over-commitment of £71.0m. It has been indicated that the Trust's CDEL limit is likely to be reduced from £11.6m to £10.4m, a reduction of £1.2m (11%).
- Forecast slippage was reviewed at the Capital Strategy Group and a proposal for reinvestment in priority areas was agreed by the Executive team on 7th September. This is reflected within the revised plan.

# Appendix 11 - Scenarios

2023/24 planned deficit (£6.5m)

Using a straight line forecast based on the month 5 YTD position and adjusting for planned expenditure, risks, mitigations and sensitivities:

| Expected changes to run rate | Risks | Mitigations |
|---|---|---|
| • Winter expenditure<br>• Energy<br>• Direct expenditure to support activity | • API/ERF impact<br>• Industrial Action<br>• Inflation<br>• Escalation costs<br>• Pay award<br>• Winter pressures | • Bridging options<br>• CIP delivery<br>• Balance sheet support |

Best Case deficit (£6.5m) – on plan
Mid Case deficit (£12.1m) - £5.6m worse than plan
Worst Case deficit (£22.4m) - £15.9m worse than plan

As part of the financial recovery work undertaken during August, a year end forecast most likely and best case forecast position were provided to PWC in line with the scenarios above.

Assumptions within mid case likely scenario:

**Escalation**
A further 3 months of escalation costs - £2.8m

**Winter pressures**
Additional costs in H2 - £2.0m

**Industrial Action**
Any further financial impact would be mitigated nationally

**API**
50% of forecast API under delivery is recovered - £1.4m
Benefit assumed from API target adjustment - £0.8m

**Bridging Options**
Assumes full delivery of the identified bridging options - £5m

**CIP**
50% of current divisional forecast is cash releasing or income - £5.6m

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

| | |
|---|---|
| **Title of report:** | Maternity and Neonatal Dashboard Report |
| **Presented to:** | Board of Directors |
| **On:** | 04 October 2023 |
| **Presented by:** | Rabina Tindale |
| **Prepared by:** | Gemma Weinberg / Simon Needham for Cathy Stanford |
| **Contact details:** | gemma.weinberg@wwl.nhs.uk |

## Executive summary

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

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

The key performance targets are measured using a RAG system which reflects national, regional, and local performance indicators. These are under constant review and may change on occasion following discussion and agreement.

• Green – Performance within an expected range.

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

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

The Maternity and Neonatal dashboard is reviewed at Directorate, Divisional and Corporate Clinical Governance Meetings.

## Recommendation(s)

The board are asked to note the August 2023 dashboard and overview of indicators as outlined below.

## Maternity and Neonatal Dashboard August 2023

### Introduction

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

### August 2023 Exception report - Maternity

### Summary

The August Maternity dashboard remains predominantly green or amber with some improving metrics demonstrated.

- There were three midwifery red flags reported. These were related to staffing and delays in IOL. There were no occasions where the unit was placed on divert. The shift coordinator was able to remain supernumerary for all shifts in August and 1-2-1 care in labour was 100%.

- There was one Maternity complaint received in August, but the service continues to receive positive feedback letters and messages from Women regarding the excellent care they have received.

- There were two stillbirths in August and one ENND (a 21+4-week MTOP who showed signs of life).

### Steis reportable Incidents

For information only - There is one ongoing STEIS in August. The baby was born here but sadly died at another unit. This baby is not on the WWL dashboard for this reason.

### Green

**The Midwife to Birth ratio** currently remains static at 1:28. Despite the ongoing challenges with staffing and high levels of activity and acuity the service has been able to maintain good standards of care with good outcomes demonstrated. Work to recruit new staff remains an ongoing priority.

**Women booked by 12+6 weeks** This has remained consistently green for 12 months.

**Women readmitted within 28 days of Delivery.** There were 0 maternal readmissions recorded in August after a spike in readmissions in July.

**Smoking at the time of Delivery (SATOD).** This has seen a significant drop from the July figures and sees it at a lower number than we have ever seen at WWL. The metric has remained green since June 2022. Work continues to promote and encourage smoking cessation throughout pregnancy.

**Supernumerary Shift coordinator.** This has remained 100% and green for the past five consecutive months.

**1:1 care in labour.** There were no women reported to have not had 1:1 care in labour in August.

**Number of registerable births.** This had dipped into amber levels in July. August sees a return to normal figures and a green level.

**All infants with Apgar's less than 7**. July saw a spike into red levels. Until this spike WWL was seeing a downward trend. August sees a drop back into green levels for this metric.

**Induction of Labour (IOL)** These levels have been very up and down over the past few months with a further spike noted in July. August sees these figures returning to green. All cases continue to be reviewed for appropriate medical reasons, gestations, and outcomes. There will be an upcoming audit as to whether the new NICE guidelines to offer IOL at T+7 are having any effect on these metrics.

**Amber**

**Skills drills / mandatory training.** These have remained green and at normal levels for the past two months after training was cancelled in May. There was no training in August which means that the metric returns to amber levels.

**Bookings**. These have seen a slight increase from July, but the metric remains amber in August.

**PN length of stay**. After a drop to green levels in April, this metric has remained in amber levels for the past 4 months.

**Skin to skin contact –** Levels have dropped after a significant rise in May. August sees the metric remaining at amber levels. Work continues to improve this metric.

**The number of mothers who have opted to breastfeed –** This saw a significant drop in July to the lowest level since November. August shows an increase to amber levels. Work continues to improve this metric.

**Red**

**Term admissions to NNU.** This figure remains red and has been for several months. July and August show a slight increase in the figure. All cases continue to be reviewed within the ATTAIN audit to ensure admissions are appropriate. A new team has been formed to look at term admissions to NNU in more detail and at the ATTAIN audit to try to improve the figures in this metric.

**3rd / 4th degree tear**. This has seen a spike in July and August. A deep dive into this metric is underway to look at why the numbers have increased.

**Re-admissions of babies within 30 days** These figures have remained green for 6 months, but August sees a spike into red levels. Most cases were due to jaundice. All cases were managed appropriately and there were no omissions in care.

**Conclusion**

Normal variation and fluctuations are noted with the figures this month and positive factors have been sustained. No issues are raised with care given or in the management of cases. The figures show green and amber indicators but do show several red areas which will be observed going forward. Persistently amber areas will also be closely observed for patterns. The maternity dashboard continues to be reviewed quarterly by GM and the Maternity Dashboard steering group.

**It should be noted that the steroids and magnesium sulphate figures are not RAG rated on the Maternity dashboard from March onwards. The figures will still be collected to look for any omissions

or patterns. However, as this metric is generally out of the clinicians' control the decision was made at Clinical Cabinet to remove the RAG rating. This will continue to be reviewed going forward. **

## August 2023 Exception report – Neonatal

### Summary

The August neonatal dashboard remains predominantly green with some improving metrics demonstrated.

- There were two neonatal babies (twins) born under 27 weeks. All babies under 27 weeks require to be born in a tertiary unit (NICU). On this occasion the mother was in labour and unable to be safely transferred out by Maternity to a tertiary maternity centre.
- The shift coordinator was supernumerary for 79% of shifts in August and above the national average. The unit was above the BAPM recommendation for majority of shifts in August.
- The unit was not closed during August.
- There were no complaints received in August.

### Steis reportable Incidents

There were no Steis incidents in August 2023.

### Green

**% of Shifts to BAPM** – This metric improved to 94% and above the 90% target. Despite the ongoing challenges with staffing and unexpected levels of activity and acuity the service has been able to maintain good standards of care with good outcomes demonstrated. Work to recruit new staff remains an ongoing priority.

**Supernumerary Shift coordinator.** This has remained above the 50% national average and green for the past five consecutive months.

**Unit Closures.** The unit was not closed on any occasion in August.

**NLS/Specialised Training.** These metrics have remained green and at normal levels for the past five months.

**% of Mothers Receiving Antenatal MgSo4** - 100% of mothers who were eligible received this treatment.

### Amber

There were no amber metrics in August.

### Red

**Admissions under 27 weeks gestation to NNU.** We had two babies (twins) born outside of the preferred Tertiary NICU centre. This was due to the mother not being able to be transferred out safely as she was in established labour.

**Term admissions to NNU.** This figure remains red now for two months. The figure over the last few months has improved from average of 8.5% from previous months at the start of the year. All cases continue to be reviewed within the ATTAIN audit to ensure admissions are appropriate. A new team has been formed to look at term admissions to NNU in more detail and at the ATTAIN audit to try to

improve the figures in this metric. There measures being taken and with the planned improvements to transitional care service by the end of this year we expect this figure to return to green.

**% of Mother Who Received Full Course of Antenatal steroids** – It should be noted that his metric differs from the parameters in the Maternity dashboard. The Maternity dashboard shows singleton babies only and the Neonatal dashboard includes all babies (single and multiple). For the Neonatal Dashboard, of the three eligible babies, there was just one whose mother received a full course of steroids. The others were twins who only had one dose before delivery.

**% of Babies receiving Delayed cord clamping**. This figure is below target due to the unexpected admissions of 27 weeks and under twins and emergency care interventions where required. Three other babies born who met criteria all received this recommendation.

**Conclusion**

Normal variation and fluctuations are noted with the figures this month and positive factors have been sustained. No issues are raised with care given or in the management of cases. The figures show green indicators but do show several red areas which will be observed going forward. Persistently flagging areas will also be closely observed for patterns. The Neonatal dashboard continues to be reviewed quarterly by GM and the Neonatal/Maternity Dashboard steering group.

# Safety Dashboard 2023

## Maternity

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

| | | Goal | Red Flag | Measure | 2022 Oct | 2022 Nov | 2022 Dec | 2023 Jan | 2023 Feb | 2023 Mar | 2023 Apr | 2023 May | 2023 Jun | 2023 Jul | 2023 Aug | 2023 Sep | 2023 Oct | 2023 Nov | 2023 Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Activity | **Number of Registerable Births** | **> 200** | **< 180** | **2022 Births** | **234** | **228** | **213** | **225** | **169** | **194** | **214** | **215** | **213** | **183** | **234** | | | | |
| | **Number of Bookings (*one month retrospective* )** | **≥ 240** | **≤ 200** | **2022 Bookings** | **254** | **258** | **215** | **260** | **247** | **249** | **201** | **241** | **237** | **216** | **233** | | | | |
| | **Normal Births as % of Births** | ≥ 60% | < 55% | Nat Standard | 39.74% | 52.19% | 46.48% | 52.44% | 50.89% | 49.48% | 45.79% | 45.58% | 50.70% | 46.99% | 46.58% | | | | |
| | % of Successful Planned Home Births | | | Births/month | 0.43% | 1.32% | 0.94% | 1.78% | 2.96% | 0.00% | 1.40% | 0.93% | 2.82% | 1.09% | 1.28% | | | | |
| | **Instrumental Deliveries as % of Births** | < 12% | > 15% | Nat Average | 12.39% | 7.46% | 7.04% | 8.44% | 7.10% | 7.22% | 12.15% | 8.84% | 12.68% | 13.66% | 9.40% | | | | |
| | **Total Caesarean Sections as % of Births** | < 29% | ≥ 34% | GM Average | 47.44% | 39.91% | 46.01% | 39.11% | 42.01% | 42.27% | 40.65% | 45.12% | 36.15% | 38.25% | 44.02% | | | | |
| | % Emergency Caesaean Sections | | | | 28.63% | 25.44% | 30.52% | 24.44% | 25.44% | 28.35% | 22.43% | 26.51% | 21.13% | 27.32% | 26.50% | | | | |
| | % Elective Caesarean Sections | | | | 18.80% | 14.47% | 15.49% | 14.67% | 16.57% | 13.92% | 18.22% | 18.60% | 15.02% | 10.93% | 17.52% | | | | |
| | % of Category 1 Caesarean Sections with Delay in Knife to Skin (*over 30 minutes* ) | | | | 16.60% | 5.55% | 27.77% | 37.50% | 0.00% | 23.07% | 41.60% | 23.80% | 0.00% | 7.69% | 10.52% | | | | |
| | % of Category 2 Caesarean Sections with Delay in Knife to Skin (*over 75 minutes* ) | | | | 37.03% | 19.44% | 23.80% | 26.60% | 16.60% | 15.78% | 16.66% | 7.14% | 20.00% | 21.42% | 24.13% | | | | |
| | Number of Successful VBAC Deliveries | | | Births/month | 6 | 5 | 4 | 3 | 1 | 7 | 3 | 3 | 6 | 5 | 5 | | | | |
| | % of Caesarean Sections at Full Dilatation | | | Births/month | 3.60% | 7.69% | 6.12% | 4.55% | 7.04% | 9.76% | 5.75% | 12.37% | 3.90% | 2.86% | 5.83% | | | | |
| | **Induction of Labour as % of Women Delivered** | **< 38%** | **≥ 42%** | **Births/month** | **37.61%** | **40.79%** | **40.85%** | **31.11%** | **42.60%** | **47.94%** | **35.98%** | **45.12%** | **37.09%** | **43.17%** | **38.89%** | | | | |
| | % of Women Induced when RFM is the Only Indication (*< 39 weeks* ) | | | | 0.43% | 0.44% | 0.00% | 1.78% | 0.59% | 0.52% | 0.47% | 0.47% | 0.00% | 0.00% | 0.43% | | | | |
| | % of Women Induced for Suspected SGA | | | | 4.27% | 4.39% | 7.51% | 2.67% | 5.92% | 9.79% | 5.61% | 4.19% | 5.63% | 6.01% | 4.70% | | | | |
| | **Average Postnatal Length of Stay** | **≤ 1.5** | **≥ 1.8** | **Births/month** | **1.8** | **1.6** | **2** | **1.8** | **1.8** | **1.9** | **1.5** | **1.8** | **1.8** | **1.7** | **1.7** | | | | |
| | Number of In-Utero Transfers In from Other Units | | | | 1 | 1 | 1 | 2 | 0 | 0 | 4 | 5 | 5 | 4 | 3 | | | | |
| | Number of In-Utero Transfers Out to Other Units | | | | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 3 | 6 | 0 | 0 | | | | |
| | %of Women Smoking at Booking | | | 2022 Bookings = 17% | 12.20% | 14.30% | 11.62% | 11.15% | 11.74% | 10.44% | 9.45% | 11.60% | 8.86% | 12.50% | 14.10% | | | | |
| | **% of Women Smoking at Delivery** | **14%** | **17%** | **2022 Births** | **9.44%** | **11.89%** | **10.84%** | **7.72%** | **11.24%** | **13.47%** | **11.68%** | **10.90%** | **9.38%** | **13.30%** | **6.95%** | | | | |

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Percentage of Babies in Skin-to-Skin Within 1 Hour of Birth** | **≥ 80%** | **≤ 70%** | **Regional average** | **76.09%** | **75.77%** | **75.94%** | **74.32%** | **78.11%** | **84.90%** | **52.61%** | **83.00%** | **79.25%** | **74.86%** | **76.29%** | | | | |
| | **Percentage of Women Initiating Breastfeeding** | **≥ 55%** | **≤ 50%** | **2022 Births** | **54.35%** | **47.14%** | **57.08%** | **56.76%** | **60.95%** | **54.69%** | **74.88%** | **52.00%** | **59.91%** | **49.18%** | **54.74%** | | | | |
| | **Percentage of Women Booked by 12+6 Weeks** | **≥ 90%** | **≤ 80%** | **Nat Standard** | **92.91%** | **93.80%** | **95.81%** | **94.23%** | **95.14%** | **96.39%** | **96.02%** | **94.19%** | **96.62%** | **93.98%** | **94.85%** | | | | |
| **Workforce** | **Prospective Consultant Hours on Delivery Suite** | **60 hours** | **< 60 hours** | **Nat Standard** | **60** | **60** | **60** | **60** | **60** | **60** | **60** | **60** | **60** | **60** | **60** | | | | |
| | **Midwife: Birth Ratio** | **≤ 1:28** | **≥ 1:24** | **WTE/Births** | **1.28** | **1.28** | **1.28** | **1.28** | **01:28** | **1.28** | **1.28** | **1.28** | **1.28** | **1.28** | **1.28** | | | | |
| | **1:1 Care in Labour** | **100%** | **< 100%** | **Nat Standard** | **98.99%** | **98.80%** | **100.00%** | **98.93%** | **99.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | | | | |
| | **Percentage of Shifts Where Shift Co-Ordinator Able to Remain Supernumerary** | **100%** | **< 100%** | **Nat Standard** | **100.00%** | **98.30%** | **98.30%** | **100.00%** | **100.00%** | **98.20%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | | | | |
| | Diverts: Number of Occasions Unit Unable to Accept Admissions | | | | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 0 | | | | |
| | Diverts: Number of Women During Period Affected by Unit Closure | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | | | | |
| | **Attendance at Skills Drills/Mandatory Training** | **≥ 8%** | **< 8%** | **Training Database** | **8.40%** | **9.16%** | **9.16%** | **10.53%** | **0.00%** | **15.27%** | **11.72%** | **0.00%** | **13.82%** | **12.80%** | **0.00%** | | | | |
| **Maternal Morbidity** | **3rd/4th Degree Tear as % of Births** | **< 3%** | **≥ 4%** | **2022 Births** | **1.72%** | **1.32%** | **2.36%** | **1.45%** | **2.04%** | **4.54%** | **3.22%** | **0.85%** | **1.48%** | **6.19%** | **3.05%** | | | | |
| | % of Episiotomies in Normal Birth | | | Births/month | 4.30% | 5.88% | 5.05% | 5.08% | 6.98% | 9.38% | 8.16% | 6.12% | 2.78% | 9.30% | 5.50% | | | | |
| | Episiotomies with Episcissors | | | | 81.25% | 87.50% | 85.00% | 83.33% | 94.44% | 84.00% | 90.91% | 86.36% | 84.00% | 92.59% | 92.59% | | | | |
| | PPH 500 – 1499mls as % of Births | | | Births/month | 40.60% | 42.10% | 38.90% | 35.59% | 35.50% | 38.02% | 38.86% | 40.00% | 34.91% | 42.62% | 34.48% | | | | |
| | PPH 1500 – 2499mls as % of Births | | | Births/month | 2.13% | 0.87% | 2.81% | 3.57% | 0.59% | 3.09% | 3.27% | 3.70% | 2.88% | 2.18% | 6.41% | | | | |
| | PPH > 2.5L as % of Births | | | Births/month | 0.85% | 0.43% | 0.93% | 0.45% | 0.00% | 0.52% | 0.93% | 0.00% | 0.94% | 0.00% | 0.00% | | | | |
| | Number of Blood Transfusions ≥ 4 Units | | | Births/month | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | |
| | Number of Women Requiring Level 2 Critical Care | | | Births/month | 3 | 0 | 3 | 0 | 0 | 5 | 2 | 1 | 2 | 2 | 1 | | | | |
| | Number of Women Requiring Level 3 Critical Care | | | Births/month | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| | Maternal Deaths | | | Nat rate per 1000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| | **Number of Women Re-Admitted Within 28 Days of Delivery** | **≤ 1** | **> 4** | **16 in 2022** | **4** | **3** | **3** | **2** | **0** | **2** | **2** | **2** | **0** | **4** | **0** | | | | |
| | Number of Women Readmitted Within 28 Days of Delivery with Infection / Query Sepsis | | | | 0 | 2 | 0 | 0 | 1 | 2 | 2 | 1 | 0 | 4 | 0 | | | | |
| | Stillbirths** | | | Nat rate 3.5 per 1000 births | 0 | 1 | 1 | 2 | 0 | 2 | 2 | 0 | 1 | 0 | 2 | | | | |
| | Early Neonatal Deaths (*before 7 days*) | | | Nat rate per 1000 births | 3 | 0 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | | | | |
| | Number of Babies Born Under 37 Weeks | | | | 20 | 13 | 17 | 23 | 12 | 18 | 10 | 18 | 21 | 17 | | | | | |
| | **Number of Neonates with Apgars < 7 at 5 Minutes (≥ *37 weeks gestation*)** | **≤ 0** | **> 3** | **GM avg. 10 per 1000** | **2** | **3** | **7** | **4** | **4** | **3** | **3** | **3** | **0** | **4** | **2** | | | | |

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Neonatal Morbidity & Mortality | HIE 2 & 3 > 37 Weeks (*reported retrospectively* ) | | | GM avg. 1.95 per 1000 | 1 | 0 | 2 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 1 | | | |
| | Shoulder Dystocia as % of Births | | | Births/month | 0.00% | 0.88% | 2.35% | 1.78% | 0.59% | 0.52% | 1.87% | 1.40% | 0.47% | 1.64% | 1.28% | | | |
| | Singleton Babies Born < 30 Weeks Gestation | | | Births/month | 1 | 0 | 0 | 1 | 1 | 2 | 1 | 0 | 2 | 0 | 1 | | | |
| | **% Whose Mother Received $MgSO_4$** | 100% | 90% | Rolling % of eligible babies | 0.00% | N/A | N/A | 0.00% | 0.00% | 50.00% | 100.00% | N/A | 50.00% | N/A | 100.00% | | | |
| | Singleton Babies Born < 34 Weeks Gestation | | | Births/month | 7 | 2 | 5 | 2 | 2 | 4 | 4 | 4 | 3 | 4 | 1 | | | |
| | **% Whose Mother Received Full Course of Steroids (*1 week prior to delivery* )** | 100% | 90% | Rolling% of eligible babies | 100.00% | 0.00% | 83.33% | 50.00% | 50.00% | 100.00% | 25.00% | 100.00% | 66.67% | 25.00% | 100.00% | | | |
| | **Mothers Who Did Not Receive Full Course and Omissions in Care Noted** | **0** | **> 1** | **Eligible Mothers** | **N/A** | **0** | **0** | **0** | **0** | **N/A** | **0** | **0** | **0** | **0** | **0** | | | |
| | % of Babies Who Had Defered Cord Clamping | | | | 84% | 84% | 81% | 82% | 82% | 82% | 85% | 84% | 92% | 84% | 81% | | | |
| | % of Babies Born < 37 Weeks Whose Mother Recieved IV Antibiotics | | | | 35% | 31% | 12% | 22% | 0% | 44% | 50% | 50% | 14% | 35% | 35% | | | |
| | **Unexpected Term Admissions to NNU (*as % of births > 37 weeks gestation* )** | **3.50%** | **> 4.5%** | **Births > 37 weeks/month** | **3.81%** | **8.45%** | **8.16%** | **8.08%** | **10.13%** | **8.67%** | **5.82%** | **5.64%** | **5.73%** | **6.67%** | **6.67%** | | | |
| Risk Management | **Number of Babies Re-Admitted Within 28 Days of Birth** | **< 16** | **> 20** | **194 in 2022** | **21** | **12** | **22** | **17** | **8** | **16** | **9** | **11** | **9** | **14** | **20** | | | |
| | Number of Incidents Reported | | | | 66 | 51 | 59 | 78 | 50 | 84 | 74 | 94 | 86 | 95 | 77 | | | |
| | Number of Concise Investigations | | | | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | |
| | Number of StEIS Reported Incidents | | | | 2 | 0 | 0 | 2 | 0 | 1 | 0 | 0 | 1 | 3 | 1 | | | |
| | Number of Midwifery Red Flags Reported | | | | 5 | 1 | 5 | 5 | 1 | 4 | 1 | 0 | 2 | 5 | 3 | | | |
| | Number of Complaints | | | | 0 | 1 | 0 | 1 | 1 | 2 | 2 | 4 | 2 | 0 | 1 | | | |
| | Number of Letters of Claim Received | | | | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | |

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

| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Q1 | Q2 | Q3 | Q4 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Women Delivered | 220 | 169 | 193 | 212 | 211 | 208 | 180 | 230 | | | | | 582 | 631 | 410 | 0 | 1623 |
| Number of Registerable Births | 225 | 169 | 194 | 214 | 215 | 213 | 183 | 234 | | | | | 588 | 642 | 417 | 0 | 1647 |
| Number of Bookings( retrospective 1 month ) | 260 | 247 | 249 | 201 | 241 | 237 | 216 | 233 | | | | | 756 | 679 | 449 | 0 | 1884 |
| Normal Births as % of births | 118 | 86 | 96 | 98 | 98 | 108 | 86 | 109 | | | | | 300 | 304 | 195 | 0 | 799 |
| % of Successful Planned Home Births | 4 | 5 | 0 | 3 | 2 | 6 | 2 | 3 | | | | | 9 | 11 | 5 | 0 | 25 |
| Instrumental Deliveries as % of births | 19 | 12 | 14 | 26 | 19 | 27 | 25 | 22 | | | | | 45 | 72 | 47 | 0 | 164 |
| Total Caesarean Sections as % of births | 88 | 71 | 82 | 87 | 97 | 77 | 70 | 103 | | | | | 241 | 261 | 173 | 0 | 675 |
| % Emergency Caesaean Sections | 55 | 43 | 55 | 48 | 57 | 45 | 50 | 62 | | | | | 153 | 150 | 112 | 0 | 415 |
| % Elective Caesarean Sections | 33 | 28 | 27 | 39 | 40 | 32 | 20 | 41 | | | | | 88 | 111 | 61 | 0 | 260 |
| % of Category 1 Caesarean Sections with Delay in Knife to Skin (over 30 minutes) | 37.50% | 0.00% | 23.07% | 41.60% | 23.80% | 0.00% | 7.69% | 10.50% | | | | | 60.57% | 65.40% | 18.19% | | 144.16% |
| % of Category 2 Caesarean Sections with Delay in Knife to Skin (over 75 minutes) | 26.60% | 16.60% | 15.78% | 16.66% | 7.14% | 20.00% | 21.42% | 23.30% | | | | | 58.98% | 43.80% | 44.72% | | 147.50% |
| Number of successful VBAC deliveries | 3 | 1 | 7 | 3 | 3 | 6 | 5 | 5 | | | | | 11 | 12 | 10 | 0 | 33 |
| %of Caesarean Sections at Full Dilatation | 4 | 5 | 8 | 5 | 12 | 3 | 2 | 6 | | | | | 17 | 20 | 8 | 0 | 45 |
| Induction of Labour as % of women delivered | 70 | 72 | 93 | 77 | 97 | 79 | 79 | 91 | | | | | 235 | 253 | 170 | 0 | 658 |
| % of women induced when RFM is the only indication <39 weeks | 4 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | | | | | 6 | 2 | 1 | 0 | 9 |
| % of women induced for Suspected SGA | 6 | 10 | 19 | 12 | 9 | 12 | 11 | 11 | | | | | 35 | 33 | 22 | 0 | 90 |
| Average Postnatal Length of Stay | 1.8 | 1.8 | 1.9 | 1.5 | 1.8 | 1.8 | 1.7 | 1.7 | | | | | 14 | 5.1 | 3.4 | 0 | 14 |
| Number of In-utero transfers in from other units | 2 | 0 | 0 | 4 | 5 | 5 | 4 | 3 | | | | | 2 | 14 | 7 | 0 | 23 |
| Number of In-utero transfers out to other units | 1 | 0 | 0 | 1 | 3 | 6 | 0 | 0 | | | | | 1 | 10 | 0 | 0 | 11 |
| %of Women Smoking at Booking | 11.15% | 11.74% | 10.44% | 9.45% | 11.60% | 8.86% | 12.50% | 14.10% | | | | | 33% | 0.2991 | 0.266 | 0 | 0.8984 |
| % of Women Smoking at Delivery | 7.72% | 11.24% | 13.47% | 11.68% | 11% | 9.38% | 13.30% | 7.0% | | | | | 0.3243 | 0.3196 | 0.2025 | 0 | 0.8464 |
| Babies in Skin-to-Skin within 1 hour of birth | 165 | 132 | 163 | 111 | 177 | 168 | 137 | 177 | | | | | 460 | 456 | 314 | 0 | 1230 |
| Percentage of Women Initiating Breastfeeding | 126 | 103 | 105 | 158 | 110 | 127 | 90 | 127 | | | | | 334 | 395 | 217 | 0 | 946 |
| Percentage of Women booked by 12+6 weeks | 245 | 235 | 240 | 193 | 227 | 229 | 203 | 221 | | | | | 720 | 649 | 424 | 0 | 1793 |
| Prospective Consultant hours on Delivery Suite | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | | | | | 180 | 180 | 120 | 0 | 480 |
| Midwife: Birth Ratio | 01:28 | 01:28 | 01:28 | 01:28 | 01:28 | 1.28 | 1.28 | 1.28 | | | | | 0.183333333 | 1.4022 | 2.56 | 0 | 4.14556 |
| 1:1 Care in Labour | 98.93% | 99% | 100% | 100% | 100% | 100% | 100.00% | 100% | | | | | 3.9793 | 3 | 2 | 0 | 7.9793 |
| Percentage of shifts where shift Co-ordinator able to remain supernumerary | 100% | 100% | 98.20% | 100% | 100 | 100 | 100 | 100 | | | | | 2.982 | 201 | 200 | 0 | 403.982 |
| Diverts: Number of occasions unit unable to accept admissions | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 0 | | | | | 0 | 1 | 2 | 0 | 3 |
| Diverts: Number of women during period affected by unit closure | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 | 0 | 0 | 0 | 0 |
| Number of Midwives in Post | 133 | 132 | 131 | 128 | 124 | 123 | 125 | 124 | | | | | 396 | 375 | 249 | 0 | 1020 |
| Attendance at Skills Drills/Mandatory Training | 14 | 0 | 20 | 15 | 0 | 17 | 16 | 0 | | | | | 34 | 32 | 16 | 0 | 82 |
| 3rd/4th Degree Tear as % of births | 2 | 2 | 5 | 4 | 1 | 2 | 7 | 4 | | | | | 9 | 7 | 11 | 0 | 27 |
| Episiotomies in Normal Birth | 6 | 6 | 9 | 8 | 6 | 3 | 8 | 6 | | | | | 21 | 17 | 14 | 0 | 52 |
| PPH >2.5L as % of births | 1 | 0 | 1 | 2 | 0 | 2 | 0 | 0 | | | | | 2 | 4 | 0 | 0 | 6 |
| Number of Blood Transfusions≥ 4 Units | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | | 0 | 0 | 0 | 0 | 0 |
| Number of Women Requiring Level 2 Critical Care | 0 | | 5 | 2 | 1 | 2 | 2 | 1 | | | | | 5 | 5 | 3 | 0 | 13 |
| Number of Women Requiring Level 3 Critical Care | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 | 0 | 0 | 0 | 0 |
| Maternal Deaths | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 | 0 | 0 | 0 | 0 |
| Number of women re-admitted within 28 days of delivery | 2 | 0 | 2 | 2 | 2 | 0 | 4 | 0 | | | | | 4 | 4 | 4 | 0 | 12 |
| Number of Women Redmitted Within 28 Days of Delivery with Infection / Query Sepsis | 0 | 0 | 2 | 2 | 1 | 0 | 4 | 0 | | | | | 9 | 3 | | | |
| Stillbirths ** | 2 | 0 | 2 | 2 | 0 | 1 | 0 | 2 | | | | | 4 | 3 | 2 | 0 | 9 |
| Early Neonatal Deaths (before 7 days) | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | | | | | 2 | 1 | 1 | 0 | 4 |
| Number of Babies Born Under 37 Weeks | 23 | 12 | 18 | 10 | 18 | 21 | 17 | 22 | | | | | 141 | | | | |
| Number of Neonates with Apgars <7 at 5 minutes (≥37 weeks gestation) | 4 | 4 | 3 | 3 | 3 | 0 | 4 | 2 | | | | | 11 | 6 | 6 | 0 | 23 |
| HIE 2 &3 > 37 weeks (reported retrospectively) | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 1 | | | | | 3 | 0 | 1 | 0 | 4 |
| Shoulder Dystocia | 4 | 1 | 1 | 4 | 3 | 1 | 3 | 3 | | | | | 6 | 8 | 6 | 0 | 20 |
| Singleton Babies born <30 weeks gestation | 1 | 1 | 2 | 1 | 0 | 2 | 0 | 1 | | | | | 4 | 3 | 1 | 0 | 8 |
| % whose mother received magnesium sulphate | 0 | 0 | 1 | 100% | N/A | 1 | N/A | 1 | | | | | 2 | 2 | 1 | 0 | 4 |
| Singleton Babies born <34 weeks gestation | 2 | 2 | 4 | 4 | 4 | 3 | 4 | 1 | | | | | 8 | 11 | 5 | 0 | 24 |
| % whose mother received full course steriods (1 week prior to delivery) | 1 | 1 | 4 | 1 | 4 | 2 | 1 | 1 | | | | | 6 | 7 | 2 | 0 | 15 |
| Births >37 weeks gestation | 198 | 158 | 173 | 189 | 195 | 192 | 165 | 210 | | | | | 529 | 576 | 375 | 0 | 1480 |
| Unexpected Term Admissions to NNU as % of births > 37 weeks gestation. | 16 | 16 | 15 | 11 | 11 | 11 | 11 | 14 | | | | | 47 | 33 | 25 | 0 | 105 |

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of babies re-admitted with 28 days of birth | 17 | 8 | 16 | 9 | 11 | 9 | 14 | 20 | | | | | 41 | 29 | 34 | 0 | 104 |
| Number of indicents reported | 78 | 50 | 84 | 74 | 94 | 86 | 95 | 77 | | | | | 212 | 254 | 172 | 0 | 638 |
| Number of Concise Investigations | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 | 0 | 0 | 0 | 0 |
| Number of StEIS Reported Incidents | 2 | 0 | 1 | 0 | 0 | 1 | 3 | 1 | | | | | 3 | 1 | 4 | 0 | 8 |
| Number of Midwifery Red Flags Reported | 4 | 1 | 4 | 1 | 0 | 2 | 5 | 3 | | | | | 9 | 3 | 8 | 0 | 20 |
| Number of Complaints | 1 | 1 | 2 | 2 | 4 | 2 | 0 | 1 | | | | | 4 | 8 | 1 | 0 | 13 |
| Number of Letters of Claim Received | | 0 | | 0 | 0 | 0 | 0 | 0 | | | | | 0 | 0 | 0 | 0 | 0 |
| | | | | | | | | | | | | | 0 | 0 | 0 | 0 | 0 |
| | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | 0 | 0 | 0 | 0 | 0 |
| Live Births | 222 | 169 | 192 | 211 | 215 | 212 | 183 | 232 | | | | | 1636 | 638 | 415 | 0 | 1636 |
| **REGIONAL METRICS** | | | | | | | | | | | | | | | | | |
| Number of Live Births born ≥16 weeks to <24 weeks | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 1 | | | | | 4 | | | | 8 |
| Number of Live Births born ≥24 weeks to <37 weeks | 23 | 12 | 18 | 10 | 18 | 20 | 17 | 19 | | | | | 137 | | | | 211 |
| Number of Live Births born ≥24 weeks to <34 weeks | 6 | 2 | 4 | 3 | 6 | 8 | 4 | 5 | | | | | | | | | |
| Number of Live Births ≥38 weeks | 180 | 136 | 152 | 169 | 173 | 167 | 147 | 191 | | | | | | | | | |
| Number of Live Births ≥39 weeks | 145 | 112 | 110 | 131 | 135 | 134 | 117 | 144 | | | | | | | | | |
| Number of Episiotomies performed | 24 | 18 | 25 | 33 | 22 | 25 | 27 | 27 | | | | | | | | | |
| Number of babies born <3rd centile | 13 | 9 | 13 | 8 | 7 | 9 | 7 | 11 | | | | | | | | | |
| Number of Major Haemorrhages > 2500mls | 1 | 0 | 1 | 2 | 0 | 2 | 0 | 0 | | | | | | | | | |
| Intrapartum Stillbirths | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | | | | |
| Number of Early Neonatal Deaths 20+0 to 23+6 weeks | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | | | | | | | | | |
| Number of Early Neonatal Deaths > 24 weeks | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | | | | |
| Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received magnesium sulphate | 3 | 1 | 3 | 3 | 6 | 7 | 2 | 5 | | | | | | | | | |
| Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received steroids | 3 | 1 | 4 | 1 | 6 | 7 | 1 | 1 | | | | | | | | | |
| Number of babies less than 3rd centile delivered >38 weeks | 6 | 2 | 8 | 1 | 4 | 1 | 2 | 7 | | | | | | | | | |
| Number of women smoking at the time of booking | 29 | 29 | 26 | 19 | 28 | 21 | 27 | 33 | | | | | | | | | |
| Number of women smoking at delivery | 17 | 19 | 26 | 25 | 23 | 20 | 24 | 16 | | | | | | | | | |
| Friends & Family Test:Q2 Birth:Percentage returned complete | . | . | . | . | . | . | . | . | . | . | . | . | | | | | |
| Friends & Family Test:Q2 Birth:Percentage of completed surveys returned as recommended | | | | | | | | | | | | | | | | | |
| Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were symptomatic | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | | | | | | | | | |
| Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were asymptomatic | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | | | | |
| Number of babies born at Home Midwife NOT present | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | | | | |
| Number of babies born in Other location Midwife NOT present | 2 | 2 | 2 | 3 | 1 | 2 | 1 | 1 | | | | | | | | | |
| Episiotomies with Episcissors | 20 | 17 | 21 | 30 | 19 | 21 | 25 | 25 | | | | | | | | | |
| Mothers who did not receive full course and omissions in care noted | 0 | 0 | N/A | 0 | 0 | 0 | 0 | 0 | | | | | 0 | 0 | 0 | 0 | 0 |
| PPH 500-1499mls as % of births | 79 | 60 | 73 | 82 | 87 | 74 | 78 | 80 | | | | | 613 | 0 | 158 | 0 | 613 |
| PPH 1500-2499mls as % of births | 8 | 1 | 6 | 7 | 8 | 6 | 4 | 15 | | | | | 55 | 243 | 19 | 0 | 55 |
| Do not enter figures % of babies that received steriods | #REF! | #REF! | #REF! | #REF! | #REF! | #REF! | #REF! | #REF! | #REF! | #REF! | #REF! | #REF! | | | | | |
| % of babies who had differed cord clamping - ENTER NUMBER OF BABIES | . | | 159 | 181 | 180 | 196 | 154 | 190 | | | | | | | | | |
| % do not enter figures here of babies who had differed cord clamping | #VALUE! | 0.00% | 883.33% | 1810.00% | 1000.00% | 933.33% | 905.88% | 950.00% | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | | | | | |
| % of babies born <37 weeks who's mother recieved IV Antibiotics ENTER NUMBER OF BABIES | . | | 8 | 5 | 9 | 3 | 6 | 6 | | | | | | | | | |
| Do not enter figures here % of babies born <37 weeks who's mother recieved IV Antibiotics | #VALUE! | 0.00% | 44.44% | 50.00% | 50.00% | 14.29% | 35.29% | 30.00% | #DIV/0! | #DIV/0! | #DIV/0! | #DIV/0! | | | | | |

| | | Indicator | 2022 Data | | | | | 2023 Data | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | YTD |
| DENOMINATOR Metrics | 1 | Number of Bookers | 220 | 232 | 254 | 258 | 215 | 260 | 247 | 249 | 201 | 241 | 237 | 216 | 233 | | | | | 1884 |
| | 2 | Number of Registrable Births | 238 | 191 | 234 | 228 | 213 | 225 | 169 | 194 | 214 | 215 | 213 | 183 | 234 | | | | | 1647 |
| | 3 | Number of Women Delivered | 234 | 190 | 233 | 227 | 212 | 220 | 169 | 193 | 212 | 211 | 208 | 180 | 230 | | | | | 1623 |
| | 4 | Number of Successful Planned Home Births | 4 | 4 | 1 | 3 | 2 | 4 | 5 | | 3 | 2 | 6 | 2 | 3 | | | | | 25 |
| | 5 | Number of Midwifery Led Unit births | 234 | 190 | 233 | 227 | 212 | 220 | 169 | 193 | 212 | 211 | 208 | 180 | 230 | | | | | 1623 |
| | 6 | Number of Live Births at any gestation | 238 | 191 | 234 | 228 | 213 | 225 | 169 | 194 | 214 | 215 | 213 | 183 | 232 | | | | | 1645 |
| | 7 | Number of Live Births born ≥16 weeks to <24 weeks | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 4 |
| | 8 | Number of Live Births born ≥24 weeks to <37 weeks | 16 | 24 | 20 | 13 | 17 | 23 | 12 | 18 | 10 | 18 | 20 | 17 | 19 | | | | | 137 |
| | 9 | Number of Live Births born ≥24 weeks to <34 weeks | 9 | 4 | 2 | 2 | 5 | 6 | 2 | 4 | 3 | 6 | 8 | 4 | 5 | | | | | 38 |
| | 10 | Number of Live Births ≥37 weeks | 220 | 162 | 210 | 213 | 196 | 198 | 158 | 173 | 189 | 195 | 192 | 165 | 210 | | | | | 1480 |
| | 11 | Number of Live Births ≥38 weeks | 202 | 143 | 193 | 192 | 170 | 180 | 136 | 152 | 169 | 173 | 167 | 147 | 191 | | | | | 1315 |
| | 12 | Number of Live Births ≥39 weeks | 160 | 112 | 146 | 158 | 138 | 145 | 112 | 110 | 131 | 135 | 134 | 117 | 144 | | | | | 1028 |
| | 13 | Number of Episiotomies performed | 34 | 22 | 32 | 24 | 20 | 24 | 18 | 25 | 33 | 22 | 25 | 27 | 27 | | | | | 201 |
| | 14 | Episiotomies with Episcissors | 28 | 21 | 26 | 21 | 17 | 20 | 17 | 21 | 30 | 19 | 21 | 25 | 25 | | | | | 178 |
| | 15 | Number of babies born <3rd centile | 11 | 14 | 16 | 14 | 14 | 13 | 9 | 13 | 8 | 7 | 9 | 7 | 11 | | | | | 77 |
| | 16 | Number of Maternal Deaths | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 |
| | 17 | Number of Blood Transfusions ≥ 4 Units | 0 | 1 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | | 0 |
| | 18 | Number of Women Requiring Level 2 Critical Care | 3 | | 3 | 0 | 3 | 0 | | 5 | 2 | 1 | 2 | 2 | 1 | | | | | 13 |
| | 19 | Number of Women Requiring Level 3 Critical Care | 0 | | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 |
| | 20 | Number of Major Haemorrhages ≥ 2500mls | 2 | 1 | 2 | 1 | 3 | 1 | 0 | 1 | 2 | 0 | 2 | 0 | 0 | | | | | 6 |
| | 21 | Number of Women readmitted to same Obstetric unit within 30 days of delivery | 0 | 1 | 4 | 3 | 3 | 2 | 0 | 2 | 2 | 2 | 0 | 4 | 0 | | | | | 12 |

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **MATERNAL Morbidity and Mortality Metrics** | **22** | Number of 3rd and 4th degree tears | 7 | 4 | 4 | 3 | 5 | 2 | 2 | 5 | 4 | 1 | 2 | 7 | 4 | | | | | 27 |
| | **23** | Number of Episiotomies in normal birth | 4 | 7 | 4 | 7 | 5 | 6 | 6 | 9 | 8 | 6 | 3 | 8 | 6 | | | | | 52 |
| | **24** | Number of Emergency LSCS | 42 | 43 | 67 | 58 | 65 | 55 | 43 | 55 | 48 | 57 | 45 | 50 | 62 | | | | | 415 |
| | **25** | Number of Elective LSCS | 38 | 30 | 44 | 33 | 33 | 33 | 28 | 27 | 39 | 40 | 32 | 20 | 41 | | | | | 260 |
| | **26** | Number of LSCS at Full Dilatation | 1 | 3 | 4 | 7 | 6 | 4 | 5 | 8 | 5 | 12 | 3 | 2 | 6 | | | | | 45 |
| | **27** | Number of Operative Vaginal Deliveries | 34 | 16 | 29 | 17 | 15 | 19 | 12 | 14 | 26 | 19 | 27 | 25 | 22 | | | | | 164 |
| | **28** | Number of Normal Vaginal Deliveries | 123 | 106 | 93 | 119 | 99 | 118 | 86 | 96 | 98 | 98 | 108 | 86 | 109 | | | | | 799 |
| | **29** | Number of Inductions (excluding augmentations) | 98 | 73 | 88 | 93 | 87 | 70 | 72 | 93 | 77 | 97 | 79 | 79 | 91 | | | | | 658 |
| | **30** | Number of women induced only when RFM is the only indication < 39 weeks | 2 | 1 | 1 | 1 | 0 | 4 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | | | | | 9 |
| **PERINATAL Morbidity and Mortality Metrics** | **31** | Number of Stillbirths | 1 | 1 | 0 | 1 | 1 | 2 | 0 | 2 | 2 | 0 | 1 | 0 | 2 | | | | | 9 |
| | **32** | Number of Intrapartum Stillbirths | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 |
| | **33** | Number of Early Neonatal Deaths 20+0 to 23+6 weeks | 0 | 0 | 2 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | | | | | 3 |
| | **34** | Number of Early Neonatal Deaths > 24 weeks | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 |
| | **35** | Number of Neonates with suspected HIE Grade 2 and 3, ≥ 37 Weeks | 0 | 0 | | 0 | | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 1 | | | | | 4 |
| | **36** | Number of Neonates with Apgars <7 at 5 Minutes, ≥ 37 Weeks | 4 | 4 | 2 | 3 | 7 | 4 | 4 | 3 | 3 | 3 | zero | 4 | 2 | | | | | 23 |
| | **37** | Number of admissions to Neonatal Unit ≥ 37 Weeks | 4 | 15 | 8 | 18 | 16 | 16 | 16 | 15 | 11 | 11 | 11 | 11 | 14 | | | | | 105 |
| | **38** | Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received magnesium sulphate | 5 | 3 | 2 | 0 | 4 | 3 | 1 | 3 | 3 | | 7 | | 5 | | | | | 22 |
| | **39** | Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received steroids | 5 | 4 | 2 | 0 | 5 | 3 | 1 | 4 | 1 | 6 | 7 | | 1 | | | | | 23 |
| | **40** | Number of babies less than 3rd centile delivered >38 weeks | 5 | 5 | 8 | 9 | 4 | 6 | 2 | 8 | 1 | 4 | 1 | 2 | 7 | | | | | 31 |
| | **41** | Average Postnatal Length of Stay for Women | 1.6 | 1.7 | 1.8 | 1.6 | 2 | 1.8 | 1.8 | 1.9 | 1.5 | 1.8 | 1.8 | 1.7 | 1.7 | | | | | 14 |
| | **42** | Number of In-utero Transfers In | 2 | 2 | 1 | 1 | 1 | 2 | 0 | 0 | 4 | 5 | 5 | 4 | 3 | | | | | 23 |
| | **43** | Number of In-utero Transfers Out | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 3 | 6 | 0 | 0 | | | | | 11 |
| | **44** | Diverts: Number of occasions the unit has been unable to accept admissions | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 0 | | | | | 3 |

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **PROCESS** | **45** | Diverts: Number of women during the period affected by the units closures | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 |
| | **46** | Number of women booked by 12 + 6 weeks | 199 | 206 | 236 | 242 | 206 | 245 | 235 | 240 | 193 | 227 | 229 | 203 | 221 | | | | | 1793 |
| | **47** | Number of women smoking at the time of booking | 39 | 27 | 31 | 37 | 25 | 29 | 29 | 26 | 19 | 28 | 21 | 27 | 33 | | | | | 212 |
| | **48** | Number of women smoking at delivery | 30 | 17 | 22 | 27 | 23 | 17 | 19 | 26 | 25 | 23 | 20 | 24 | 16 | | | | | 170 |
| | **49** | Number of women initiating breast feeding including attempted and expressed | 136 | 118 | 125 | 107 | 121 | 126 | 103 | 105 | 158 | 110 | 127 | 90 | 127 | | | | | 946 |
| | **50** | Number of babies that received Skin to Skin contact within 1 hour of birth | 184 | 141 | 175 | 172 | 161 | 165 | 132 | 163 | 111 | 177 | 168 | 137 | 177 | | | | | 1230 |
| | **51** | Number of successful VBAC deliveries | 5 | 3 | 6 | 5 | 4 | 3 | 1 | 7 | 3 | 3 | 6 | 5 | 5 | | | | | 33 |
| **Patient Experience** | **52** | Friends & Family Test:Q2 Birth:Percentage returned complete | | | | | | | | | . | | | | | | | | | 0 |
| | **53** | Friends & Family Test:Q2 Birth:Percentage of completed surveys returned as recommended | | | | | | | | | . | | | | | | | | | 0 |
| **Workforce** | **54** | Number of women receiving 1:1 midwifery in labour | 1 | 1 | 1 | 1 | 180 | 185 | 0.99 | 1 | 173 | 171 | 176 | 160 | 1 | | | | | 868 |
| | **55** | Midwife to Birth Ratio | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 1.28 | 1.28 | 1.28 | | | | | 143.8 |
| **COVID -19** | **56** | Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were symptomatic | 2 | 0 | 2 | 0 | 3 | 1 | | | 1 | | | | | | | | | 2 |
| | **57** | Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were asymptomatic | 0 | 0 | 0 | 0 | 0 | | | | 0 | | | | | | | | | 0 |
| **Safety** | **58** | Number of babies born at Home Midwife NOT present | 2 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 |
| | **59** | Number of babies born in Other location Midwife NOT present | 0 | 0 | 3 | 1 | 0 | 2 | 2 | 2 | 3 | 1 | 2 | 1 | 1 | | | | | 14 |

# Safety Dashboard 2023

## Neonatal

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

| | | | | | 2022 | | | 2023 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Goal | Red Flag | Measure | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| Safety | **% of Shifts Staffed to BAPM** | **100%** | **< 90%** | **Badger** | **88.87** | **98.33** | **93.50** | **87.10** | **100.00** | **52.94** | **72.41** | **68.97** | **66.67** | **88.71** | **94.44** | | | | |
| | **% of Shifts with Supernumeary Shift Leader** | **100%** | **< 50%** | **Badger** | **50.97** | **52.62** | **50.16** | **54.61** | **57.10** | **57.42** | **56.90** | **67.24** | **65.00** | **85.48** | **79.63** | | | | |
| | **Unit Closed Due to Capacity** | **0** | **≥ 1** | **Datix** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | | | | |
| | **Unit Closed Due to BAPM/Staffing** | **0** | **≥ 1** | **Datix** | **0** | **1** | **0** | **0** | **0** | **0** | **1** | | | **0** | **0** | | | | |
| Admissions | Number of Births from Maternity | | | Maternity Data | 234 | 228 | 213 | 224 | 170 | 194 | 214 | 215 | 213 | 183 | 234 | | | | |
| | **Admissions Under 27 Weeks to NNU** | **< 1** | **≥ 1** | **Badger** | **0** | **0** | **0** | **1** | **0** | **0** | **0** | **0** | **1** | **0** | **2** | | | | |
| | Admissions 27+1 – 34 Weeks to NNU | | | Badger | 16 | 28 | 31 | 35 | 22 | 34 | 30 | 32 | 7 | 4 | 6 | | | | |
| | Total Admissions to Neonatal Unit | | | Badger | 16 | 28 | 31 | 36 | 22 | 34 | 30 | 33 | 41 | 37 | 29 | | | | |
| | Transitional Care Admissions: 34 – 36+6 | | | Badger | 2 | 3 | 1 | 4 | 3 | 2 | 1 | 5 | 7 | 11 | 8 | | | | |
| | Transitional Care Admissions: 37+ | | | Badger | 6 | 6 | 3 | 4 | 6 | 4 | 6 | 12 | 15 | 12 | 12 | | | | |
| | Total TC Admissions | | | Badger | 8 | 9 | 4 | 8 | 9 | 6 | 7 | 17 | 22 | 23 | 20 | | | | |
| | Number of unexpected Term Admissions to NNU | | | | 6 | 17 | 18 | 18 | 16 | 15 | 11 | 11 | 11 | 11 | 14 | | | | |
| | **Unexpected Term Admissions to NNU (*as % of Births > 37 Weeks Gestation*)** | **6%** | **≥ 4.5%** | **Maternity/Badger** | **2.56%** | **7.46%** | **8.45%** | **8.04%** | **9.41%** | **8.67%** | **5.82%** | **5.64%** | **5.72%** | **6.66%** | **6.66%** | | | | |
| | Unexpected Term Admissions to NNU (*as % of Total Admissions*) | | | Badger/ NWNODN | | | | | | | 36.66% | 33.33% | 26.80% | 29.72% | 50% | | | | |
| | Mothers Eligible for AN Steroids (*< 34 Weeks*) | | | NNAP/ NWNODN | 2 | 2 | 5 | 4 | 2 | 4 | 4 | 6 | 5 | 4 | 3 | | | | |
| | **% of Mothers Who Received Full Course of Antental Steroids** | **≥ 93%** | **< 89%** | **NNAP/ NWNODN** | **100%** | **50%** | **100%** | **50%** | **50%** | **75%** | **25%** | **100%** | **60%** | **25%** | **33%** | | | | |
| | Mothers Eligible for AN $MgSO_4$ (*< 30 Weeks*) | | | NNAP/ NWNODN | 1 | 0 | 0 | 1 | 1 | 1 | 1 | 0 | 2 | 0 | 2 | | | | |
| | **% of Mothers Receiving Antenatal $MgSO_4$** | **≥ 85%** | **< 73%** | **NNAP/ NWNODN** | **100%** | **NA** | **NA** | **0** | **0** | **100%** | **100%** | **NA** | **50%** | **N/A** | **100%** | | | | |
| | Babies Eligible for Delayed Cord Clamping | | | NNAP/ NWNODN | 2 | 2 | 6 | 6 | 2 | 3 | 4 | 6 | 8 | 4 | 5 | | | | |

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NNAP | **% of Babies Receiving Delayed Cord Clamping** | **≥ 85%** | **< 73%** | **NNAP/ NWNODN** | **100.00%** | **100.00%** | **66.67%** | **66.67%** | **0.00%** | **33.33%** | **25.00%** | **100.00%** | **75.00%** | **50.00%** | **60.00%** | | | | |
| | Babies Eligible for Temperature on Admission (*< 32 Weeks* ) | | | NNAP/ NWNODN | 2 | 1 | 1 | 1 | 2 | 2 | 1 | 6 | 8 | 4 | 5 | | | | |
| | % of Babies With Temperature Within First Hour of Admission (*< 32 Weeks* ) | | | NNAP/ NWNODN | 100% | 100% | 100% | 0 | 50% | 100% | 100% | 6 | 8 | 3 | 5 | | | | |
| | % of Babies With Temperature on Admission of 36.5°C – 37.5°C (*< 32 Weeks* ) | | | NNAP/ NWNODN | 50% | 100% | 100% | 0 | 50% | 100% | 100% | 6 | 7 | 3 | 5 | | | | |
| | Babies Eligible for Senior Review | | | NNAP/ NWNODN | 11 | 23 | 27 | 28 | 21 | 27 | 15 | 18 | 22 | 18 | 21 | | | | |
| | Number of Babies Receiving Senior Review Within 24 Hours | | | NNAP/ NWNODN | 7 | 19 | 26 | 28 | 21 | 26 | 14 | 18 | 20 | 17 | 17 | | | | |
| | % of Babies Receiving Senior Review Within 24 Hours | | | NNAP/ NWNODN | 63.64% | 82.61% | 96.30% | 100% | 100% | 96.29% | 93.30% | 100% | 91% | 94.40% | 80.90% | | | | |
| | Total Ward Rounds Where Parents Present | | | NNAP/ NWNODN | 20 | 27 | 28 | 31 | 22 | 21 | 22 | 23 | 27 | 20 | 17 | | | | |
| | % of Ward Rounds Where Parents Present | | | NNAP/ NWNODN | 100% | 92.59% | 100% | 100% | 95.45% | 100% | 95.70% | 100% | 96.30% | 90% | 85% | | | | |
| | % of Eligible Babies Reciving Retinopathy Screening (*ROP* ) | | | NNAP/ NWNODN | 100% | N/A | 33% | 100% | N/A | N/A | 33% | 50% | 50% | 100% | 100% | | | | |
| | % of Babies With Central Line Blood Infections | | | NNAP/ NWNODN | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| | Babies Eligible for Follow-Up At 2 Years | | | NNAP/ NWNODN | 0 | 4 | 0 | 2 | 4 | 1 | 0 | 1 | 2 | 0 | 4 | | | | |
| | % of Babies Receiving Follow-Up At 2 Years | | | NNAP/ NWNODN | N/A | 75% | N/A | 50% | 50% | 100% | N/A | 100% | 50% | N/A | 50% | | | | |
| Incidents | Number of Incidents Reported | | | Datix | 11 | 12 | 15 | 17 | 16 | | 23 | 9 | 23 | | 11 | | | | |
| | Number of Network Exception Reports | | | NWNODN | 1 | 0 | 2 | 2 | 2 | | 1 | 0 | | | 0 | | | | |
| | **Number of Concise Investigations** | **0** | **≥ 1** | **Datix** | **0** | **0** | **0** | **0** | **0** | | **0** | **0** | **0** | **0** | **0** | | | | |
| | **Number of StEIS Reported Incidents** | **0** | **≥ 1** | **Datix** | **0** | **0** | **0** | **0** | **0** | | **0** | **0** | **0** | **0** | **0** | | | | |
| | **Number of Complaints** | **< 2** | **≥ 2** | **Datix** | **0** | **0** | **0** | **0** | **0** | | **0** | **0** | **0** | **0** | **0** | | | | |
| | **Number of Letters of Claim Received** | **0** | **≥ 1** | **Datix** | **0** | **0** | **0** | **0** | **0** | | **0** | **0** | **0** | **0** | **0** | | | | |
| | | | | | | | | | | | | | | | | | | | |
| ding | **% of Mothers Expressing Breast Milk in First 24 Hours Following Baby's Admission to NNU** | | | Unicef/ NWNODN | 52.90% | 35.70% | 51.50% | 50% | 9.10% | 17.60% | 27.60% | 8% | 7.30% | 17.40% | 11.50% | | | | |
| | **% of Babies Receiving Human Milk in First 24 Hours Following Admission to Neonatal Unit** | | | Unicef/ NWNODN | 52.90% | 28.60% | 51.50% | 38.90% | 9.10% | 17.60% | 24.10% | 12% | 12.20% | 17.40% | 19.20% | | | | |
| | **% of Babies Receiving Human Milk on Discharge from Neonatal Unit** | | | Unicef/ NWNODN | 77.80% | 25% | 69.70% | 69.20% | 9.50% | 11.10% | 31% | 20.80% | 0 | 8.70% | 4% | | | | |
| | **% of Mothers Expressing Breast Milk on Discharge from Neonatal Unit** | | | Unicef/ NWNODN | 72.70% | 25% | 63.90% | 64.10% | 9.50% | 11.10% | 25.00% | 12.50% | 0 | 8.70% | 0 | | | | |
| | **% of Mothers Breastfeeding on Discharge from Neonatal Unit** | | | Unicef/ NWNODN | 77.80% | 14.30% | 57.60% | 48.70% | 4.80% | 3.70% | 25.00% | 16.70% | 0 | 4.30% | 0 | | | | |

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breastfee | Number of Babies Eligible to Receive Breast Milk in the First Two Days of Life (*< 34 Weeks*) | | | NNAP/ NWNODN | 2 | 3 | 6 | 6 | 2 | 3 | 4 | 6 | 8 | 3 | 5 | | | | |
| | **% of Babies < 34 Weeks Receiving Breast Milk in First Two Days of Life** | | | NNAP/ NWNODN | 0 | 33.33% | 50% | 33.33% | 50% | 33.33% | 50% | 33.30% | 75% | 66.70% | 100% | | | | |
| | Number of Babies < 34 Weeks Eligible for Breast Milk at Day 14 | | | NNAP/ NWNODN | 5 | 1 | 6 | 6 | 3 | 1 | 4 | 3 | 7 | 2 | 5 | | | | |
| | **% of Babies < 34 Weeks Receiving Breast Milk at Day 14** | | | NNAP/ NWNODN | 80% | 0 | 66.67% | 100% | 66.67% | 100% | 75% | 66.70% | 71.40% | 100% | 60% | | | | |
| | Number of Babies < 34 Weeks Eligible for Breast Milk at Discharge | | | NNAP/ NWNODN | 5 | 4 | 5 | 7 | 1 | 1 | 6 | 4 | 9 | 3 | 6 | | | | |
| | **% of Babies < 34 Weeks Receiving Breast Milk at Discharge** | | | NNAP/ NWNODN | 80% | 50% | 60% | 85.71% | 0 | 100% | 33.30% | 50% | 66.70% | 33.30% | 66.70% | | | | |
| | | | | | | | | | | | | | | | | | | | |
| Activity | Care Days ICU (*HRG1*) | | | Badger | 15 | 5 | 9 | 11 | 5 | 40 | 16 | 7 | 44 | 3 | 20 | | | | |
| | Care Days HDU (*HRG2*) | | | Badger | 52 | 42 | 41 | 29 | 19 | 77 | 61 | 115 | 39 | 56 | 71 | | | | |
| | Care Days SC (*HRG3, HRG4, HRG5, and code9*) | | | Badger | 173 | 173 | 251 | 198 | 101 | 173 | 237 | 172 | 270 | 214 | 198 | | | | |
| | **Cot Capacity ICU %** | | | Badger | 48.39% | 16.67% | 29.03% | 35.48% | 17.86% | 129% | 53.30% | 22.58% | 146% | 9.60% | 64.50% | | | | |
| | **Cot Capacity HDU %** | | | Badger | 55.91% | 46.67% | 44.09% | 31.18% | 22.62% | 82.70% | 67.77% | 123.60% | 43.33% | 60.20% | 76.30% | | | | |
| | **Cot Capacity SC %** | | | Badger | 55.81% | 57.67% | 80.97% | 63.87% | 36.07% | 55.80% | 79% | 55.48% | 90% | 69.03% | 63.80% | | | | |
| | **Overall Cot Capacity %** | | | Badger | 55.30% | 52.38% | 69.35% | 54.84% | 31.89% | 69.04% | 74.70% | 68% | 84% | 62.09% | 71.40% | | | | |
| | Care Days TC (*HRG3*) | | | Badger | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| | Care Days TC (*HRG4*) | | | Badger | 51 | 56 | 23 | 35 | 53 | 21 | 17 | 40 | 64 | 63 | 51 | | | | |
| | Care Days TC (*HRG5*) | | | Badger | 8 | 1 | 0 | 3 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| | Care Days TC (*code 9*) | | | Badger | 4 | 10 | 5 | 2 | 2 | 0 | 0 | 0 | 0 | 2 | 0 | | | | |
| | Total TC Care Days | | | Badger | 63 | 67 | 28 | 40 | 57 | 21 | 17 | 40 | 64 | 65 | 51 | | | | |
| | **Overall TC Cot Capacity %** | | | Badger | 50.81% | 55.83% | 22.58% | 32.26% | 50.89% | 16.93% | 14.16% | 32.25% | 53.33% | 52.40% | 41.12% | | | | |
| Training | **NLS Accrediated** | **≥ 70%** | **< 70%** | **WWL** | **94.44%** | **91.43%** | **91.43%** | **97.22%** | **94.74%** | **91.00%** | **92.30%** | **90%** | **92.10%** | **92.10%** | **94.74%** | | | | |
| | **NLS In-House** | **≥ 90%** | **< 90%** | **WWL** | **97.56%** | **97.56%** | **97.56%** | **97.56%** | **97.56%** | **100.00%** | **100%** | **100%** | **100%** | **100%** | **97.56%** | | | | |
| | **Qualified In Speciality of Intensive Neonates** | **≥ 70%** | **< 70%** | **WWL** | **84.21%** | **81.08%** | **81.08%** | **84.21%** | **85.00%** | **85.00%** | **85%** | **85%** | **85%** | **85%** | **85%** | | | | |
| | **Foundation In Neonates** | **≥ 70%** | **< 70%** | **WWL** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **98.00%** | **100%** | **100%** | **100%** | **100%** | **100%** | | | | |
| | **Family Intergrated Care** | **≥ 85%** | **< 85%** | **WWL** | **97.62%** | **97.62%** | **97.62%** | **97.62%** | **97.62%** | **90.00%** | **91.10%** | **93.30%** | **97.80%** | **93.30%** | **100%** | | | | |
| | **Unicef BFI** | **100%** | **< 80%** | **WWL** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **98.00%** | **99%** | **99%** | **100%** | **100%** | **100%** | | | | |

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Perinatal Mental Health | ≥ 80% | < 80% | HEE | 88.57% | 94.29% | 94.29% | 94.29% | 88.57% | 88.00% | 88% | 88% | 100% | 100% | 88.57% | | | | |

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| | |
|---|---|
| **Title of report:** | Maternity Perinatal Quality Surveillance (Report incorporating Q4 Data) |
| **Presented to:** | Board of Directors |
| **On:** | 04 October 2023 |
| **Presented by:** | Rabina Tindale Chief Nurse |
| **Prepared by:** | Eve Broadhurst Head of Governance Maternity and Child Health |
| **Contact details:** | T: 01942 772993 E: eve.broadhurst@wwl.nhs.uk |

**Executive summary**

The Perinatal Quality Surveillance model incorporates the 5 principles outlined in NHSE/I document *Implementing a revised perinatal quality surveillance model* (2020) with a view to increasing oversight and perinatal quality at trust-board, local, regional, and national level, integrating perinatal clinical quality into the ICS structures, and providing clear lines of responsibility and accountability in addressing quality concerns at each level of the system.

The purpose of quarterly Perinatal Quality Surveillance report is to provide oversight and assurance to the Board that there are effective systems of clinical governance and monitoring of safety for Maternity and Neonatal services.

**Incidents and investigations**

Q4 has seen an increase in StEIS reported incidents as compared to Q3.

Q4 has seen a decrease in HSIB referrals as compared to Q3.

A themed analysis of StEIS incidents reported incidents has been undertaken with a focus on CTG monitoring. All learning identified and assurance that robust actions in place, monitored via SIRI.

**Feedback and complaints**

The MVP have undertaken a piece of work on women's experience of mental health support and provided examples of excellent care when the service is accessed, and suggestions for improvement which has been shared with the service lead.

4 complaints were received in Q4 with no re-current sub-themes. 1 of the complaints will be managed by Information Governance.

**Risks**

The Risk Register has been included for maternity and neonatal services. 1 new corporate risk (15) in relation to lack of obstetrics and gynaecology on-call rota has been opened and approved. An outline business case is underway and due for submission in April. 1 risk in relation to MSD data submission has been closed.

**Ockenden 2**

Q4 has seen progress against the 15 IAE Ockenden Actions. Where actions require national/regional input an action plan has been put in place to ensure IEAs are mitigated within our capabilities in the interim. Progress is also monitored via the LMNS.

**Maternity Incentive scheme Year 4**

No update. CNST compliance was submitted in February 2023 with 3 exception action plans.

**ATAIN**

Q3 audit found unexpected term admission rate to the neonatal unit to be 5.97%. 2 admissions were thought to be avoidable. The last months have seen an increase in term admissions. Weekly MDT ATAIN meetings led by governance are now scheduled to enable timely review, support, and oversight. The initial focus will be to embed the warm bundle as respiratory distress continues to be the principal reason for admissions.

**Mortality and PMRT**

Q4 - 4 stillbirths and 2 NNDs. Some immediate incidental learning has been identified and shared. PMRT where applicable underway.

1 case of an antenatal stillbirth from 2022 has been finalised at PMRT meeting in Q4 – care graded A. (No issues in care identified)

**Saving Babies Lives**

Q4 shows compliance in all 5 elements. SBL training at around 92% - all those non-compliant have been contacted to ensure supported to compete.

**Mandatory training**

Q4 shows all training is on course and scheduled for the year.

**Maternity dashboards**

The figures above show a continued spike in term admissions to NNU since September of Q2 22-23. These cases have all been investigated and no patterns or omissions in care were noted. When compared against the GMEC average WWL are not an outlier and have remained persistently lower than the GMEC average.

6 out of 8 mothers who required a full course of antenatal steroids received them. 2 needed delivery expedited so could not receive full course of antenatal steroids. There were no omissions in care.

**Workforce/ Safe staffing**

There are currently 15.05 midwifery vacancies. Recruitment remains ongoing. There is a recruitment day planned for May 2023 which will capture the students who are completing their training in September 2023 from the GM and neighbouring universities. WWL has expressed an interest in recruiting 3 International Midwives from Cohort 3 of the Northwest recruitment programmes.

A workforce review has been completed alongside the analysis of the recently received Birth-rate Plus report which has identified an additional staffing shortfall. A full staffing review paper will be submitted to Board by the end of Q4, which will include the proposals for the development of enhanced Community Midwifery teams who will provide support for the most vulnerable and those living in deprivation within the Borough in order to improve outcomes for mothers and babies within this group.

**GMEC data**

In Q4, WWL has performed better than the GM average in rates of emergency LSCS, neonatal deaths, stillbirths, term admissions to NNU, neonates with HIE diagnosis of 2 and 3 ≥37 weeks.

WWL has performed worse than the GM average in smoking at the time of delivery, major haemorrhage >2.5l, pre-term births and term babies Apgar score <7 at 5 minutes.

**Recommendations**

It is requested that the Board of Directors and executives review the contents of this paper to be aware of the recommendations within the quarterly report and gain assurance of the progress towards compliance in reaching the Ockenden essential actions (IEAs) from both reports which are continuing to be considered and implemented within the Division and that the Maternity Incentive scheme standards whilst not fully compliant, the mitigating action plans provide assurance that these actions are now compliant against the standards.

**Contents**

**Maternity Perinatal Quality Surveillance Report**

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

1. **Obstetrics/Maternity incidents occurring in Q1 23 – NPSA Severity**

| | Jan 23 | Feb 23 | Mar 23 | Apr 23 | May 23 | Jun 23 | |
|---|---|---|---|---|---|---|---|
| **No Harm** | 84 | 59 | 82 | 67 | 79 | 81 | |
| **Low** | 5 | 7 | 8 | 8 | 8 | 3 | |
| **Moderate** | 1 | 0 | 2 | 1 | 0 | 0 | |
| **Severe** | 0 | 0 | 0 | 0 | 0 | 0 | |
| **Death** | 0 | 0 | 0 | 0 | 0 | 0 | |
| **Total** | **91** | **66** | **92** | **76** | **87** | **84** | |

In Q1 there were 0 incidents with moderate harm or above

**1.1 Incidents and Investigations – Serious Incidents**

| | Jan 23 | Feb 23 | Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Incidents reported to StEIS** | 0 | 1 | 2 | 0 | 0 | 1 | | | | | | |
| **HSIB referrals** | 1 | 1 | 1 | 0 | 0 | 0 | | | | | | |
| **Accepted HSIB referrals** | 1 | 0 | 1 | 0 | 0 | 0 | | | | | | |

Q1 has seen a decrease in the number of incidents reported to StEIS when compared to Q4.

1 incident has been reported to StEIS in Q1 – Maternity Unit Divert. Letter of apolgy sent to the 1 family affected.

Q1 has seen a decrease in the number of cases referred to HSIB when compared to Q4.
0 incidents have been referred to HSIB of which 0 have been accepted for investigation.

It is important to note that WWL have a clear process for the identification and investigation of Serious Incidents and have an open and transparent approach to this, however some cases may not be reported to StEIS may not be in the month that the incident occurred although early StEIS reporting is a priority.

### 1.2 Learning from StEIS Investigations – CTG monitoring as a theme.

In 2022 through to March 2023 a total of 11 incidents have been StEIS reported. 5 of the 11 cases have identified sub-optimal CTG management. A deep dive into these incidents has identified the learning below. Robust action plans have already been implemented and improvement work continues, led by the Fetal Surveillance Leads and monitored through SIRI.

| Learning | Occurrence |
|---|---|
| cCTG - STV <3 not identified as a precursor to increased morbidity and mortality | 1 |
| cCTG used inappropriately in the presence of uterine activity | 1 |
| cCTG used inappropriately following induction of labour | 1 |
| cCTG – maternal pulse picking up on CTG trace giving false reassurance of fetal wellbeing | 1 |
| FSE not utilised when significant loss of contact on intrapartum CTG trace | 2 |
| Misinterpretation of intrapartum CTG | 1 |
| Lack of holistic risk assessment - uterine rupture was not considered in the presence of fetal bradycardia | 1 |
| Antenatal CTG classified using intrapartum classification | 1 |
| No evidence of systematic CTG interpretation/CTG sticker not used | 1 |
| Discharge home when CTG changes present, and induction of labour indicated | 1 |
| Delay in commencing CTG on delivery suite in the presence of meconium-stained liquor with no supporting documentation | 1 |
| Consideration not given to reducing syntocinon in the presence of tachysystole | 1 |
| 5-minute assessment of fetal wellbeing not undertaken in the 2nd stage of labour | 1 |
| Escalation to shift leader should occur if difficulties arise monitoring the fetal heart | 1 |

* cCTG = computerised CTG. Dawes Redman criteria is used on WWL cCTG.
* Tachysystole refers to contractions >5 every 10 minutes in the presence of a normal CTG.

### 1.3 HSIB overview

| January 2019- June 2023 | Cases to date | |
|---|---|---|
| | Total number referrals | 18 |
| | Cases rejected | 8 |
| | Total investigations to date | 10 |
| | Total investigations completed | 8 |
| | Current active cases | 2 |
| | Exception reporting | No cases currently have exceptions |

1 finalised report received from HSIB in Q1.
This was the case of an early neonatal death following placental abruption. HSIB identified no learning or safety recommendations in the report. No actions required.

### 1.4 Learning from completed investigations.

In Q1, 3 investigations were finalised a ESG. Actions will be uploaded to DATIX, and progress monitored through SIRI.

| WEB number | Date | Incident | Learning |
|---|---|---|---|
| WEB13076 StEIS 2023/518 | Aug 2022 | Stillbirth – Maternal DKA | Importance of prompt escalation of uncontrolled diabetes to medics, in ward setting.<br>Being unwell can make glucose control more difficult.<br>Importance of prompt escalation when women do not attend appointments to ensure support can be put in place. |
| WEB133349 StEIS 2022/23472 | Oct 2022 | Neonatal death – Eclampsia | Importance of urinalysis at every antenatal appointment<br>Importance of considering raised BP/proteinuria as possible pre-eclampsia and initiation of MgS04 to allow transfer to tertiary unit at earliest opportunity.<br>Importance of arranging a growth scan to provide more information of a baby's condition. |
| WEB133593 | Oct 2022 | NND (MTOP) | The risk assessment documentation process needs streamlining to minimise the risk on information not being captured and visible to all staff.<br>Women who have had previous late miscarriages are at high risk of pre-term labour and should be offered cervical length scans.<br>There needs to be clear processes on ANC re roles and responsibilities of who books cervical length scans.<br>There needs to be clear processes for consultation in ANC when women have more than one complex risk factor. |

**1.5 Investigation progress– overview**

Q4 has seen momentum progressing investigations through Trust processes.

At the end of Q4, 7 investigations from 2022 are open. 5 of which have now been received in Division and scheduled for ESG.

It is recognised that some of the investigations have exceeded optimal timeframes for completion. The priority moving forward will be to ensure that staff are supported to complete reviews in a timely manner.

| WEB number | Date | Incident | Progress | Stage | Plan |
|---|---|---|---|---|---|
| WEB126471 | May 2022 | Uterine rupture/Therapeutically Cooled (HSIB) | Final report received | Review in division | ESG 6.4.2023 |
| WEB127439 | June 2022 | Therapeutically Cooled | Received in Division | Review in Division | ESG 6.4.2023 |

| | | | | | |
|---|---|---|---|---|---|
| WEB 130683 | Aug 2022 | Neonatal Death (HSIB) | Received in Division | Review in Division | ESG 6.4.2023 |
| WEB131315 | Sep 2022 | Therapeutically Cooled | Received in Division | Review in Division | Schedule for ESG |
| WEB132507 | Sep 2022 | PPH/Hysterectomy | Received in Division | Review in Division | ESG - 6.4.23 |
| WEB132660 | Oct 2022 | Therapeutically Cooled (HSIB) | Draft report received | Fac Acc returned to HSIB | Await final HSIB |
| WEB136351 | Dec 2022 | Neonatal stroke (HSIB) | In progress | HSIB interviews | Support HSIB with info required |

**2. MVP Feedback**

In January 2023 Wigan Borough MVP gathered information from service users regarding their experience of mental health support with some excellent feedback and suggestions for improvement. Findings have been shared with the Perinatal Specialist Mental Health Lead.

| Theme | Issue | Suggestion |
|---|---|---|
| Excellent mental health support when accessed. | Services not promoted enough to families | Is mental health support information highlighted in new antenatal packages so families know when, how and where to access support? |
| Communication between teams/Trust | Sometimes communication between providers felt disjointed – service users felt that trusts and teams did | Is there a way of making sure that families who birth outside |

| | | |
|---|---|---|
| | not communicate with each other effectively leading to them feeling that they blamed each other for any issues that arose | of the area feel more supported? |
| Poor 6-week GP check | Mums felt that GPs were not really interested in them at the 6-week check and that mental health was rarely discussed. | Do GPs need additional support? Could they provide leaflets with details of support groups/how to access support if needed? |

### 2.1 Complaints

| Formal Complaints | Jan 23 | Feb 23 | Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Maternity | 0 | 2 | 2 | | | | | | | | | |
| NNU | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | |

In Q4, 4 formal complaints have been received for maternity services with the maternity matrons and managers continuing to meet with women and their families before discharge to deal with any immediate concerns. The maternity service offers a debrief service which women can access to discuss their care.
No complaints have been received for NNU.
No recurrent themes have been identified within Q4.

- Clinical equipment
- Staff attitudes and behaviours
- Patient care
- IG breach (this has now been transferred to Information Governance team to manage)

It is important to recognise that the number of complaints remains low, and the compliments received far outweigh concerns.

### 3. Risk register – Maternity and neonatal services

| Live Risk Register | Significant (15+) | High (8-12) | Moderate (4-6) | Low Risk (1-3) |
|---|---|---|---|---|
| | 1 | 10 | 9 | 0 |

| | | | | |
|---|---|---|---|---|
| New risks under review | MAT | 3727 | Euroking To PAS Error Risk | 9 |
| Awaiting approval | NEO | 3695 | CritiCool Cooling Machine (Neonatal patients) beyond repair | 12 |
| | MAT | 3669 | Potential inability to undertake more than 1 emergency delivery at a time due to number of theatres available. | 8 |

| | | | | |
|---|---|---|---|---|
| | | 3725 | Junior Doctors Strike | 6 |
| Open Approved Risks | MAT | 3604 | Obstetrics and Gynaecology On-Call Availability Risk | 15 |
| | MAT | 3616 | Compliance with Maternity Incentivisation Scheme Year 4 | 12 |
| | MAT | 3656 | Inability to transfer maternity patients to and from the unit as required due to NWAS strike action. | 12 |
| | MAT | 3605 | Obstetricians and Gynaecologists on call rotas not allocating compensatory rest | 12 |
| | MAT | 3362 | Midwifery Staffing Shortages | 12 |
| | NEO | 1977 | Specialist AHP services should be available in all units for neurodevelopment and family integrated care | 12 |
| | MAT | 1037 | CTG Misinterpretation | 10 |
| | MAT | 3667 | Emergency Evacuation from Maternity Birthing Pool | 8 |
| | MAT | 3659 | Insufficient number of Resuscitaires within the Delivery Suite for New-born resuscitation | 8 |
| | MAT | 2581 | Sustainability of Maternity Services | 8 |
| | NEO | 2281 | There are a significant number of staff who do not have current accreditation for NLS course | 8 |
| | MAT | 3672 | Lack of availability of NLS accredited training resulting in potential risk to quality of new-born life support. | 6 |
| | MAT | 1758 | Delivery suite coordinator should be supernumerary at all times. | 6 |
| | MAT | 3400 | Screening for GBS at 36 weeks gestation in women with a history of GBS (group B beta-haemolytic streptococcus) infection | 6 |
| | MAT | 140 | Backflow of raw sewage due to blocked drains | 6 |
| | NEO | 1975 | BAPM staffing guidelines - Staff shortages on the Neonatal unit | 6 |
| | MAT | 1469 | The risk of abduction from the maternity unit | 5 |

| | | | | |
|---|---|---|---|---|
| | MAT | 3426 | Out of area women cared for under different SGA/FGR guidance | 4 |
| | MAT | 2459 | Transportation and supply of Entonox (Nitrous oxide 50% and oxygen 50%) by Community Midwives for use at Homebirths | 4 |
| | NEO | 1978 | Access to a Neonatal Dietician competent in Neonatal nutrition | 4 |

In Q4, 1 significant risk relating to the lack of separate obstetric and gynaecology on-call consultant rotas has been opened and approved in line with Ockenden IAE actions and an outline business case is underway and due for submission in April.

1 moderate risk in relation to the collection and submission of MSDS data has been closed as the target score has been met.

Risks continue to be pro-actively managed within the Division with all risk with a score of 8 – 12 reviewed every 3 months. The risk register is tabled at the monthly Obstetrics/Gynaecology Clinical Cabinet for over-sight.

**4. Ockenden 2 update**

| Q3 Update | | Local Actions | | | N/A | Trust Corp Action | National/ regional Action |
|---|---|---|---|---|---|---|---|
| | | Red | Amber | Green | | | |
| EA1 | Workforce planning and sustainability | 0 | 2 | 5 | | | 4 |
| EA2 | Safe staffing | 0 | 2 | 7 | | | 1 |
| EA3 | Escalation and accountability | 0 | 3 | 1 | | | 1 |
| EA4 | Clinical governance-leadership | 0 | 1 | 4 | | 2 | |
| EA5 | Clinical governance – incident investigation and complaints | 0 | 1 | 6 | | | |
| EA6 | Learning from maternal deaths | 0 | 0 | 2 | | | 1 |
| EA7 | Multidisciplinary training | 0 | 2 | 5 | | | |
| EA8 | Complex antenatal care | 0 | 2 | 3 | | | |
| EA9 | Preterm birth | 0 | 0 | 4 | | | |
| EA10 | Labour and birth | 0 | 1 | 3 | 2 | | |
| EA11 | Obstetric anaesthesia | 0 | 0 | 7 | | | 1 |
| EA12 | Postnatal care | 0 | 1 | 3 | | | |
| EA13 | Bereavement care | 0 | 0 | 4 | | | |
| EA14 | Neonatal care | 0 | 2 | 4 | | | 2 |
| EA15 | Supporting families | 0 | 0 | 3 | | | |
| | Total | 0 | 17 | 61 | 2 | 2 | 10 |

Q4 has seen progress against the 15 IAE Ockenden Actions. Where actions require national/regional input an action plan has been put in place to ensure IEAs are mitigated within our capabilities in the interim. Progress is also monitored via the LMNS.

**5. Maternity Incentive Scheme Year 4**

The service has 3 action plans in place against safety Actions 2, 3 and 4 as 1 element in each has not met the full compliance. We have received communication that the action plans are not approved by NHSR therefore full compliance will not be achieved for Year 4 as in previous years.

**6. Avoiding Term Admissions into Neonatal Units (ATAIN)**

| **Q3** | Total Term Live Births | Total Term Admissions to NNU | Unexpected Term Admissions to NNU | 'Avoidable' admissions to NNU |
|---|---|---|---|---|
| Oct – Dec 2022 | 619 | 39 (6.3%) | 37 (5.97%) | **2** |

In Q3, the unexpected term admission to NNU rate was under 6% of total term live births.

Avoidable admissions

1 admission to the NNU due respiratory reasons was determined to be avoidable. After a short stay on the NNU (<4 hrs) the baby was transferred back to TC therefore separation of mother and baby was kept to a minimum.

1 admission to the NNU due to feeding/weight loss was determined to be potentially avoidable. Due to a low temperature the baby had been put on 2 hourly breastfeeds – as a result was not thermoregulating due to short amounts of time on the cot warmer. Blood Glucose was normal throughout.

*It is important to note that 4 of the 39 admissions to the NNU were from home due to lack of bed capacity on Children's Ward.

The principal reason for admission to the NNU continues to be respiratory distress. ATAIN actions will focus on embedding the 'Warm Bundle' into practice to support staff optimise care of the neonate in the first hour of life.

Weekly MDT ATAIN meetings led by the Deputy Governance Lead are now scheduled to enable timely review, support, and oversight.

| **MIS Year 4 specific data** | | |
|---|---|---|
| Number of admissions to NNU that would have met TC admission criteria but were admitted to NNU due to staffing or capacity | Number of babies that were admitted to NNU because of their need for nasogastric tube feeding but would have been cared for on TC if NGT feeding was supported there | Number of babies that remained on NNU because of their need for nasogastric tube feeding but would have been cared for on TC if NGT feeding was supported there |
| 0 | 0 | 0 |

## 7. Perinatal Mortality Review Tool (PMRT) and Stillbirth Data

### 7.1 Mortality overview

| | April 22 | May 22 | June 22 | July 22 | Aug 22 | Sept 22 | Oct 22 | Nov 22 | Dec 22 | Jan 23 | Feb 23 | Mar 23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Q1 22-23 | | | Q2 22-23 | | | Q3 22-23 | | | Q4 22-23 | | |
| Total births | 203 | 242 | 209 | 220 | 238 | 191 | 234 | 228 | 213 | 224 | 170 | 194 |
| Total Stillbirths | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 1 | 2 | 0 | 2 |
| MTOP & Lethal Anomalies ≥ 24 weeks | | | | | | | | | | 1 | 0 | 1 |
| Total Neonatal Deaths (0 days – 28 days) | 0 | 0 | 0 | 0 | 1 | 0 | 3 | 1 | 1 | 1 | 1 | 0 |
| Early neonatal deaths (0-7 days) | 0 | 0 | 0 | 0 | 1 | 0 | 3 | 1 | 1 | 1 | 1 | 0 |
| Maternal Deaths | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

The NHS Long Term plan has set a target of reducing stillbirths and neonatal deaths by 50% by 2025. That would require England and Wales to reduce its stillbirth rate to 2.6 stillbirths per 1,000 births and the neonatal death rate to 1.5 neonatal deaths per 1,000 births. Posted 9 August 2022 data released by the Office for National Statistics (ONS) has confirmed that rates of stillbirth in England and Wales increased from 3.8/1000 births in 2020 to 4.1/1000 in 2021. The data also shows that there continues to be significant variation in stillbirth rates across different parts of England and Wales.

### 7.2 Stillbirths

There were 4 stillbirths in Q4. All subject to 72hr review, 3 will be subject to PMRT.

- 33+0 Antenatal Stillbirth. PMRT review commenced (awaiting cytogenetics and placental histology). Immediate learning noted that LFTs undertaken for itching – no documentation why taken (info from mother). Taken day before birth – would not have affected the outcome.
- 36+1 Antenatal Stillbirth Twin 2 – PMRT review commenced, no investigations required due to fetal abnormality and poor prognosis. No immediate learning.
  25+6 medical termination/feticide for fetal anomaly, reported to MBRRACE for information only.
- 35+5 Antenatal Stillbirth. PMRT commenced. Accepted placental, cytogenetics and full post-mortem investigations. Immediate learning was that TORCH screen was not undertaken (polyhydramnios) – reason not documented. Mother had previously declined maternal bloods as needle phobic.

### 7.2.1 Multiple Pregnancy

Of the 4 stillbirths in Q4, 1 was twin pregnancy. The 2nd twin demised due to a known lethal anomaly.

### 7.2.2 Social deprivation

Of the 4 stillbirths in Q4, 2 had a social deprivation score of 2**.** The women were under the care of the 'Daisy' Team Midwives who provide enhanced care for vulnerable women.

### 7.3 Neonatal Deaths

The were 2 neonatal deaths at WWL in Q4. Both were MTOPs, 1 at 18+ 5 weeks and 1 at 21+5 weeks. No learning identified.

### 7.3 PMRT

| Grade | Care in Antenatal Period | Percentage (%) | Care in Postnatal Period | Percentage (%) |
|---|---|---|---|---|
| A | 1 | 100% | 1 | 100% |
| B | 0 | 0 | 0 | 0 |
| C | 0 | 0 | 0 | 0 |
| D | 0 | 0 | 0 | 0 |
| In Q4, 1 case of an antenatal stillbirth from 2022 was finalised in the PMRT meeting. The panel concluded there were no care or service delivery issues, and the antenatal, intrapartum, and postnatal care were graded A. | | | | |

*A – No issues in care identified
*B – Care issues that would have made no difference to the outcome
*C - Care issues that may have made a difference to the outcome
*D – Care issues which were likely to have made a difference to the outcome

### 8. Saving Babies Lives (SBL)

| Element 1 Reducing Smoking in Pregnancy | Compliance | Improvement Plan |
|---|---|---|
| CO at booking | 96% | Some stock issues for disposable equipment rectified. Audit regularly undertaken. Band 7 & Band 4 post out for advert to develop the team |
| CO at 36 weeks | 98% | |
| Element 2 Risk Assessment and surveillance for FGR | Compliance | Improvement Plan |
| Risk at booking | 100% | |
| Detection of <3rd centile at >37+6 | 96% | |

| Element 3 Reduced Fetal Movements | Compliance | Improvement Plan |
|---|---|---|
| Women attending for RFM receiving computerised CTG | 100% | |
| Women receiving RFM leaflet prior to 24 weeks gestation. | 100% | |
| Element 4 Effective fetal monitoring in labour | Compliance | Improvement Plan |
| Midwifery staff received fetal monitoring training | 98% | |
| Element 5 Reducing preterm births | Compliance | Improvement Plan |
| Antenatal steroids | 96.5% | |
| MgS04 | 100% | |
| Correct birthplace | 100% | |
| SBL Training | | |
| SBL Training (Elements 1,2,3,5) | 92% | All contacted via e mail and face-to-face to address any ongoing issues with access, time allocation or learning challenges. |

## 8. Mandatory Training Compliance for Q4

### 8.1 Mandatory Training Compliance Midwifery

| | Number attended in Q4 | Percentage of staff | Rolling percent |
|---|---|---|---|
| BLS | 37 | 24% | 91% |
| NLS | 37 | 24% | 91% |
| PROMPT | 34 | 22% | 88% |

From April 2023 the structure of mandatory training will be changing. Each staff member will be allocated a full day for both PROMPT, Fetal Physiology and personalised care with additional half day sessions covering BLS, NLS, Safeguarding, Infant feeding, SSSA (mentorship), Suturing and Epidural update. From April 2024 there will be a critical care update in place of personalised care. (CNST core competency requirements).

### 8.2 Mandatory Training Compliance Other Specialities

| | PROMPT | |
|---|---|---|
| | Number attended in Q4 | Rolling percentage |
| Consultant Obstetrician | 2 | 83% |
| Obstetric registrar | 1 | 75% |
| Anaesthetist | 0 | 100% |
| MSW | 5 | 86% |

Both PROMPT and Fetal Physiology training is multidisciplinary with compulsory attendance from Midwives and Obstetricians PROMPT is compulsory for all Maternity Support Workers and Obstetric Anaesthetists. All Obstetric registrars and consultants booked on for training this year. To date no Anaesthetists are booked on for PROMPT this year.

### 8.3 Mandatory Fetal Physiology Training

| | Jan 2023 | Rolling % | Feb 2023 | Rolling % | Mar 2023 | Rolling % |
|---|---|---|---|---|---|---|
| Midwives | 11 | 94% | 15 | 96% | 11 | 98% |
| Obstetricians | 1 | 100% | 1 | 100% | 0 | 92% |
| Obstetric Registrars | 1 (+1GP) | 90% | 1 | 90% | 2 (+ 2 GP) | 100% |

**New Intermittent Intelligent Auscultation Standard**

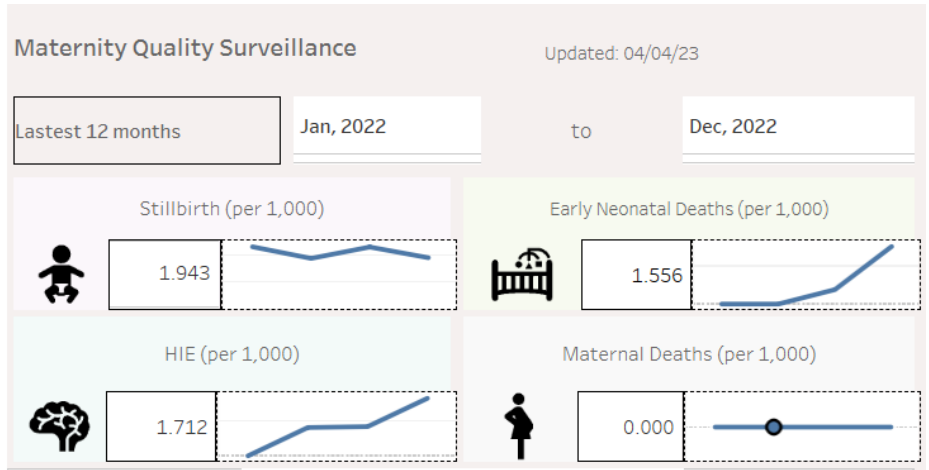
GMEC standard for (IIA) has been updated and there is a plan for a three-month role out (to include new IIA teaching presentation and assessment / ElfH Module).
Priority for midwives who provide intrapartum care (delivery suite and community), teaching to be rolled out to all midwives following this - 52 inpatient & 46 community) = 98 midwives
Number trained by the end of Q4 2022-23 = 31 midwives = **32%**

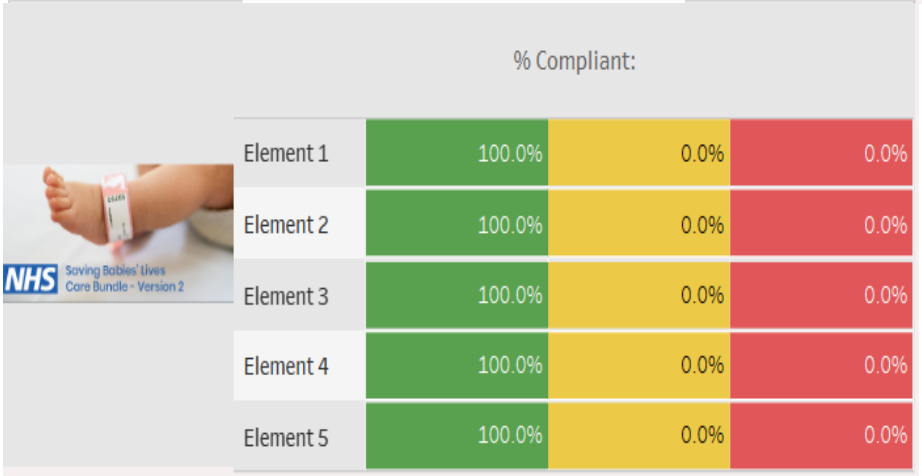
### 9. Maternity and Neonatal Dashboards – extract.

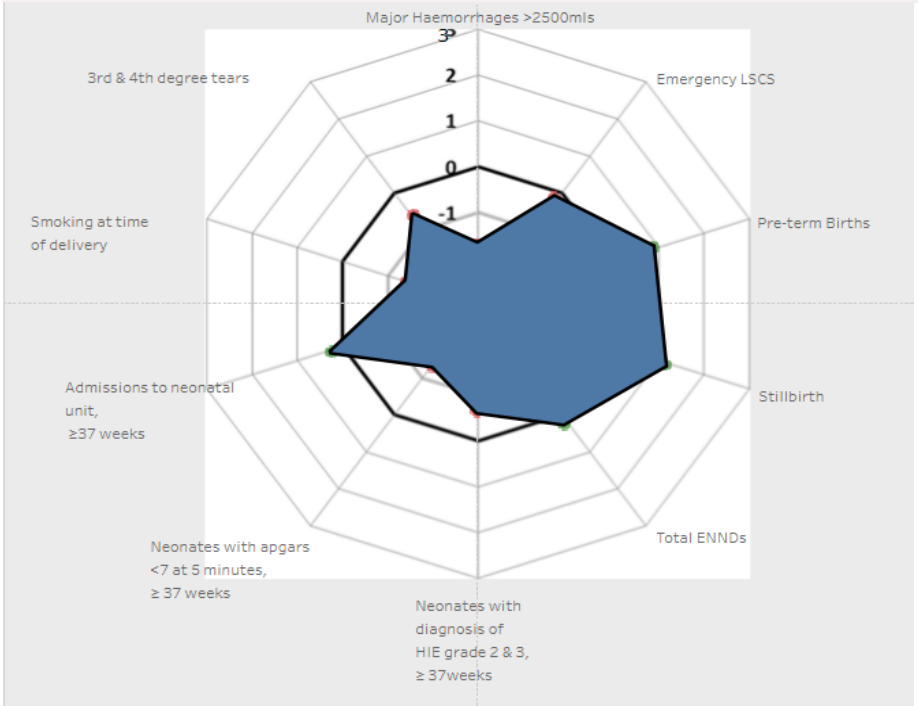
| | Metric | Standard | July 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Dec 22 | Jan 23 | Feb 23 | Mar 23 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Workforce | 1:1 care in labour | 100% | 98.6% | 100 % | 100 % | 100 % | 100 % | 100% | 98.9 % | 100 % | 100 % |
| | Supernumerary Shift Coordinator | 100% | 100% | 100 % | 100 % | 100 % | 100 % | 98.3 % | 100 % | 100 % | 98.2% |
| | Midwifery Sickness | In development | | | | | | | | | |
| | Midwifery Vacancies | | 16.76 | 20.15 | 17.75 | 14.62 | 12.71 | 12.94 | 12.84 | 10.96 | 15.05 |
| | Midwifery Red Flags | | 0 | 0 | 2 | 1 | 2 | 5 | 4 | 1 | 4 |
| Activity | Number of bookings | >240 <200 | 214 | 220 | 232 | 254 | 258 | 215 | 260 | 247 | 249 |
| | Registerable births | >200 <180 | 220 | 238 | 191 | 234 | 228 | 213 | 224 | 170 | 194 |
| | Induction of Labour as % births | <38% >=42 % | 40.91 % | 41.1 % | 38.2 % | 37.6 % | 40.7 % | 40.8 % | 31.2 % | 42.3 % | 47.9% |
| | Instrumental deliveries | 10.8% | 9.09% | 14.2 % | 8.38 % | 12.3 % | 7.46 % | 7.04 % | 8.48 % | 7.06 % | 7.22% |
| | Total C/S | 34.2% | 31.8% | 33.6 % | 38.2 % | 47.4 % | 39.9 % | 46.0 % | 39.2 % | 41.7 % | 42.2% |
| | Robson Criteria Remains under development. Awaiting upgrade to MIS. | | | | | | | | | | |

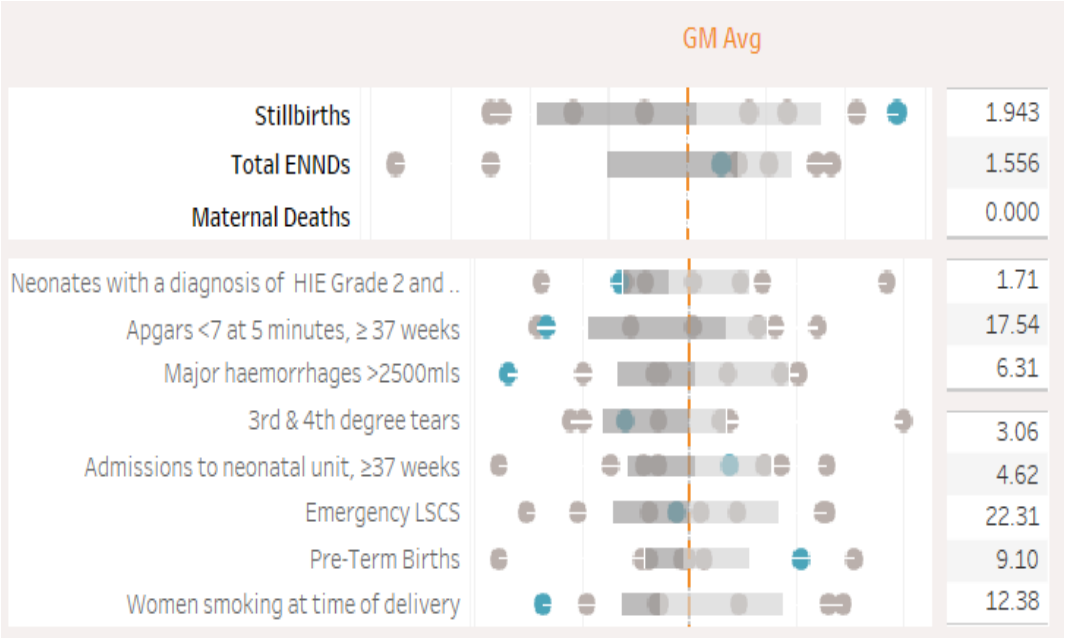
| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 3rd/4th degree tear as % of births | <3 >4 | 0.46% | 2.94 % | 2.11 % | 1.72 % | 1.32 % | 2.36 % | 0.91 % | 1.18 % | 2.59% |
| | PPH >2500 as % of births | | 0% | 0.84 % | 0.52 % | 0.87 % | 0.44 % | 1.42 % | 0.90 % | 0.59 % | 1.04% |
| Neonatal | Metric | Standard | July 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Dec 22 | Jan 23 | Feb 23 | Mar 23 |
| | Apgar's <7 at 5 minutes | <4 | 2 | 4 | 4 | 2 | 3 | 7 | 4 | 4 | 3 |
| | Unexpected term admissions to NNU (%) | 3.5% >4.5% | 3.61% | 1.82 % | 9.26 % | 3.81 % | 8.45 % | 8.16 % | 8.08 % | 10.1 % | 8.67% |
| | Babies readmitted within 28 days of birth | <16 >20 | 10 | 16 | 14 | 21 | 12 | 22 | 17 | 8 | 16 |
| | Shoulder dystocia as % of births | | 0% | 1.68 % | 1.57 % | 0.00 % | 0.88 % | 2.35 % | 1.79 % | 0.59 % | 0.52% |
| | HIE 2 & 3 >27 weeks | | 0 | 0 | 1 | 1 | 0 | 2 | 1 | 0 | |
| | Stillbirths | | 0 | 1 | 1 | 0 | 1 | 1 | 2 | 0 | 2 |
| | Early NND | | 0 | 1 | 0 | 3 | 0 | 0 | 1 | 1 | 0 |
| | Singleton babies born <30 weeks | | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 2 |
| | % Whose mother received MgSO4 | 100% | N/A | N/A | N/A | 100 % | N/A | N/A | 0 | 0 | 50 % |
| | Singleton babies born <34 weeks | | 2 | 4 | 2 | 1 | 2 | 6 | 2 | 2 | 4 |
| | % Whose mother received full course steroids | 100% | 0 | 50% | 100 % | 100 % | 0% | 83.3 % | 50% | 50% | 100 % |
| | omissions in care noted | | 0 | 0 | N/A | N/A | 0 | 0 | 0 | 0 | N/A |
| | **Dashboard Summary**<br>The figures above show a continued spike in term admissions to NNU since September of Q2 22-23. These cases have all been investigated and no patterns or omissions in care were noted. However, when compared against the GMEC average WWL are not an outlier and have remained persistently lower than the GMEC average.<br>All term admissions to NNU are looked at in detail as part on the ongoing ATAIN audit and any actions noted and added to the overarching action plan.<br>There were 8 Mothers who were eligible for steroids within Q4 22-23. Of these, 6 received a full course of steroids in the week before delivery. The other Mothers were unable to receive a complete course as delivery needed to be expedited. There were no omissions in care noted. It can be seen above that the figures for March are 100%. | | | | | | | | | | |

## 9.1 GMEC (Greater Manchester and East Cheshire) Maternity Quality Surveillance Dashboard, WWL Data - Jan 22- Dec 2022



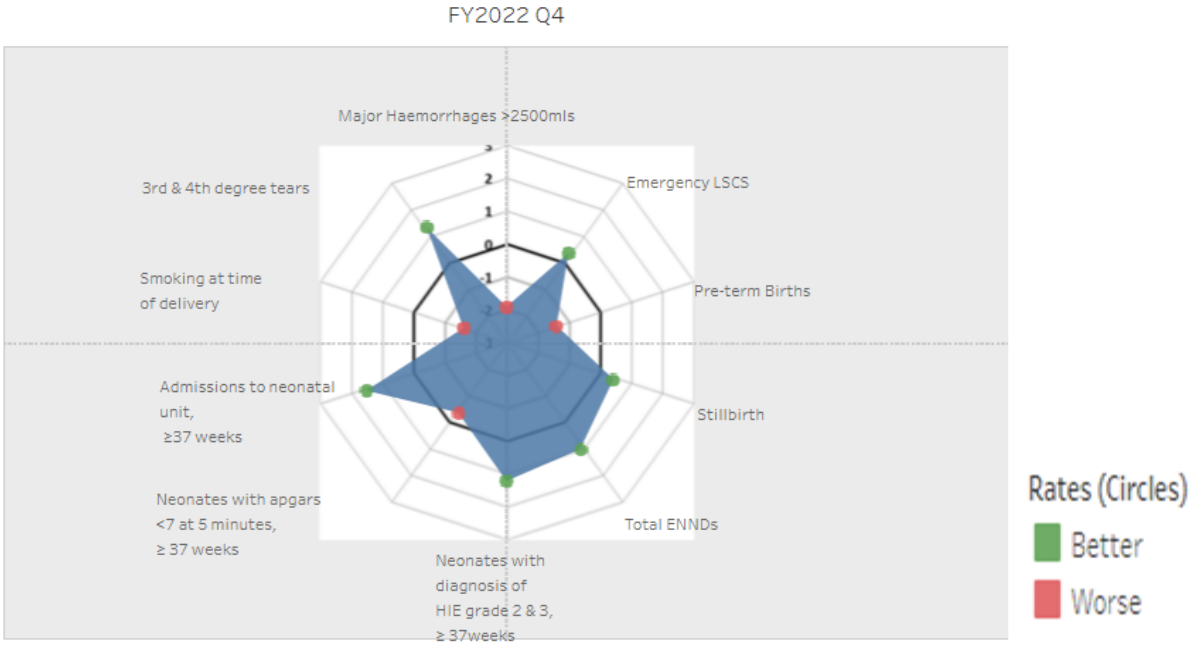






In 2022, WWL (blue dot) maintained the lowest number of SBs in the region. WWL performed better than the GM average for number of early neonatal deaths, term admissions to the NNU and pre-term births. WWL was outside the GM average for Apgar's<7 @5 at term, PPH >2.5 litres, HIE 2 or 3, and women smoking at time of delivery.

### 9.2 WWL Data compared to GMEC average – Q4.




In Q4, WWL has performed better than the GM average in rates of emergency LSCS, neonatal deaths, stillbirths, term admissions to NNU, neonates with HIE diagnosis of 2 and 3 ≥37 weeks.

WWL has performed worse than the GM average in smoking at the time of delivery, major haemorrhage >2.5l, pre-term births and term babies Apgar score <7 at 5 minutes.

**Summary**

There has been an increase in StEIS reported incidents in Q4 compared to Q3. A deep dive has been undertaken of StEIS reported incidents in 2022 through to end of March 2023 with a focus on CTG monitoring. All learning has been pulled out and assurance gained that robust actions are already in place and on-going, with a proactive approach to improving CTG monitoring management. There has been a decrease in HSIB referrals in Q4 compared to Q3 with 2 HSIB referrals being accepted for investigation.
Outcomes continue to be monitored across GMEC and importantly WWL has performed better than the GM average in rates of emergency LSCS, neonatal deaths, stillbirths, term admissions to NNU, neonates with HIE diagnosis of 2 and 3 ≥37 weeks, which reflects the compliance rates outlined in the report and the excellent work undertaken.

# Perinatal Quality Surveillance Dashboard 2023

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

| | Safe | Effective | Caring | Well-Led | Responsive | CQC Overall Rating Good (August 2023) |
|---|---|---|---|---|---|---|
| | Requires Improvement | Good | Good | Good | Good | |

| | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cardiotocograph (CTG) training and competency assessment | Midwives = 13 (94% rolling compliance)<br><br>Consultant = 1 (100% rolling compliance)<br><br>Registrars = 1 (90% rolling compliance) | Midwives = 22 (96% rolling compliance)<br><br>Consultant = 1 (100% rolling compliance)<br><br>Registrars = 1 (90% rolling compliance) | Midwives = 11 (98% rolling compliance)<br><br>Consultant = 0 (91.6% rolling compliance)<br><br>Registrars = 2 (100% rolling compliance) | Midwives = 21 (98% rolling compliance)<br><br>Consultant = 2 (91% rolling compliance)<br><br>Registrars = 1 (100% rolling compliance) | Midwives = 13 (98% rolling compliance)<br><br>Consultant = 0 (91% rolling compliance)<br><br>Registrars = 1 (100% rolling compliance) | Midwives = 16 (97.7% rolling compliance)<br><br>Consultant = 4 (91% rolling compliance)<br><br>Registrars = 0 (100% rolling compliance) | Midwives = 20 (98% rolling complaince)<br><br>Consultant = 0 (82% rolling complaince)<br><br>Registrars = 1 (87.5% rolling complaince) | **No CTG Training in August** Complaince remains as July 2023 | | | | |
| Practical Obstetric Multi-Professional Training (PROMPT) (emergency Skills Drills Training) | Midwives 11 attended (7%) rolling % 91%<br>Obstetric consultants 1 attended (8%), rolling % 92%<br>Obstetric registrars 0 attended (0%), rolling% 82%<br>Anaesthetists 0 attended (0%) rolling% 100%<br>MSW's 3 attended (8%) rolling % 92% | No PROMPT in February<br>Midwives rolling% 85%<br>MSW's rolling% 94%<br>Obs consultants rolling% 91%<br>Obs Registrar rolling% 64%<br>Anaesthetists rolling% 100% | Midwives 11 attended rolling % 88%<br>MSW 6% attended rolling% 88%<br>Consultants 9% attended rolling 82%<br>Registrars 8% attended rolling % 75%<br>Anaesthetist 0 attended rolling % 100% | Midwives 15 attended (10%) rolling % 87%<br>MSW 1 attended (3%) rolling % 86%<br>Obs consultants 1 attended (8%) rolling% 91%<br>Obs reg 0 attended rolling % 91%<br>Anaesthetists 0 attended rolling % 84% | **PROMPT cancelled May**<br>Midwives Rolling compliance 80%<br>MSW Rolling compliance 75%<br>Obstetric consultant rolling compliance 92%<br>Obstetric registrar rolling compliance 64%<br>Anaesthetists rolling compliance 65% | Midwives 17 attended (11%) Rolling % 82%<br>MSW's 6 attended (17%) Rolling % 81%<br>Obsteteric Consultants 0 attended Rolling % 83%<br>Obs Registrars 2 attended (18%) 82%<br>Anaesthetists 0 attended Rolling% 63% | Midwives 16 attended Rolling compliance 84%<br>MSW 5 attended Rolling compliance 83%<br>Obstetric Consultant 0 attended Rolling compliance 67%<br>Obstetric Registrar 2 attended Rolling compliance 100%<br>Anaesthetists 1 attended Rolling compliance 68% | **No Prompt Training in August** Complaince remains as July 2023 | | | | |
| Prospective Consultant Delivery Suite Cover ( 60 as standard for WWL) | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | | | | |
| 1:1 care in labour | 99% | 99% | 100% | 100% | 100% | 100% | 100% | 100% | | | | |
| Maternity Red Flags reported (>3) | 4 | 1 | 4 | 1 | 0 | 2 | 5 | 3 | | | | |
| Diverts: Number of occasions unit unable to accept admissions(>1) | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 0 | | | | |
| Supernumeray Shift Co-ordinator | 100% | 100% | 98% | 100% | 100% | 100% | 100% | 100% | | | | |
| The number of incidents logged graded as moderate or above ( >5) | 2 | 2 | 2 | 1 | 2 | 0 | 1 | 2 | | | | |
| All cases eligible for referral to HSIB. | 1 | 0 | 1 | 0 | 0 | 0 | 1 | 1 | | | | |
| Number of Datix submitted when shift co-ordinator not supernumerary | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Service User Voice feedback** | **Feedback from Patient**<br>A lady who recently birthed has been very complimentary regarding her care. The parents wish to donate £500 to the Delivery suite for the staff.<br><br>They have both expressed how grateful they were with the care they have received and have had a very positive experience. They felt that the changeover of staff was seamless and that they had great care from both Delivery Suite midwives, and this has continued the Maternity Ward | **Feedback from Patient**<br>The midwives at Wigan Delivery suite were amazing and looked after us well .....Liv in Wigan stood out to us the most as it seemed as if she really cared about us<br>Sam the bereavement midwife has been really supportive and has been consistent with ther follow ups | **Feedback from Patient** I just wanted to say thank you to both you and the wider neonatal and maternity teams. We were under your care a few weeks ago with our baby, and having been in for a week with both mother and baby suffering from infection (early onset sepsis ), we couldn't have felt better looked after, or more reassured by both the care and communication from the whole team. You are all a credit to the trust! | **Feedback from Patient** I did not have a positive experience as my labour ended in an emergency caesarean, but I would like to thank the midwife and student midwife who cared for me during my labour ..... they were amazing and I felt safe in their hands | **Feedback from Parents from an HSIB investigation**<br><br>The family were so complimentary about the care they received.<br>In their words, they said that they will 'NEVER forget the NHS staff [who were there for them] when they needed<br>them the most'. | **Feedback from Patient**<br>"Consultant anaesthetist was the stand out for me during surgery..... he and whole team read birth plan, stuck to it and explained everything . Mum had really bad experience with her first child suffered a lot of birth trauma and under the mental health midwives pre birth, so was really important that this experience be better... we just can't fault it....allowed me in theatre let us stay together throughout. Everyone on the ward has been so kind and helpful too. Honestly in an age of constant complaints about nhs this experience proves it's worth" "the care have had has been nothing short of brilliant" | **Maternity Voice Partnership Feedback** "I was very fortunate as despite having all my care before giving birth in a different borough as soon as I came under the care of Wigan I had great support with practitioners who communicated between each other and with me" | **Feedback from Patient**<br>We had a great experience with Wigan Maternity services throughout our journey. We mostly saw the same midwife , consistency meant that we could build a good relationship and she knew us well. They identified and acted promptly on a possible growth restriction, and they arranged for me to see another doctor when I was unsure whether induction was the right thing to do. I felt in competent hands throughout and every midwife had excellent communication skills to help reassure us, check our understanding and importantly, make the experience positive and happy! thank you!!! | | | | |
| **Staff feedback from frontline champions and walk-abouts ( Bi Monthly)** | **Formal walkabout**<br>Non Executive Director Steven Elliott and Chief Nurse Rabina Tindale undertook a walkabout across Maternity and Neonatal Unit They spoke to a junior doctor, midwives and a student. Positive feedback was shared about staff feeling supported, the on call rota and there were good learning opportunities for students | **No Formal walkabout took place** | **Formal walkabout**<br>Chief Nurse Rabina Tindale and an Non Executive Director have arranged a walkabout across Maternity in April. | **Formal walkabout**<br>Chief Nurse Rabina Tindale undertook a walkabout across all Maternity areas. Maternity staff shared that they felt supported. Positive Feedback was shared with staff that everyone was lovely | **No Formal walkabout took place**<br>Chief Nurse Rabina Tindale provided positive feedback to the team on their hard workfollowing the CQC visit on the 16th May 2023 | **Formal walkabout**<br>Deputy Chief Nurse Allison Luxon and an Non Executive Director undertook a walkabout across Maternity in June. | **No Formal walkabout took place** | **Formal walkabout**<br>Rabina Tindale, Chief Nurse with Non Executive Director's Francine Thorpe and Terry Hankin undertook a walkabout across Maternity. They were very complimentary about our service. They were assured that maternity services are in safe and dedicated hands The enthusiasm and pride all staff showed in their roles was self evident and refreshing. The unit was spotless, top marks to the housekeeper. The discussion with the bereavement lead was moving. You can be assured of our continual support. | | | | |
| **Healthcare Safety Investigation Branch (HSIB)/NHS Resolution (NHSR)/CQC or other organisation with a concern or request for action made directly with Trust** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| **Coroner Reg 28 made directly to Trust** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| **Progress in achievement of CNST 10** | Work ongoing with Year 4<br>All standards remain on Track | Evidence submitted for Year 4 | Awaiting the publication of CNST Year 5<br>(standards from Year 4 maintained ) | Awaiting the publication of CNST Year 5<br>(standards from Year 4 maintained ) | Publication of CNST Year 5 Standards<br>Review of all standards underway | Progress with standards On Track | Progress with standards OnTrack | Progress with standards OnTrack | | | | |
| **Number of StEIS Reportable Incidents** | 2 | 0 | 1 | 0 | 0 | 1 | 3 | 1 | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Stillbirths | 2 | 0 | 2 | 1 | 0 | 1 | 0 | 2 | | | | |
| Number of Neonatal Deaths | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| Number of Maternal Deaths | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| | Proportion of Midwives responding with Agree or Strongly Agree on whether they would recommend their Trust as a place to work or receive treatment ( Reported annually) | | | | | | | | % | | | |
| | Proportion of Speciality Trainees in Obstetrics &Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (Reported annually) | | | | | | | | % | | | |

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| **Title of report:** | Winter Planning Update |
| **Presented to:** | Board of Directors |
| **On:** | 4th October 2023 |
| **Presented by:** | Mary Fleming, Deputy Chief Executive |
| **Prepared by:** | Mary Fleming, Deputy Chief Executive |
| **Contact details:** | Mary.Fleming@wwl.nhs.uk |

## Executive Summary:

The winter of 2023/2024 is predicted to be particularly challenging with longer waiting times for emergency and elective care already impacting. Unscheduled care and planned care services are of equal importance and many actions are in place to protect both, including gaining Surgical Accreditation status to support ring fencing of the Trust's two surgical sites at Wrightington and Leigh. However, unscheduled care pressures may be such that some services have to be stepped back, this will be done based on clinical advice. The Trust is in the process of reviewing its core parameters and actions set out in the Full Capacity Protocol and Surge Policies against the newly issued National Operational Pressures Escalation Levels (OPEL) scores which aim to provide unified, systematic, and structured approach to escalating acute hospital urgent and emergency care operating pressures through the Emergency Preparedness, resilience, and Response framework.

WWL winter planning also forms part of the Integrated Wigan System Winter Planning process in response to NHS England winter planning exercise for 2023/24. The purpose of which is to support Greater Manchester ICB to lead a system-wide planning process ahead of winter**.** The key lines of enquiry are designed to provide a prompt for areas that require consideration, and to provide the necessary assurance that steps have been taken at a system-level to prepare for a resilient winter period. Greater Manchester ICB is responsible for producing one comprehensive response for the system, and therefore the focus is on ensuring that all parts of the system are engaged in developing the plan.

**The Wigan Locality Winter Planning Submission can be found at Appendix 1.**

**Greater Manchester Winter Planning Submission can be found at Appendix 2**

**Background**

As a Trust, we continue to be faced with interdependent challenges which impact on winter planning. These challenges are:

Industrial Action and Flow & Discharges: The Trust has now responded to multiple Junior doctor and Consultant strikes, each one escalating in terms of impact. Length of stay and high occupancy remain above planned levels, coupled with industrial action, has resulted in significant demands on urgent and emergency care services.

Additional capacity has been commissioned through three additional wards, one of which remains unfunded, a 100 virtual Ward beds and the expansion of Same Day Emergency Care. Further support to improve patient care, achieve national standards and de-escalate unfunded areas through the winter period will come through two main transformation programmes. As part of the Tier 1 allocation, WWL and the wider Wigan System will be supported by the national Emergency Care Intensive Support Team (ECIST) who will provide 120-day programme of peer-to-peer clinical guidance & support programme aimed at enhancing existing Hospital and Discharge Flow transformation streams of work. And in parallel, an out of hospital programme of work undertaken with Newton-Europe and Better Care Fund colleagues to clearly define the programmes of work which support delivery of Home First and Integration.

**Risks associated with this report and proposed mitigations.**

- Demand increased beyond forecasted levels.
- No Right to Reside do not reduce.
- Unfunded Escalated areas remain open.
- Impact on the elective recovery
- Continued Industrial Action

**Financial implications**

- Penalties linked to non-delivery of elective recovery plan.
- Unfunded escalation areas remain open.
- Increased cost pressures resulting from the higher number of no right to reside patients and blockages to patient flow in the A&E
- Additional resources are requested to provide programme direction and programme management for the system discharge and flow programme.

**People implications**

- Sickness absence and resulting temporary spend.
- Ongoing industrial action

**Wider implications**

- Greater Manchester Integrated Care Board failure to achieve Elective recovery times and associated funding.
- Impact on Northwest Ambulance Service in responding to those most in need in a timely way.
- The approach to addressing complex, system issues/priorities, will have implications for wider partnership relationships across the Wigan Borough. There may be a need for all stakeholders to pool corporate resources to ensure the enablers are in place (e.g. - Programme management and Data analytics) There will also need to be consistent governance and tracking of performance/benefits.

It is likely that the 202/24 winter period will be another huge challenge for the NHS as a whole and WWL will experience sustained pressure especially when the current position in mid-September is considered. However, many actions have been and continue to be put in place to protect service delivery with a focus on both planned and unscheduled care as equal priorities. To ensure WWL is prepared for the worst emergency plans are being updated and evaluated to provide as much resilience as possible for the benefit of both patients and staff. **Please see Appendix 1.**

**Recommendation(s)**

The Committee is asked to note progress to date alongside on-going challenges and risks outlined in the report.

# Winter 2023/24 Planning Submission

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| **ICB name:** | **NHS GM Integrated Care – Wigan Locality** |
| **Approved for submission by:** | Mel Maguinness |

This document outlines the narrative key lines of enquiry that each Integrated Care Board (ICB) are asked to respond to as part of the NHS England winter planning exercise for 2023/24. The purpose of this document, and the associated numerical planning template, is to support ICBs to lead a system-wide planning processes ahead of winter**.** The narrative questions in this document are designed to provide a prompt for areas that required consideration, and to provide the necessary assurance that steps have been taken at a system-level to prepare for a resilient winter period. ICBs are responsible for producing one comprehensive response for the system, there should be a focus on ensuring that all parts of the system, including Local Authority partners, are engaged in developing this. Updated intermediate care capacity and demand plans at HWB level will need to be agreed with local authorities and submitted in October as part of BCF quarterly reporting. The BCF plans should reflect agreed changes to capacity and demand management agreed in these ICB plans. There is a total of six key lines of enquiry with associated questions across the following areas:

a. System-working
b. High-impact interventions
c. Discharge, intermediate care, and social care
d. H2 numerical planning submission
e. Surge plans
f. Workforce

**KLOE 1: How will the system work together to deliver on its collective responsibilities?**

| Key question and points to consider | Response |
|---|---|
| **KLOE-1.1: How has each part of the system been engaged?**<br>• How have roles and responsibilities been communicated to and agreed with each part of the system? | There is a well-established Urgent and Emergency Care Improvement and Transformation Board in Wigan with senior leads from all system partners. This has clear system and organisational responsibilities. |

| Key question and points to consider | Response |
|---|---|
| | There are also daily operational and weekly escalation calls with Wrightington, Wigan and Leigh Teaching Hospitals and Greater Mamchester Mental Health to resolve any issues which require a multi-agency response/support.<br><br>There is well established working in Primary Care using structures across Primary Care Ns, Clinical and Care Professional leadership and Local Medical Committees which support working across 56 practices and links back into system partners.<br><br>There is also good communication with the GM UEC team with escalation of issues which required GM level support. |
| • How has each part of the system been engaged to support the development and delivery of the winter plan?<br>• How have local authority, social care and VCSE (voluntary, community or social enterprise) partners been engaged with developing the system winter plan? | The Wigan UEC Improvement and Transformation Board which has a wide range of stakeholders including the VCSE oversees the system plans for improvement and transformation as well as plans for winter to ensure capacity meets demand.<br><br>Primary Care Winter Planning engagement is completed through the GP Collaborative and fortnightly meetings with the LMC to agree proprieties and support requirements. This includes planning for winter and other periods of increased demand. |
| **KLOE-1.2: How will you assure that each part of the system is delivering against its roles and responsibilities?**<br><br>• What is the mechanism for system partners to hold one another to account for delivering on their roles and responsibilities? | The Healthier Wigan Partnership System Board is the formal system mechanism for holding all partners to account for system transformation, improvement, and delivery. The system reporting (via the UECB to the HWP System, Board) highlights where delivery is off track to enable remedial actions to be agreed and undertaken.<br><br>In addition, as the Wigan system is in Tier 1 for urgent and emergency care performance, we have welcomed the additional support offered through ECIST to review systems and processes to improve flow and support reductions in delayed discharges by working with all system partners (visit to WWL 6th September). We are also in the process of a 6 week “sprint” with the GM UEC team and will be commencing an intense programme of improvement with Newton Europe. |

| Key question and points to consider | Response |
|---|---|
| • How have key interdependencies between parts of the system been identified, and how will they be managed?<br>• What are the key risks to delivery of the plan in each part of the system, and how will they be mitigated? | Key independencies and risks are identified and discussed at the Wigan UEC Improvement and Transformation Board; any risk that require GM intervention/support are escalated to the GM SCC.<br><br>The key risks are workforce availability, increase in demand, the potential impact of the new variant of covid and sustainability of services. These are all on the risk register with appropriate mitigations in place. |
| **KLOE-1.3: How will the system deliver on the roles and responsibilities identified by NHSE - respond for each area as below:** | Please see Greater Manchester Response. |
| **Integrated Care Boards:** | |
| **Acute and Specialist NHS Trusts:** | |
| **Primary Care:** | |
| **Children and Young People Services:** | |
| **Community Trusts and Integrated Care Providers:** | |
| **Ambulance Trust:** | |
| **Mental Health:** | |
| **Local authorities and social care:** | |

| Key question and points to consider | Response |
|---|---|
| **KLOE-1.4: How will the ICB lead the system through the winter period?**<br>• How will 24/7 oversight of system pressures through the System Coordination Centre (SCC) be maintained?<br>• How will the ICB ensure the appropriate structures, systems and process are in place to maintain operational oversight and delivery?<br>• How will executive level and senior clinical leadership be used to deliver a successful winter for the system? | Please see Greater Manchester response, locality response below<br><br>The current model is supported by senior clinical leadership through an on-call rota of Medical Executives, similarly, the SCC is supported by an Executive On-Call rota. This model is under review to ensure that executive and senior clinical leadership are fully embedded into the operating model of the System Coordination Centre |
| **KLOE-1.4: How will the ICB lead the system through the winter period?**<br><br>• How have IPC colleagues been involved in the development of the system Winter plan? | LA, ICB and Acute trust IPC leads meet regularly to coordinate the IPC agenda and the September meeting will focus on the NHS E guidance to deliver a resilient Winter. Winter planning is also on the next locality Health Protection Board which links to our Locality Health Resilience Partnership and Wigan Borough Resilience Forum.<br>Work is underway to include our Mental Health Trust IPC leads.<br><br>Elements of system winter planning have been covered at the Local Resilience Forum and Health Protection Board. IPC colleagues are represented at these meetings and their sub structures.<br><br>IPC have been involved in the development of the anti-viral pathway for flu – which is tried and tested. |
| • What plans have been put in place to promote optimisation of IPC practices and effect Healthcare Associated Infection (HCAI) prevention/reduction in hospitals and community care settings? | WWL's Acute and community IPC lead is the lead for the system for this area and has robust system plans in place. There is a specific update on the September Health Protection Board to ensure that all system processes and procedures are in place and that all partners are undertaking their respective actions.<br><br>We are also currently undertaking a piece of work to review and re-design our IPC resource and provision across the system, to mitigate against identified risks and realise opportunities for quality improvement. This includes convening a system IPC |

| Key question and points to consider | Response |
|---|---|
| | group, options appraisal of proposed delivery models and scoping the expansion of a settings-based approach. |
| • What support has been put in place at a system level to, ensure IPC provision to care homes and step-down intermediate care facilities in preventing and reducing infection transmission, and aid capacity to discharge patients? | Our quality lead nurses work closely with our intermediate care facilities, and our Local Authority quality team support care homes in relation to assessing and supporting providers to undertake best clinical practice. Additional quality lead posts will be filled in the next few months and those roles will focus on increased assurance and improvement in intermediate care and care home settings. As a locality we are working on supporting flow and timely discharge planning, right care right setting, and are commissioning a new intermediate care provider in the next few months. All contracts have clear measures relating to IPC responsibilities and supporting safe and timely discharge of patients.<br><br>The Council Health Protection and Civil Contingencies team has an IPC function who as part of their remit provide advice, support, and guidance to care home and intermediate care facilities. An annual audit programme is in place using the Greater Manchester Care Home Audit Framework, along with a training offer (e.g., donning and doffing of PPE) and support with outbreak management. This offer is being expanded to look at IPC champions and peer to peer support over the Winter period. At system level a risk assessment is agreed and operational to support discharge where safe to do so and mechanisms are in place to provide updates on outbreak status of these settings into discharge and flow meetings. |
| **KLOE-1.6: Support for care homes**<br>• is the overall offer to care homes in supporting residents to remain well, access timely support, care, treatment, and advice and to remain in the care home for their care and treatment wherever possible avoiding unnecessary hospital admission. | There are named staff allocated to care homes providing consistent MDT support. These include named GPs, named social worker/social care officer, named Quality performance officer, and named MCA advocates. MH have access to community MH workers and community health services have access to ANP and district nurses through the community response team which is connected to the Access to therapies front door team. Primary health and Wigan ICB provide IPC support. As part of the boroughs Integrated community services and home first transformation plan, plans are in place to develop the entire system working and adapt existing pathways to ensure MDT whole system working. This also needs to include developing relationships with NWAS, out of hours response services and expansion of virtual wards. |

| Key question and points to consider | Response | |
|---|---|---|
| | PCNs through the PCN DES are delivering enhanced care in care homes, including but not limited to regular ward rounds, care planning, remote support/advice, and proactive management.<br><br>WWL also have in place the Community React Team (CRT), Advanced Nurse Practitioners and GP support for acute illness in Urgent Care 2-hour Response.<br><br>WWL Hospital at Home provides planned interventions which aid admissions avoidance.<br><br>WWL Community District Nurses provide nursing care for patients within Residential Care Homes<br><br>We also have Community Matrons who provide more intensive support to enable people to remain at home (in their Care Home bed) and facilitated timely discharge when people need to be admitted to hospital. | |
| • The recommended roles and responsibilities for each part of the system detail several areas which should support care homes and care home residents – specifically how will care homes be supported through both a proactive and reactive care approach across the following areas: | **Is this provided Y/N** | |
| ○ Enhanced health in care homes | Yes | Working in partnership between adult social care, Wigan ICB CHC and Wigan MH services and primary care.<br>PCNs through the PCN DES are delivering enhanced care in care homes, including but not limited to regular ward rounds, care planning, remote support/advice, and proactive management. |

| Key question and points to consider | Response | |
|---|---|---|
| ○ Personalised care and support planning | Yes | PCNs through the PCN DES are delivering enhanced care in care homes, including but not limited to regular ward rounds, care planning, remote support/advice, and proactive management. |
| ○ Oral health | No | There is no specific service to provide oral health care, but all health and care providers undertake holistic assessments on patients and if any oral health needs are identified, referrals to dental care practitioners are made. |
| ○ Falls prevention exercises | Yes | Falls prevention services and current priority work being undertaken by the public health team as part of the Integrated community services/home first transformation programme. |
| ○ Vaccination and immunisation – staff and residents | Yes | We are working closely with GM and all providers to support the flu and COVID vaccinations this winter. We have an active boroughwide immunisation group that involves all stakeholders and works to address barriers and health inequalities. An additional weekly meeting is currently in operation to ensure the COVID vaccination programme is successful following a number of national changes to the programme. |
| ○ Remote monitoring | | |
| ○ Urgent community response (including falls response) | Yes | WWL Community provides:<br>• Community React Team (CRT) Advanced Nurse Practitioners and GPs for acute illness within Urgent Care 2-hour Response.<br>• Hospital at Home for planned interventions which aid admissions avoidance (e.g., IV drugs and Blood Transfusions)<br>• Hospital at Home provide urgent care provision for blocked catheter management.<br>• District Nurses provide planned nursing care for patients in Residential Care Homes (e.g., Wound care, drug administration for time critical medications)<br>• Wigan Reduction of Long Lies (WROLL) ACP and AHP attends emergency falls referred by NWAS. |

| Key question and points to consider | Response | |
|---|---|---|
| ○ Provision of enhanced clinical support 2000-0800 | Yes | Provided by the GP Out of Hours service and District Nursing service |
| ○ Virtual wards | Yes | WWL Community Division provide Virtual Ward care with capacity for 100 beds for pathways which relate to:<br>• Step up.<br>• Step down<br>• Monitoring at home<br>(e.g., surgical, gastro, respiratory, covid, cardiac, frailty, orthopaedic) |
| ○ End of life care planning | Yes | EPACCS Electronic records are always available to be created, updated, and discontinued as required for each patient to enable system wide approach in delivering Palliative and End of Life Care.<br><br>End of Life care planning is delivered through PCN arrangements in collaboration with WWL Community Division who provide End of Life care via<br>District Nurse End of Life (EoL) provision in conjunction with WHISPA (Wigan Hospice service)<br><br>Wigan Hospice provides in reach support and a community teams response |
| **KLOE-1.7: Christmas and New Yea**<br>• Outline the steps, including commissioning actions, which are being taken or planned to ensure core services remain accessible to the public over the Christmas and New Year period – specifically between 18 December 2023 and 8 January 2024 in responding consider at a minimum: | The well-established Wigan system Bank Holiday planner will be utilised over the Christmas & New year and will be distributed prior to the holiday period, this is a method utilised and proven in previous years.<br><br>WWL is developing robust plans (revised on an annual basis) to ensure:<br>• Access to and availability of acute A & E services including urgent treatment centre, walk-in centre.<br>• Access to emergency medical, surgical, trauma & gynaecological interventions for all age groups | |

| Key question and points to consider | Response |
|---|---|
| • General practice | Work with PCNs and GP Alliance (Enhanced Access Contract) to ensure that capacity is focussed across the key winter period, without impacting on wider timescales. This is a method utilised and proven in previous years.<br><br>General Practice survey planned for Sept/Oct to understand the impact of Capacity and Access Improvement plans in introducing new ways of working across the period to support final planning and shared learning. |
| • Dentistry | Patients can access urgent dental treatment between 8.00am – 10.00pm every day of the year.<br>Patients needing urgent dental treatment will be offered 20 minutes appointment across all 10 GM locations – Commissioned by NHSE |
| • Community pharmacy | Ongoing work with community pharmacy to support a clear understanding of expected opening and delivery during the period. From this we would look to commission any additional capacity/opening during bank holiday periods in line with previous winter plans. |
| • Specialist helplines | • GMMH has an established Trust wide 24/7 helpline (which includes Wigan locality) linked to 111 CAS services (including direct transfer of calls via Adastra). The soft launch of 111 dial 2 for mental health is planned for December 2023.<br>• GMMH has access to Crisis Cafés (Wigan locality plans under development)<br>• Wigan Hospice 24/7 helpline |
| • Hospice support | Wigan and Leigh Hospice provides continuous inpatient EOL care facilities throughout the Christmas and New Year Period. The WHISPAR triage service will be available seven days a week using the electronic WHISPAR referral process and prioritised support to patients in their homes and community setting. 24/7 Hospice help line for patients and clinical staff will also be available.<br><br>St Annes Hospice provides additional inpatient capacity where required. |

| Key question and points to consider | Response |
|---|---|
| | Derian House Childrens Hospice provides urgent inpatient triage and admission, and outreach services will support Childrens services across Wigan borough for Palliative and EOL Care in a community setting. |

## KLOE 2: high-impact interventions

| Key question and points to consider | Response |
|---|---|
| **KLOE-2.1: How will your choices to implement the high impact initiatives from the UEC Recovery Plan support you to achieve the required 4-hour Cat 2 ambulance performance over winter?** | We have the following interventions in place:<br>1. Dedicated team leading a project on improvement of ambulance handover times. The work has progressed well and over the last quarter reduced the over 60-minute ambulance transfer delays to under 4% by July 2023.The average ambulance handover time has continued to improve and reduced to 20 minutes in June 2023. This work will continue over the summer/autumn period.<br>2. Flow improvement project in the form of:<br>a. Streaming of patients to alternative services (Medical SDEC, Frailty SDEC, streaming to virtual ward)<br>b. Scheduled – unscheduled care initiative that frees up beds for the A & E and provides flow to alleviate handover delays.<br>c. Development of a Discharge Planning Unit that will focus keeping patients from deconditioning while supporting early discharges.<br>d. Discharge before 12 noon and enhanced weekend discharge programme |

| Key question and points to consider | Response |
|---|---|
| | The dedicated support from ECIST and Newton Europe will support with the improvement programmes and ensuring sustainability of transformation. |
| As per the Universal Improvement Offer, you have submitted self-assessments against all 10 high impact initiatives and have identified 4 of the high impact initiatives to prioritise ahead of winter.<br>• Are there other high-impact interventions relevant to the system that are being prioritised?<br>• Are there robust plans in place to make a material impact on these interventions ready for winter?<br>• How will the system monitor progress against these interventions?<br>• What executive leadership for priority interventions is in place? | WWL have not completed the UEC maturity assessment – as per letter from Sarah Jane Marsh – the UEC maturity matrix is not for Trusts receiving Tier 1 support.<br><br>Information data pack for the national team visit which covers the 10 High impact initiatives is embedded.<br>  <br>Slides for ECIST Visit.pptx<br><br>The dedicated intense support from ECIST and Newton Europe will support the development and delivery of any further system or service improvements/interventions required. Monitoring of progress will be embedded as part of this process.<br><br>Executive Leadership is via the HWP System Board. The Executive Directors responsible for the system improvements are the Deputy CEO, WWL, Director of Integration WWL/Wigan Council and the DPBL NHS GM Wigan. |
| **KLOE-2.2: How will the system ensure adequate improvement capability and capacity is in place to deliver on the high-impact interventions?**<br>• How many Recovery Champions have you identified?<br>• How will Recovery Champions supported to develop their improvement capability?<br>• How will Recovery Champions supported to commit sufficient time to the priority interventions? | We have not identified any specific recovery champions as this is aper of everyone's role who works to improve urgent and emergency care across Wigan. The members of the UECB are the leads for this area at senior level.<br><br>We have a number of Discharge and Flow Transformation Programmes in place with identified leads.<br>The programmes are:<br>1. Enhancement of Medical SDEC – achieving its targets<br>2. Frailty SDEC<br>3. Red to Green and implementation of EDD (using Nationally published guidance in Model Hospital) |

| Key question and points to consider | Response |
|---|---|
| • How will you make use of the full range of support available to all organisations in the system through tiers 1 and 2 where relevant and the universal support offer? | 4. Ambulance hand over programme<br>5. Additional streaming of A & E patients to Virtual Ward<br>6. Streaming of patients from inpatient beds (step down) to Virtual Ward<br><br>GM ICB is sharing the outputs from each of the recovery champion sessions with WWL to that we can learn from good practice in other localities.<br><br>WWL is also a part of the target support as part of the Tier 1 process |

**KLOE 3: discharge, intermediate care, and social care**

| Key question and points to consider | Response |
|---|---|
| **KLOE-3.1: What plans have been put in place to ensure effective joint working with relevant local authorities and social care?**<br>• Do care transfer hubs have clear line of sight to capacity challenges across intermediate and social care? | As part of the Integrated community services/home first transformation programme a review has been undertaken regarding community IMC capacity in the borough. Plans are currently being implemented regarding re modelling and re provision of these community beds including, JHRU (WWL), Community IMC beds (Care Homes), CAU (WWL) and The Rowens. Significant investment has been made into reablement capacity and the home first team.<br><br>There are daily operational calls with all system partners where any issues with capacity or delays are discussed, with issues which require director level support discussed at the escalation calls (x2 per week). |
| • Do you have a named system lead for discharge across health and social care to facilitate joint management of risk over the winter period? | Sharon Barber, Director of Integrated Service, Wigan Council/WWL, Mary Fleming, Deputy CEO WWL and Melissa Maguinness, DPBL NHS GM Wigan Locality. |

| Key question and points to consider | Response |
|---|---|
| • Are care transfer hubs fully operational with the relevant partners working together and reviewing all available data to deliver improvements? | As part of the integrated community services and home first transformation programme the existing TOCH team is currently under review with imminent steps in place to develop this service to be timelier, review pathways and review D2A paperwork and processes.<br>The social care element of this MDT has been restructured and is already functioning in a way that expediates discharge and retains people up to 6 weeks post discharge to prevent /reduce readmissions and create consistency for people and their families. Social care and health data is closely monitored. |
| • How will you ensure that the Discharge Ready Date field is being comprehensively completed to enable the metric to be published before winter, and subsequently used to improve local services? | The discharge ready fields will be available to WWL in October 2023 because of a HIS upgrade (this has taken some time due to the supplier ability to implement). |
| • What are the plans for escalation between the NHS, local authority, social care and VCSE providers to mitigate delays in discharging patients from general and acute and community beds over the winter period? And for step up / admission avoidance? | There are daily MDT escalation meetings already in place that can be increased if needed. A senior escalation meeting takes place twice per weekly and can also be increased.<br>The system employs a full time VCSFE worker based upon the wards to expediate discharge as well as pensioners link services available to take people home from hospital and ensure they are safe and warm once transported home.<br>This model also applies to MH services and wards.<br>Work regarding expansion of admission avoidance schemes/services is currently being developed through the Integrated community services and home first programme of work and includes the ongoing development of CRT, home first and virtual wards. |
| **KLOE-3.2: How will you meet any gap between demand and capacity identified in your Better Care Fund (BCF) intermediate care capacity and demand plan, or any additional gap because of demand that may occur over and above forecast levels:** | In our actual recent BCF submission we did not at the time forecast any gap between demand and capacity – this was on the basis of the additional 22/23 discharge funding being transferred into 23/24 BCF allocations – whilst we did assume additional demand through the 23/24 winter period in our figures, we were able to reconcile this through the following narrative in our submission. |

| Key question and points to consider | Response |
|---|---|
| • All Health and Wellbeing Boards have submitted BCF demand and capacity plans for intermediate care (step up and step down) for 2023/24. At ICB level, is there an intermediate care gap between demand and capacity projected for the winter period (November 2023 - March 2024)? And is there an intermediate care gap in your Intermediate Care level surge / super surge plans? | All assumptions regarding future demand and capacity are based on an analysis of recent actual activity with respect to length of stay in bed-based services and the average hours per home care package for each service. The demand and capacity projections for the winter period 2023/24 have been informed by previous learning and reflects the confidence of the locality in being able to flex key services in response to a potential rise in demand from acute services through key winter periods. This is due to the models of support we have established in the locality coupled with our relationship-based model of commissioning with the local care market. We also have some services which are delivered internally which gives additional flexibility and confidence in our ability to respond to temporary peaks in demand.<br><br>If any surges in demand occur, we will spot purchase additional home based and care home capacity to meet this. |
| • What are the plans to meet this gap through improving productivity, e.g., through reducing length of stay (in acute or community beds), or through reducing overprescription? Are there any further plans to meet this gap through increased commissioning of bedded and non-bedded intermediate care? If so, how much will this cost? Have these plans been developed with local authorities? | There are ongoing improvement plans to reduce NEL admissions and length of stay in the acute wards. There are also significant system wide plans to support more people to stay well and independent at home and support more people back to their own home post a hospital stays. Increased capacity has been commissioned for IMC – both home and bed base and the occupancy and LoS in the IMB bed base is being maximised.<br><br>The ECIST and Newton Europe work is supporting with these system wide plans. |
| • How well developed are these plans and will they be in place (agreed, commissioned, and provided) by winter? Have these plans been shared with local authorities to inform the refreshed BCF plans that will be required in October? | All plans to commission bedded or non-bedded intermediate care are co-produced with system partners and are overseen by the Discharge and Flow Board (includes Admission Avoidance and Home First programmes). Wigan Council is leading this work, and these will form the basis of the refreshed BCF in October 2023. |
| **KLOE-3.3: Community hospital and Intermediate Care capacity** | The integrated community services and home first programme of will influence reduced length of stay by the alignment of care pathways focusing upon home first model of care. Community therapy in partnership with social care and reablement |

| Key question and points to consider | Response |
|---|---|
| • What steps will you take to deliver an improvement in the average length of stay across your community hospital beds by March 24? | will in reach into community beds supporting timely discharge planned throughout the programme of IMC being provided by community beds providers.<br>The transformation of the social care teams will remain consistent post discharge from hospital for a period of 6 weeks.<br>The introduction of IMC at Home. |
| • How will you improve Community Bed productivity and efficiency to maximise flow? | Consistent MDT community presence in the IMC services supporting people home. Ensuring that the current SOPs are appropriate and identify expectations of the service providers. Being clear about outcomes, support to be provided and expectations of timeliness of intervention and when to escalate, ask for support if progress is not taking place with individuals to ensure appropriate interventions by the MDTs to ensure the right outcomes for the person and their family and maximise flow. |
| • What plans do you have in place to develop a therapy-led intermediate care service for people on discharge pathways 1 and 2 to be in receipt of the service in a timely way? | We already have a home first service supporting people home from hospital and this has been invested in and recruitment is actively taking place to develop this service which is effective, showing good outcomes and importantly follows the home first principals expected by the borough.<br>We have a fully embedded TOCH pathway 1 team in place for 12 months and permanent funding secured. This team is run by reablement staff, home care 72 hours response staff, housing and VCSFE and has made a significant impact in moving people from P2 to P1 with no waiting list for P1 people.<br>We are now through our integrated community service/home first transformation plan developing a therapy led MDT front door team in partnership with our CAU in covering and taking people from ED and the wards and focusing upon admission avoidance and in expediating discharge using a therapy led and MDT (social care) intervention. We would like to expand this into Virtual wards.<br>System response – IMC Model<br>Council response - Reablement Model<br>WWL Response - IMC Therapy in Community Beds (Pathway 2) |

**KLOE 4: H2 numerical submission**

| Key question and points to consider | Response |
|---|---|
| **KLOE-4.1: demand assumptions**<br>• Explain any revised demand assumptions that are captured in the template. | Please see Greater Manchester System Response. |
| • Is there variance against demand assumptions for year to date. | |
| **KLOE-4.2: supply**<br>• Explain any variance in supply against the agreed 2023/24 plan. | Please see Greater Manchester System Response. |

**KLOE 5: Escalation plans**

| Key question and points to consider | Response |
|---|---|
| **KLOE-5.1: Describe the system escalation plan.**<br>• Using the anticipated non-elective demand scenario outlined in the numerical submission describe the point at which demand would outstrip the capacity profiled for surge and the steps that the system will take to respond to this. | Based on the submission in H2 of 2022-23, in the planning round – we have submitted that we will be at 99% occupancy towards the end of the fiscal year 2023-24. Additional capacity in the home care and care home market would be sourced in capacity exceeds expected levels.<br><br>Specific steps:<br>Discharge and Flow programme with 5 underpinning workstreams<br>Development & implementation of a Discharge Planning Unit for appropriately identified patients to enhance their discharge out of the acute hospital.<br>Development & implementation of a 'Frailty at Front Door Service' – a multidisciplinary approach to avoid admissions and support care in the community while preventing deconditioning of patients & eliminating corridor care. |

| Key question and points to consider | Response |
|---|---|
| • Specifically outline the consequences of this on other services. | WWL NHS Trust, has successfully throughout the Winter of 2022-23, managed the winter pressures through a systematic expansion of bed capacity to avoid a crisis while not compromising on elective activity. We plan to continue to deliver our planned elective activity while managing seasonal increasing demand on urgent and emergency care services |
| • Describe plans in place to expand adult and paediatric critical care capacity if needed? | We will work with system partners & GM colleagues to provide additional capacity through:<br>1. Mutual Aid<br>2. Reactivating plans implemented during COVID |
| • Describe the whole system escalation plan including primary care, social care, and local authority. | This is managed through the daily escalation calls, in which all partners are involved. The escalation calls are in place twice a week. Escalation for GM mutual aid is in place and via the GM SCC as required. Silver and gold meetings will be stood up in accordance with the Wigan system escalation policy |
| • Describe how capacity, including capacity in high-impact intervention areas e.g., ARI hubs, will be expanded if demand exceeds planned capacity. | Capacity in high impact areas, such as SDEC, CRT etc will be expanded if demand outstrips capacity.<br><br>ARIs will be stepped up over the winter period to meet demand over the season. |
| **KLOE-5.2: Early warning**<br>• Describe the system approach to monitoring demand and early warning systems in place. | Greater Manchester has access to wealth of data, including live feeds from acute and mental health providers. The SCC monitors system demand and supports the enactment of appropriate actions in response to increasing levels of pressure. |

**KLOE 6: Workforce**

| Key question and points to consider | Response |
|---|---|
| **KLOE-6.1: How will you ensure adequate staffing levels are in place to meet anticipated demand?**<br>• How have you modelled your workforce requirements for permanent clinical and non-clinical staff to deliver a resilient | Primary Care are regularly adjusting workforce requirements to manage demand as much as possible, utilising the core contract and enhanced access services. Learning from previous years will be utilised to ensure |

| Key question and points to consider | Response |
|---|---|
| winter – ensure that you have considered all parts of the system. | critical periods after bank holidays have additional staff available across General Practice to support in potential "surges" in patients.<br><br>Social care workforce is modelled upon existing high-level demand. It can in its current capacity manage some seasonal surge but would have to draw upon other parts of its system if this increased significantly. There could also be a budgetary impact if we had to grow and invest into additional home care capacity.<br><br>WWL is developing a whole organisation workforce plan (clinical and non-clinical for all acute and community services) |
| • Do you have the required level of staffing in place to deliver the planned capacity outlined in the 2023/24 operating plan for the system? | Yes |
| • If there is a deficit in workforce what are your plans to meet this – how confident is the system in meeting this deficit? | There is currently no deficit in social care workforce services but there is a requirement to look at developing a night support service to enhance the home first services. This would require system additional investment and transformation.<br><br>WWL is developing a whole organisation workforce plan (clinical and non-clinical for all acute and community services) |
| • How much temporary workforce is required to support across winter? | There may be a requirement given a significant surge/increased demand be a requirement for additional home care or agency social worker's staff.<br><br>WWL is developing a whole organisation workforce plan (clinical and non-clinical for all acute and community services) |
| • Have you onboarded current staff within all partner organisations to staff banks for deployment during periods of escalation? | This work is underway as part of the wider workforce planning |

| Key question and points to consider | Response |
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| • What plans to you have to maximise the community workforce to ensure rehabilitation and reablement are delivered to all people requiring Intermediate Care services? | Reablement teams and home care services have already been significantly invested in to manage current demand and surge. |
| **KLOE-6.2: How will the system work together to support one another from a workforce perspective?**<br>• Are the correct systems and processes in place to support the deployment of staff from one provider to another where necessary? | Within social care staff can be deployed from within the council to where risk and priority are a priority.<br><br>All Provider Trusts are now signed up to NHS Professionals.<br><br>WWL has established systems in place to redeploy staff across services which need additional capacity. |

| Key question and points to consider | Response |
|---|---|
| **KLOE-6.3: How will staff wellbeing be prioritised across winter?**<br>• What initiatives are in placed to support staff wellbeing across the winter? | Some initiatives are already in place to support the workforce by visible senior leadership, sharing of and inclusion of the workforce in transformation plans and opportunities for teams to get to know each other and build trust, confidence, and value each other profession, roles, and challenges.<br>Social care staff have regular supervision, team meetings / briefings and see and talk to senior leaders.<br><br>All Wigan staff are kept fully up to date with of all the GM wellbeing programmes and the individual organisational support services and offers. |
| • When is planned and unplanned absenteeism expected to be highest and are arrangements in place to ensure this is aligned with demand and capacity? | Christmas holidays will be managed with backup if required. Social care services will be open through the holidays excluding Christmas day.<br><br>WWL is developing a whole organisation workforce plan (clinical and non-clinical for all acute and community services) |
| • What plans are in place to support a successful vaccination programme for influenza and Covid-19 if recommended for staff and volunteers? | We are working closely with GM and all providers to support the flu and COVID vaccinations this winter. We have an active boroughwide immunisation group that involves all stakeholders and works to address barriers and health inequalities. An additional weekly meeting is currently in operation to ensure the COVID vaccination programme is successful following a number of national changes to the programme. |
| **KLOE-6.4: How are you maximising the role of VCSE partners?**<br>• What assumptions have been made about the role of VCSE partners in supporting the workforce this winter? | We already have VCSFE support in place as described above. |
| • What steps have you taken to maximise the role of VCSE partners this winter? | We have good relationships with our VCSFE providers, and they are part of the UEC board and could be called upon to look to offer additional support if required. |

| Key question and points to consider | Response |
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| | Examples of the support already in place:<br>• the use of voluntary transport services via Pensioners Link to ease pressures of NHS transportation services<br>• Support speedier pathway 0/1 discharges via providing food parcels and free shopping services including utility vouchers via welfare support, and voluntary organisations such as The Brick, Pensioners Link, Fur Clempt, Veteran Services etc.<br>• Provide stop gap heating supplies for patients to discharge home safely and be followed up by our AWARM scheme.<br>• Prioritise homeless patients for discharge with support from ABEN and the Quality hotel to ensure place of safety.<br>• Provide suitable clothing and essentials for discharging patients with support from The Brick and other similar organisations |
| • How will the relationship with VCSE partners be managed at a system-level to ensure the greatest level of integration and joint working? | MH commissioning budgets have allocated 20% of investment to be used in partnership with VCSFE services.<br>The Council and partnership with Wigan ICB have a programme of work with VCSFE leads.<br>The UEC board and MH transformation board have VCSFE leads members |
| • What steps has the system taken to maximise the role of NHS and Care Volunteer Responders? | We are currently unaware of the potential to use this resource. We have as a system a strong volunteer base that is utilised locally as can be seen from the answers above. |

# Winter 2023/24 Planning Submission

| | |
|---|---|
| **ICB name:** | **NHS Greater Manchester Integrated Care** |
| **Approved for submission by:** | NHS GM UEC Board |

**Notes on completion:**

1. This document outlines the narrative key lines of enquiry that ICBs are asked to respond to as part of the NHS England winter planning exercise for 2023/24.
2. The purpose of this document, and the associated H2 numerical planning template, is to support ICBs to lead a system-wide planning processes ahead of winter.
3. The narrative questions in this document are designed to provide a prompt for areas that required consideration, and to provide the necessary assurance that steps have been taken at a system-level to prepare for a resilient winter period.
4. The narrative submission should be completed in conjunction with the H2 numerical planning submission, and system partners should refer to the system winter roles and responsibilities issued as part of the winter planning process on 27 July 2023.
5. Recently completed UEC Maturity Indices that were issued as part of the NHS Impact improvement offer should be considered alongside these plans to inform system thinking on which areas locally require the most focussed attention in the run up to, and during, winter.
6. ICBs are responsible for producing one comprehensive response for the system, there should be a focus on ensuring that all parts of the system, including Local Authority partners, are engaged in developing this. Updated intermediate care capacity and demand plans at HWB level will need to be agreed with local authorities and submitted in October as part of BCF quarterly reporting. The BCF plans should reflect agreed changes to capacity and demand management agreed in these ICB plans.
7. There is a total of six key lines of enquiry with associated questions across the following areas:

    a. System-working
    b. High-impact interventions
    c. Discharge, intermediate care, and social care
    d. H2 numerical planning submission
    e. Surge plans
    f. Workforce

**KLOE 1: How will the system work together to deliver on its collective responsibilities?**

| Key question and points to consider | Response |
|---|---|
| **KLOE-1.1: How has each part of the system been engaged?**<br><br>• How have roles and responsibilities been communicated to and agreed with each part of the system?<br>• How has each part of the system been engaged to support the development and delivery of the winter plan?<br>• How have local authority, social care and VCSE (voluntary, community or social enterprise) partners been engaged with developing the system winter plan? | The GM UEC Team has engaged with the locality UEC leads and wider colleagues including Mental Health, NWAS, ASC, chief operating officers, place based leads and wider stakeholders to ensure plans are in place for winter.<br><br>As part of the KLOE and numerical template, GM have requested each localities winter plans and these plans will be signed off by GM ICB executive. |
| **KLOE-1.2: How will you assure that each part of the system is delivering against its roles and responsibilities?**<br><br>• What is the mechanism for system partners to hold one another to account for delivering on their roles and responsibilities?<br>• How have key interdependencies between parts of the system been identified, and how will they be managed?<br>• What are the key risks to delivery of the plan in each part of the system, and how will they be mitigated? | The overall assurance for delivering the roles and responsibilities of the winter plan sit with the GM UEC Board, which meets monthly with a wide range of stakeholders. The Board is chaired by the GM ICB COO in partnership with the GM Trust Provider Collaborative UEC Lead. The GM Board requires each of the 10 localities to be represented and for each of the sector leads to be represented to ensure clear communication and oversight of the large and complex system.<br>The Board governance can be seen in the chart below which describes the interdependencies between the system. |

| Key question and points to consider | Response |
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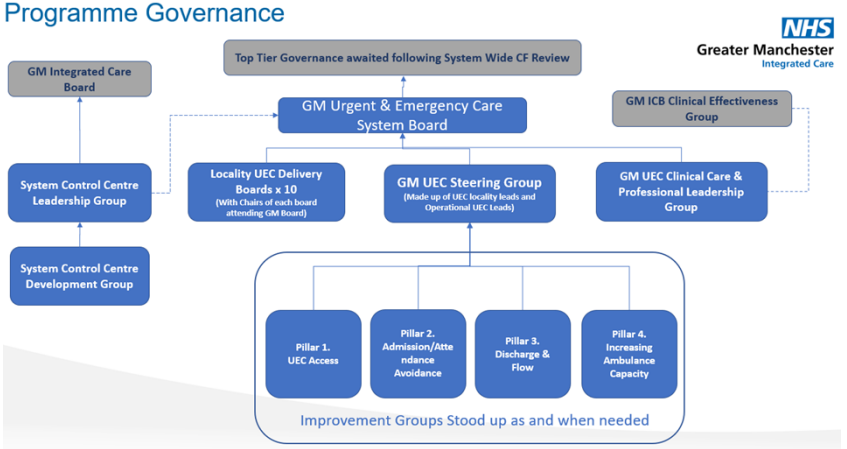
| | Programme Governance<br>  <br><br>The GM UEC Team monitors and mitigates the risks on the Board risk register and is updated monthly. The key risks identified for the GM system are the following: -<br>• Workforce challenges - the ability to recruit and cover service provision in the event of IPC issues or further IA.<br>• Industrial action - disruption to the system and flow, impacting on the delivery of community services and UEC services, dependant of the nature of the IA.<br>• Demand exceeding capacity.<br>• Infection Control Outbreaks and high prevalence of viruses in the community such as Covid & Flu, causing additional demand in the system,<br>• Finance challenges, impacting on the delivery of services. GM face significant financial pressure across the whole ICS, YTD this position has worsened and is requiring the system to make some difficult decisions that may impact on service delivery. |

| Key question and points to consider | Response |
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| | • Increased demand and long delays for Mental Health patients<br>• Risks relating to care home capacity, with a number of localities experiencing Care home closures or re-registrations, impacting on flow out of hospital.<br>Further detail of specific locality risks can be seen in each of the locality submissions.<br>The System Control Centre (SCC) support the monitoring of performance on a day to day, escalation, and risk management. The GM model has the ability to stand up the GM SCC Leadership Group dependant on the level of escalation to ensure risks are managed and collective mutual aid across the system can be sought, |
| **KLOE-1.3: How will the system deliver on the roles and responsibilities identified by NHSE - respond for each area as below:**<br>• Integrated Care Boards<br>• Acute and Specialist NHS Trusts<br>• Primary Care<br>• Children and Young People services<br>• Community Trust and Integrated Care Providers<br>• Ambulance Trusts (where the ICB is the lead commissioner)<br>• Mental Health | **Integrated Care Boards**: Integrated Care Boards and Integrated Care Partnerships – along with the legal requirement to create an ICS strategy and an NHS Joint Forward Plan |
| | **Acute and Specialist NHS Trusts:** NHS Trusts and FTs – received a legal duty to collaborate – became partner members of ICB boards and the expectation to join provider collaboratives and place-based partnerships.<br>GM has a strong well established Trust Provider Collaborative (TPC). The collaborative work together through combined CEO leadership, with relevant triumvirate groups also working in partnership, such as Chief Operating Officers, Chief Nurses and Chief Medical Directors. |

| Key question and points to consider | Response |
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| | The TPC work collectively for improved outcomes of patients across GM, ensuring mutual aid when necessary and that individual organisational decisions do not have negative impact on others across GM wherever possible. |
| | **Primary Care:** GM Primary Care Collaborative Brings together primary care representatives from across GM to support transformation and be the voice of primary care at scale. They continually review focus to ensure most effective delivery of the primary care agenda.<br><br>Together they deliver the following objectives through their collaborative working.<br><br>The Optimisation of:<br>• GM Community Urgent Eye Care Service to avoid presentation at UEC<br>• Dental Quality Scheme – enabling greater access for patients.<br>• Community Pharmacy Referral Scheme<br>• Embedding GP/Community Pharmacy Interface principles, alleviating pressures for providers therefore preventing unnecessary attendances/appts and resilience in dispensing<br>• Enabling self-referrals / direct access to community services as per Op Planning Guidance and NHSE Primary Care Access Recovery Plan to alleviate pressures/enable capacity in General Practice |

| Key question and points to consider | Response |
|---|---|
| | • Pan GM wide support for mobilisation of locality schemes, i.e. enabling integrated pathways, direct booking, reporting of activity data<br>• Embedding primary/secondary care interface principles as directed by the GM Working Group building on the GM principles and recommendations in the NHSE Primary Care Access Recovery Plan<br>• Ensuring uptake of GM/National training to General Practice / PCNs to adopt the Modern General Practice Access Model<br>Further locality level details can be found in the locality KLOE submissions. |
| | **Children and Young People Services:** GM Children and Young People's Group is to have joint oversight for delivery of CYP services, ensure alignment of priorities across health and care, review system performance and understand transformation needs.<br>The CYP network are linked into the winter planning process for GM, work collectively across providers and are well connected to the SCC to ensure escalation is managed if necessary. |
| | **Community Trusts and Integrated Care Providers:** The GM Sustainable services group and Place based partnership committees ensure the community trusts deliver on the roles and responsibilities, further information of these at locality level can be found in the locality submissions. |
| | **Ambulance Trust:** NWAS are member of the GM Trust Provider Collaborative which supports in the delivery of |

| Key question and points to consider | Response |
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| | improving category 2 ambulance response times by Collectively assessing and implementing solutions where services are vulnerable in their current configuration, to deliver better patient outcomes, or greater efficiency and quality.<br>The trust drive consistency to enable appropriate and efficient system level management of services, deliver resilience and mutual aid across current services to respond to peaks and troughs in demand, as well as sharing best practice. NWAS are well engaged in the Gm UEC Board and the GM SCC structures. |
| | **Mental Health:** The GM Provider led Mental Health Group brings together all mental health providers in GM to support transformation and commissioning of mental health services at scale. It also supports and oversees the transformation of mental health services and advance equalities in access, experience, and outcomes for people with MH needs.<br>Mental Health providers are fully connected into the GM UEC Board and the SCC structures, ensuring any interdependencies between the UEC and MH agenda are recognised and understood, avoiding duplication and ensuring good joined up working.<br>Further details on the Mental Health Winter planning work can be found in the supporting documents. |
| | **Local authorities and social care:** Place based partnership committees and Health and Well Being boards, as well as Neighbourhood boards help facilitate the effective delivery of services at a local level, maximising the use of local resources and coordinating care effectively to prevent ill health. |

| Key question and points to consider | Response |
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| | Further detail on these can be found in the locality's submissions. |
| **KLOE-1.4: How will the ICB lead the system through the winter period?**<br><br>• How will 24/7 oversight of system pressures through the System Coordination Centre (SCC) be maintained?<br>• How will the ICB ensure the appropriate structures, systems and process are in place to maintain operational oversight and delivery?<br>• How will executive level and senior clinical leadership be used to deliver a successful winter for the system? | The Greater Manchester System Control Centre (GM SCC) was established on the 1st of December 2022 in line with specification guidance and is well established.<br>The operating model is currently under review to ensure alignment with revised guidance published in August 2023 and a revised System Coordination Centre will be established by the 1st of November 2023 with appropriate structures and processes in place to maintain operational oversight and delivery.<br>The SCC has daily oversight of the GM system with live data feeds from all providers and wider parts of the system. In addition to the National OPEL escalation procedures, GM have an agreed set of escalation management policies that are operationalised by the SCC. These policies and procedures allow for the system to come together to support de-escalation through key actions and mutual aid processes. Escalation management is embedded as well as strong links with EPRR structures.<br>The current model is supported by senior clinical leadership through an on-call rota of Medical Executives, similarly, the SCC is supported by an Executive On-Call rota. This model is under review in line with the revised guidance, to ensure that executive and senior clinical leadership are fully embedded into the operating model of the System Coordination Centre.<br>The SCC reports through to NHS GM's Board and is held to account by NHS GM ICB. The chart below highlights the |

| Key question and points to consider | Response |
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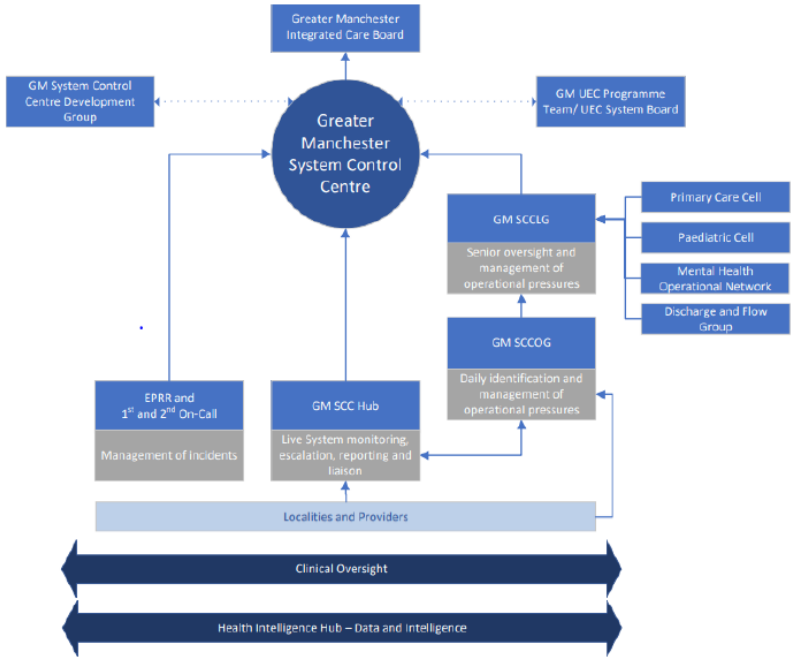
| | governance of the SCC and the model that supports the escalation.<br>  <br><br>Reviews of rotas to cover the resourcing of the operational SCC model are underway to ensure sufficient capacity and cover on a day-to-day basis over the challenging winter period. |
| **KLOE-1.5: Infection Prevention and Control (IPC)** | Detailed plans for IPC management at locality level can be found in the locality submissions. |

| Key question and points to consider | Response |
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| • How have IPC colleagues been involved in the development of the system Winter plan?<br>• What plans have been put in place to promote optimisation of IPC practices and effect Healthcare Associated Infection (HCAI) prevention/reduction in hospitals and community care settings?<br>• What support has been put in place at a system level to, ensure IPC provision to care homes and step-down intermediate care facilities in preventing and reducing infection transmission, and aid capacity to discharge patients? | Any IPC issues affecting flow are monitored through the SCC at GM level and through the TPC through the Chief Nurses and DIPC's. |
| **KLOE-1.6: Support for care homes**<br><br>• What is the overall offer to care homes in supporting residents to remain well, access timely support, care, treatment, and advice and to remain in the care home for their care and treatment wherever possible avoiding unnecessary hospital admission.<br>• The recommended roles and responsibilities for each part of the system detail several areas which should support care homes and care home residents – specifically how will care homes be supported through both a proactive and reactive care approach across the following areas:<br>  ○ Enhanced health in care homes<br>  ○ Personalised care and support planning<br>  ○ Oral health<br>  ○ Falls prevention exercises. | Through our locality and integrated neighbourhood working, we take an integrated approach to supporting care homes and driving performance and quality improvements jointly together across health and social care.<br><br>Our locality commissioning takes a system perspective to ensure that the relevant services have been commissioned to support people to continue to live well in care homes.<br><br>We are currently experiencing high levels of risk in our nursing care homes and have agreed as a system that we will bolster and grow some of our exiting best practice e.g. based on the enhanced health in care homes framework, blended roles etc. to further support our independent care home providers during this time of heightened risk and into the future, to ensure long-term market sustainability |

| Key question and points to consider | Response |
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| ○ Vaccination and immunisation – staff and residents<br>○ Remote monitoring<br>○ Urgent community response (including falls response)<br>○ Provision of enhanced clinical support 2000-0800<br>○ Virtual wards<br>○ End of life care planning | Through our living well at home programme, care homes can access funding to digitise their social care records, and we are currently considering how best to promote better personalised care and support planning across social care settings.<br>GM ICB are leading the commencement of vaccination programme across Care Homes, which will commence in line with national guidelines.<br><br>Across GM some localities are looking to increase referrals via community pathways into virtual ward services, this is looking to further improve on the 80% bed occupancy by end September 2023 and beyond. 2 pathways have been clinically agreed and are live, other pathways actively being worked upon to support as we lead into Winter.<br><br>Care Homes have access to UCR across GM, although access is good and response performance in GM benchmarks well, further work to increase referrals into 2-hour UCR via all sources including primary care and care homes with a particular focus on NHS111 and 999 is ongoing.<br><br>Localities looking to improve flow through A&E departments with increase in direct referral into SDEC to include care homes. There will be some further communication work across GM to promote SDEC services to maximise utilisation.<br><br>GM is supporting systems to use all available capacity across the market, with regard to Enhanced Help in care Homes |

| Key question and points to consider | Response |
|---|---|
| | (EHCH). Work will be undertaken to improve the use of Transfer of Care Hubs (TOCH), working with local authorities and system partners to understand short and long-term packages of care over the next year but to support the Winter period.<br><br>Further details for each locality can be found in the locality submissions. |
| **KLOE-1.7: Christmas and New Year**<br><br>• Outline the steps, including commissioning actions, that are being taken or planned to ensure core services remain accessible to the public over the Christmas and New Year period – specifically between 18 December 2023 and 8 January 2024 in responding consider at a minimum:<br><br>○ General practice<br>○ Dentistry<br>○ Community pharmacy<br>○ Specialist helplines<br>○ Hospice support | Please see the locality submissions for the details of commissioning in each locality.<br><br>In addition to this, the Greater Manchester System Control Centre provides oversight and assurance to bank holiday arrangements to ensure that cover is appropriate and mitigate any identified risks where appropriate, this includes liaising with all localities and partner organisations.<br><br>The GM CAS (Clinical Assessment Service) has been commissioned at a GM level to support patients directed from 999 & 111. In preparation for winter detailed demand and capacity modelling has been done for this service, which has resulted in a re-profiling exercise for the service, this will now allow for increased capacity over winter to support and increased demand through 999 and 111. |

**KLOE 2: high-impact interventions**

| Key question and points to consider | Response |
|---|---|
| **KLOE-2.1: How will your choices to implement the high impact initiatives from the UEC Recovery Plan support you to achieve the required 4-hour Cat 2 ambulance performance over winter?**<br><br>As per the Universal Improvement Offer, you have submitted self-assessments against all 10 high impact initiatives and have identified 4 of the high impact initiatives to prioritise ahead of winter.<br><br>• Are there other high-impact interventions relevant to the system that are being prioritised?<br>• Are there robust plans in place to make a material impact on these interventions ready for winter?<br>• How will the system monitor progress against these interventions?<br>• What executive leadership for priority interventions is in place? | The GM system are engaged in the national UEC improvement support programme and the maturity matrix has been completed by all localities, which identified issues with ARI Hubs, Single Point of Access, Virtual Wards and Frailty.<br><br>Pan GM initiatives, have included: -<br>• The GM Hospital Handover Improvement working group to support sustaining the improvement in Handover and supporting the achievement of the required 4 hour Cat 2 performance.<br><br>• A Winter learning event with Divisional Directors of Performance/Managing Directors within acute providers, to understand what worked well last winter to inform decisions for this year has taken place and learning has been shared.<br><br>The GM UEC Team are working with ECIST, GIRFT and our focussed localities to provide support to the improvement of these areas.<br>The GM UEC Board has oversight of performance improvement and provides support to localities via UEC Locality Boards.<br>Further detail on how localities are ensuring compliance in this area can be found in the locality submissions. |

| Key question and points to consider | Response |
|---|---|
| **KLOE-2.2: How will the system ensure adequate improvement capability and capacity is in place to deliver on the high-impact interventions?**<br><br>• How many Recovery Champions have you identified?<br>• How will Recovery Champions supported to develop their improvement capability?<br>• How will Recovery Champions supported to commit sufficient time to the priority interventions?<br>• How will you make use of the full range of support available to all organisations in the system through tiers 1 and 2 where relevant and the universal support offer? | GM have identified 25 iUEC recovery champions from across Greater Manchester from Providers, localities, and the GM UEC team.<br><br>Support will be offered through ECIST and GIRFT for some Tier 1 initiatives, in addition there is access to Pan GM peer support networks and improvement groups.<br><br>Each locality submission, includes further details. |

**KLOE 3: discharge, intermediate care, and social care**

| Key question and points to consider | Response |
|---|---|
| **KLOE-3.1: What plans have been put in place to ensure effective joint working with relevant local authorities and social care?**<br><br>• Do care transfer hubs have clear line of sight to capacity challenges across intermediate and social care?<br>• Do you have a named system lead for discharge across health and social care to facilitate joint management of risk over the winter period? | From a GM perspective access to real time data for Adult social care capacity is a challenge, particularly for workforce, however work is ongoing with localities to improve this identified gap.<br><br>There are named leads at GM level for discharge across health and social care, within the ICB and through the DAS network. These are also available with regard to Mental Health Discharge. Discussions take place through the GM Discharge & Flow Group, which can escalate up to the GM Board if required. |

| Key question and points to consider | Response |
|---|---|
| • Are care transfer hubs fully operational with the relevant partners working together and reviewing all available data to deliver improvements?<br>• How will you ensure that the Discharge Ready Date field is being comprehensively completed to enable the metric to be published before winter, and subsequently used to improve local services?<br>• What are the plans for escalation between the NHS, local authority, social care and VCSE providers to mitigate delays in discharging patients from general and acute and community beds over the winter period? And for step up / admission avoidance? | Not all care transfer hubs are fully operational, this was identified in the Maturity Matrix. Work continues at locality level.<br><br>VCSE partners are included in all the GM Level Governance Meetings, and the Gm escalation framework recognises the pressures in VCSE providers.<br><br>VCSE partners play a key role in locality discussions and delivery of UEC, further details can be found in each locality submission. |
| **KLOE-3.2: How will you meet any gap between demand and capacity identified in your Better Care Fund (BCF) intermediate care capacity and demand plan, or any additional gap as a result of demand that may occur over and above forecast levels:**<br><br>• All Health and Wellbeing Boards have submitted BCF demand and capacity plans for intermediate care (step up and step down) for 2023/24. At ICB level, is there an intermediate care gap between demand and capacity projected for the winter period (November 2023 - March 2024)? And is there an intermediate care gap in your Intermediate Care level surge / super surge plans?<br>• What are the plans to meet this gap through improving productivity, e.g., through reducing length of stay (in acute or community beds), or through reducing overprescription? Are there any further plans to meet this | Please see details in each of the locality submissions. |

| Key question and points to consider | Response |
|---|---|
| gap through increased commissioning of bedded and non-bedded intermediate care? If so, how much will this cost? Have these plans been developed with local authorities?<br>• How well developed are these plans and will they be in place (agreed, commissioned, and provided) by winter? Have these plans been shared with local authorities to inform the refreshed BCF plans that will be required in October? | |
| **KLOE-3.3: Community hospital and Intermediate Care capacity**<br><br>• What steps will you take to deliver an improvement in the average length of stay across your community hospital beds by March 24?<br>• How will you improve Community Bed productivity and efficiency to maximise flow?<br>• What plans do you have in place to develop a therapy-led intermediate care service for people on discharge pathways 1 and 2 to be in receipt of the service in a timely way? | Please see details in each of the locality submissions. |

**KLOE 4: H2 numerical submission**

| Key question and points to consider | Response |
|---|---|
| **KLOE-4.1: demand assumptions**<br><br>• Explain any revised demand assumptions that are captured in the template.<br>• Is there variance against demand assumptions for year to date. | There has been no revision of the demand assumptions from any of the providers within Greater Manchester that have been captured within the template. The planned A&E and NEL activity remains the same as what was submitted within the operational planning round.<br><br>Year to date GM is slightly under the planned activity for both A&E and NEL Admissions |
| **KLOE-4.2: supply**<br>• Explain any variance in supply against the agreed 2023/24 plan. | Changes have been made regarding G&A Bed capacity across GM, some providers have re-profiled their capacity, by either reducing capacity in the early winter months, compared to original plans, or increasing capacity in the later winter months in the form of escalation beds. One of our providers has re-designated a G&A ward to a community ward, which is resulting in a reduction of G&A beds compared to their original submission. These providers include NCA, MFT & WWL.<br><br>As a system our localities continue to work hard on preventing A&E and NEL admissions. The work includes increased activity in SDEC, UCR, Virtual Wards and other services. Through 111 and access to the DoS, this supports the patient journey to the most appropriate service and keeping them away from the ED front door. |

**KLOE 5: Escalation plans**

| Key question and points to consider | Response |
|---|---|
| **KLOE-5.1: Describe the system escalation plan**<br><br>• Using the anticipated non-elective demand scenario outlined in the numerical submission describe the point at which demand would outstrip the capacity profiled for surge and the steps that the system will take to respond to this.<br>• Specifically outline the consequences of this on other services.<br>• Describe plans in place to expand adult and paediatric critical care capacity if needed?<br>• Describe the whole system escalation plan including primary care, social care, and local authority.<br>• Describe how capacity, including capacity in high-impact intervention areas e.g., ARI hubs, will be expanded in the event that demand exceeds planned capacity. | Greater Manchester has an agreed Escalation Framework, which enables the system to understand the levels of pressure across all parts of the GM system including primary care, social care, acute trust sites and mental health.<br>Action cards are in place for all system partners to respond to whole system pressure. This is currently under review of as part of the system-wide implementation of the revised OPEL framework.<br>The above is actioned through the SCC, further details for each locality can be found in the locality submissions. In addition further information regarding Mental Health providers can be found in the supplementary documents. |
| **KLOE-5.2: Early warning**<br><br>• Describe the system approach to monitoring demand and early warning systems in place. | Greater Manchester has access to wealth of data, including live feeds from acute and mental health providers. The SCC monitors system demand and supports the enactment of appropriate actions in response to increasing levels of pressure.<br><br>Additional locality information can be found in the locality submissions. |

**KLOE 6: Workforce**

| Key question and points to consider | Response |
|---|---|
| **KLOE-6.1: How will you ensure adequate staffing levels are in place to meet anticipated demand?**<br><br>• How have you modelled your workforce requirements for permanent clinical and non-clinical staff to deliver a resilient winter – ensure that you have considered all parts of the system.<br>• Do you have the required level of staffing in place to deliver the planned capacity outlined in the 2023/24 operating plan for the system?<br>• If there is a deficit in workforce what are your plans to meet this – how confident is the system in meeting this deficit?<br>• How much temporary workforce is required to support across winter?<br>• Have you onboarded current staff within all partner organisations to staff banks for deployment during periods of escalation?<br>• What plans to you have to maximise the community workforce to ensure rehabilitation and reablement are delivered to all people requiring Intermediate Care services? | Each locality repose will contain details of the specifics of locality providers; however the GM team have worked with NWAS as a Pan GM service to understand the plans for staffing and demand management.<br><br>The following information has been provided by our NWAS partners to give a level of assurance against this KLOE.<br><br>The workforce position remains on track with the month 4 total wte for the Trust being 6867 against a planned position of 6939 wte. The factors affecting the position being slightly behind plan relate to a reconfiguration of training plans to address shortfalls in driver training capacity, this has affected the profile of courses across the year and the current shortfall to plan should be rectified across future quarters. There is an ongoing review of our position against the submitted plan with regular reviews of the position with Finance colleagues.<br><br>Recruitment strategy - comprehensive recruitment plans for front line and call centre roles, with an aim to maximise operation resources over the winter period. Recruitment plan include the UEC Recovery plan investment. The progress against the workforce elements of the plan are monitored through a UEC Recovery Plan group. |

| Key question and points to consider | Response |
|---|---|
| | Strategies to maximise frontline and call taker recruitment include:<br>• Deployment of attend only NQP Paramedics to ensure that Paramedic Graduates start prior to the winter period and then pick up blue light driving at a later date<br>• EMT 1 recruitment campaign<br>• Ongoing adverts for Qualified EMT 1 and Paramedic recruitment<br>• 999 contact centre training plans are robust and current projection would see an over establishment in early Q4. As such, meetings are ongoing to finalise exact requirements and will potentially lead to standing down some courses in Q4. Current projections will put 999 call taker resources in a healthy position for the winte<br>• 111 health Advisor recruitment remains a challenge with ongoing discussion on how to mitigate. Actions include:<br>• Deployment of a comprehensive contact centre recruitment campaign, aiming to attract candidates who may not review traditional NHS advertising methods e.g. NHS jobs<br>• Utilising agency staff to fill training courses where there are short notice gaps in course numbers. These staff are employed on a 12 week temp to permanent contract<br>• Development of a joint 999 and 111 call taking JD which would allow the future flex of resources<br>• Ongoing focus on retention strategies including the development of a refreshed exit interview strategy<br>• Clinical Hub recruitment – Following UEC recover plan monies, the development of Band 7 Advanced |

| Key question and points to consider | Response |
|---|---|
| | Practitioner -Urgent and Emergency Care role in Clinical Hub. Campaign underway to recruit 75 practitioners (either Paramedics or nurses). Currently recruited 50 practitioners and further recruitment campaign to commence in September.<br><br>Attraction strategy – Specific focus on attracting a diverse pool of candidates to all roles. Initiatives around attraction include positive action work to support attracting applicants from the diverse communities the Trust serves. The Trust engaged an external consultant to undertake a recruitment audit earlier this year. And this has resulted in a number of recommendations to improve the Trusts recruitment and attraction to all minority groups with a specific focus on those from Black Asian and Ethnic Minority Backgrounds. |
| **KLOE-6.2: How will the system work together to support one another from a workforce perspective?**<br><br>• Are the correct systems and processes in place to support the deployment of staff from one provider to another where necessary? | GM NHS Provider Trusts are now signed up as a system to the NHS Digital Staff Passport, Wave 3, which is scheduled November through to March. This will support portability of temporary movers at pace across the system. In the interim, the use of bank and honorary contracts will be used to support deployment of staff.<br><br>All Provider Trusts are now signed up to NHS Professionals.<br><br>GM has complied with the NHSE requirement for a system workforce management model to support the deployment of additional workforce across the system in times of Surge following the transition of the Covid-19 Vaccination and Reservist programme to a localised system approach. |

| Key question and points to consider | Response |
|---|---|
| | Workforce has been transferred to NHSP, Step forward Reserves, Bolton Federation to support deployment across the system.<br><br>It is important to note that this system will require future resource and funding to optimise deployment as per the previous model that supported deployment of GM reserves.<br><br>Further details at locality level regarding this KLOE can be found in the individual locality submissions.<br>In addition, further information worked through with Mental Health providers can be found in the supplementary documents. |
| **KLOE-6.3: How will staff wellbeing be prioritised across winter?**<br><br>• What initiatives are in placed to support staff wellbeing across the winter?<br>• When is planned and unplanned absenteeism expected to be highest and are arrangements in place to ensure this is aligned with demand and capacity?<br>• What plans are in place to support a successful vaccination programme for influenza and Covid-19 if recommended for staff and volunteers? | NHS GM will continue to deliver the GM Wellbeing Programme, promoting the wellbeing provision from a prevention to response intervention basis. This includes:<br><br>• Access to the **GM Wellbeing Toolkit** and **Wellbeing Engagement Quiz** to support individuals and teams, in particular line managers.<br>• **Programme of workshops and sessions** to provide awareness and support including Financial Wellbeing, Mental Wellbeing, Menopause Awareness, Stress & Burnout.<br>• Promotion of **universal and NHS GM support provision**, including EAP, GM Resilience Hub and crisis support where required. |

| Key question and points to consider | Response |
|---|---|
| | • Continue to build and support the network of **Wellbeing Champions** and MHFA-ers with ongoing support.<br>• Provide **Information, Advice and Guidance** to the network of colleagues for improved awareness and access to provision, including Wellbeing Leads, Guardians, Champions, OH colleagues, People Services and senior / locality leaders.<br><br>For staffing in the ICB – A private provider (Community Pharmacist) will be commissioned to provide services across each locality – Budget currently being established. Local Community Pharmacy will continue to offer flu and covid vaccinations to the population and workforce.<br><br>Ongoing development of the NWAS Trust's wellbeing offer. Through UEC Recovery Plan the Trust has invested in an expansion of the Wellbeing and Engagement team to include:<br>• Wellbeing and Engagement Advisor – to focus on specific projects, training and support for managers<br>• Wellbeing Officers x4 -aligned to each area of the Trust (Cheshire and Mersey, Cumbria, Greater Manchester and Lancashire) the posts will work in areas to engage with staff around the wellbeing offer, undertake promotion and develop local initiatives.<br><br>Absence management – ongoing proactive support of absence management within the Trust. Further investment in the HRBP team to support managers with management of sickness. |

| Key question and points to consider | Response |
|---|---|
| | Further details at locality level regarding this KLOE can be found in the individual locality submissions |
| **KLOE-6.4: How are you maximising the role of VCSE partners?**<br>• What assumptions have been made about the role of VCSE partners in supporting the workforce this winter?<br>• What steps have you taken to maximise the role of VCSE partners this winter?<br>• How will the relationship with VCSE partners be managed at a system-level to ensure the greatest level of integration and joint working?<br>• What steps has the system taken to maximise the role of NHS and Care Volunteer Responders? | VCSE Partners recognised as a key component of winter planning particularly around supporting hospital discharge and admission avoidance.<br><br>It has been highlighted that the need for timeliness of any VCSE support asks is considered, to give time to scale up to meet demand.<br><br>There are links with key GM VCSE Networks to help influence and shape ICB strategy and planning along with seats at the table at essential points.<br><br>Further details at locality level regarding this KLOE can be found in the individual locality submissions |

| | |
|---|---|
| **Title of report:** | Standing Financial Instructions Annual Review |
| **Presented to:** | Board of Directors |
| **On:** | 4 October 2023 |
| **Presented by:** | Shirley Martland – Associate Director of Financial Services and Payroll |
| **Prepared by:** | Consent |
| **Contact details:** | T: 01942 773786 E: shirley.martland@wwl.nhs.uk |

**Executive summary**

The purpose of this paper is to seek approval of the changes made to the Trust's Standing Financial Instructions (SFIs) and Budgetary Control and Delegation Arrangements and to ask the Board of Directors to accept these changes.

These changes have been recommended following the scheduled annual review of the SFIs. It should be noted that further changes may be required in the coming months, due to the implementation of a set of standardised financial controls across the Greater Manchester ICS.

**Link to strategy**

None.

**Risks associated with this report and proposed mitigations**

There are no risks associated with this report.

**Financial implications**

This report has no direct financial implications.

**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.

## Report

### Background

The SFIs detail the financial responsibilities, policies, and procedures to be adopted by the Trust and are designed to ensure that its financial transactions are carried out in accordance with the law and government policy to achieve probity, accuracy, economy, efficiency, and effectiveness.

Each year a review of the SFI's is undertaken to ensure that the policy accurately reflects current policies, procedures, and practice.

### Key changes

The SFIs have been updated to include a section on the Bribery Act 2010 and the implications that this has on the organisation. A change has been made to the budget transfer section to refer to transfers from staff to non-pay budgets not being permitted unless agreed and documented by the Executive Team or agreed as part of the business planning process.

Other minor changes include reference to the Local Counter Fraud Specialist being accredited and clarification on the annual declaration of interest process and the pay banding of those staff to which this process applies to.

Further details of the above changes can be found in Appendix 1.

### Greater Manchester Financial Controls

The Greater Manchester ICB has recently issued a set of standardised financial controls to all providers. These are to support and provide assurance on grip and control in response to the challenging financial position across the system. The controls include a range of pay and non-pay measures which are currently being operationalised, with an update due to be provided to the Executive Team on 14th September 2023.

Following implementation of these controls it is anticipated that further changes will be required to the SFIs. These will be brought back to the Board for their approval at a future meeting.

### Recommendation

It is recommended that the Board adopt the changes made, as endorsed by the Audit Committee.

## Appendix 1: Changes to the Standing Financial Instructions

**SFI 2. Audit, Fraud, Corruption, Bribery and Security *(page 9)***

Added in the word 'Accredited' before the term Local Counter Fraud Specialist throughout this section.

***Added (page 12)***

**SFI 2.20** The Bribery Act (2010) came into force on 1st July 2011. Under the Bribery Act it is a criminal offence for organisations to fail to prevent bribes being paid on their behalf. Organisations which fail to take appropriate steps to avoid the risk of bribery taking place will face large fines and even the imprisonment of the individuals involved and those who have turned a blind eye to the problem.

**SFI 2.21** The Act:

(a) makes it a criminal offence to give or offer a bribe, or to request, offer to receive or accept a bribe, whether in the UK or abroad (the measures cover bribery of a foreign public official);

(b) makes it an offence for a director, manager or officer of a business to allow or turn a blind eye to bribery within the organisation; and

(c) introduces a corporate offence of failure to prevent bribery by persons working on behalf of a commercial organisation

**SFI 2.22 Security Management *(page 12)***

Removed NHS Counter Fraud Authority Standards for providers from the below paragraph.

Under the NHS Standard Contract, all organisations providing NHS services must put in place and maintain appropriate security management arrangements. In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance on NHS security management, and NHS Counter Fraud Authority Standards for providers.

**SFI 3.15 Budget transfer – virement *(page 15*)**

Added 'unless agreed and documented, by the Executive Team or as part of the business planning process to the following sentence':

Transfers from staff to non-pay budgets. NB: Transfers from non-pay to staff budgets are not allowable.

**SFI 22.2 Declarations of Interest *(page 53)***

Expanded the following sentence to include reference to ‘any member of staff on any other salary scale at Band 8d and above including all consultants and medical staff’.

Staff members at Band 8d and above will be asked to confirm on an annual basis that their entry on the register of interests is accurate and provide updates as required.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

# Standing Financial Instructions

Approved by the Board of Directors: 1st February 2023
Review date: September 2023

The WWL Way

## FOREWORD

Within the Terms of Authorisation issued by the sector regulator, NHS foundation trusts are required to demonstrate the existence of comprehensive governance arrangements in accordance with the Health and Social Care (Community Health and Standards) Act 2003.

The standard requires boards to ensure that there are management arrangements in place to enable responsibility to be clearly delegated to all staff and those representing the Trust. Additionally, the Board has drawn up locally generated rules and instructions, including delegation arrangements and financial procedural notes, for use within the Trust. Collectively these comprehensively cover all aspects of (financial) management and control. They set the business rules which directors, employees and the Council of Governors (including employees of third parties contracted to the Trust) must follow when taking action on behalf of the Board.

SFIs are mandatory for all directors, employees including temporary, fixed term and contract staff and members of the Council of Governors.

**CONTENTS**

Further references and financial procedures are retained in the Finance Department section of the intranet.

The following policies are specifically referenced.

- Intellectual Property Policy
- Commercial Representatives Policy
- Counter Fraud, Corruption and Bribery Policy and Response Plan
- Conflicts of Interest Policy
- Disciplinary Policy
- Code of Conduct Policy
- The Charity's Income and Expenditure Guidance documents.
- Temporary Staffing Policy

The Trust's Constitution, Standing Orders and the Schedule of Matters Reserved are also referenced.

## SFI 1. INTRODUCTION

### Purpose and scope

SFI 1.1 These Standing Financial Instructions (SFIs) detail the financial responsibilities, policies and procedures to be adopted by the Foundation Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

SFI 1.2 These SFIs also detail the delegation by the Board of powers and approval limits to officers of the Trust, and as such, contain the Trust's Scheme of Delegation.

SFI 1.3 The Trust's Schedule of Matters broadly outlines those decisions and duties specifically reserved to the Board of Directors. These matters are not delegated, and as such, the Schedule of Matters represents the Trust's Scheme of Reservation. It is therefore recommended that the Schedule of Matters is read in conjunction with these SFIs and the Scheme of Delegation contained herein.

SFI 1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Finance Officer must be sought before acting.

SFI 1.5 Failure to comply with Standing Financial Instructions can in certain circumstances be regarded as a disciplinary matter that could result in dismissal. Compliance with this document will be monitored by the Finance Department and all potential breaches of Fraud reported to the Local Counter Fraud Specialist.

SFI 1.6 If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Finance Officer as soon as possible. Please refer to Appendix A for further details on compliance.

SFI 1.7 Where failure to comply with this document constitutes a criminal offence it may result in a criminal investigation and criminal sanctions being applied.

SFI 1.8 These Instructions are equally applicable to the Trust's charitable funds with regards to procurement and transactions.

### Terminology

SFI 1.9 Any expression to which a meaning is given in the National Health Service Act 2006, National Health Service and Community Care Act 1990 and other acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Financial Instructions, and in addition:

(a) **"Trust"** means **Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust.**

(b) "**Accounting Officer"** means the officer responsible to Parliament for the resources under their control. They are responsible for ensuring the proper stewardship of public funds and assets. The National Health Service Act 2006 designates the Chief Executive of the NHS Foundation Trust as the Accounting Officer. The definition of duties and responsibilities of the Accounting Officer are set out within the NHS Foundation Trust Accounting Officer Memorandum.

(c) **"Board"** means the Chairman, Executive Directors and Non-Executive Directors of the Trust collectively as a body.

(d) **"Council of Governors"** means the Council of Governors as constituted within the Constitution.

(e) **"Budget"** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

(f) **"Budget holder"** means the director or employee with delegated authority from the Accounting Officer to manage finances (income and expenditure) for a specific area of the organisation.

(g) **"Budget manager**" means an employee directly responsible to a budget holder.

(h) **"Budget operator**" has delegated power from a budget manager to control a particular budget(s). Such delegation of powers shall be within defined parameters and shall be recorded in writing.

(i) **"NHS England"** means the office of the Regulator of Health Services of England.

(j) **"Chairman of the Board (or Trust)"** is the person appointed by the Council of Governors to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chairman of the Trust" shall be deemed to include the Vice-Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable.

(k) **"Chief Executive"** means the Chief Officer (and the Chief Accounting Officer) of the Trust.

(l) **"Chief Finance Officer"** means the Chief Financial Officer of the Trust.

(m) **"Executive Director"** means a Director of the Trust who may also be an officer.

(n) **"Non-Executive Director"** means a member of the Board of Directors who does not hold an executive office of the Trust.

(o) **"Officer"** means an employee of the Trust or any other person holding a paid appointment or office with the Trust.

(p) **"Secretary"** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chairman and monitor the Trust's compliance with the law, Standing Orders, and guidance from NHS England and the Department of Health and Social Care.

(q) **"Committee"** means a committee or sub-committee created and appointed by the Trust.

(r) **"Committee members"** means persons formally appointed by the Board to sit on or to chair specific committees.

(s) **"Charitable funds"** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under s90 of the NHS Act 1977 and the NHS and Community Care Act 1990, as amended.

(t) **"SFIs"** means Standing Financial Instructions.

(u) **"SOs"** means Standing Orders, which are contained within the Trust's Constitution.

SFI 1.10 Wherever the title Chief Executive, Chief Finance Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other Director or employees who have been duly authorised to represent them.

SFI 1.11 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

**Responsibilities and delegation**

SFI 1.12 **The Board of Directors** exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) defining specific responsibilities placed on members of the Board and employees as indicated within these Instructions.

SFI 1.13 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. All other powers have been delegated to such other committees as the Trust has established. These provisions are set out in the Trust's Schedule of Matters.

SFI 1.14 The Chief Executive and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control. Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accounting Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met; and has overall responsibility for the Trust's system of internal control.

SFI 1.15 The Chairman and Chief Executive must ensure suitable recovery plans are in place to ensure business continuity in the event of a major incident taking place.

SFI 1.16 It is a duty of the Chief Executive to ensure that members of the Board, employees, and all new appointees are notified of, and put in a position to understand their responsibilities within, these Instructions.

SFI 1.17 In line with the requirements of the NHS Act (2006) the Chief Executive and Chief Finance Officer shall monitor and ensure compliance with NHS Counter Fraud Authority standards for Providers for Fraud, Bribery and Corruption, in accordance with the NHS Standard Contract.

SFI 1.18 The Chief Finance Officer is responsible for:

(a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of segregation of duties and internal checks are prepared, documented and maintained to supplement these instructions; and

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Finance Officer include:

(a) the provision of financial advice to the Trust, Directors and employees;

(b) the design, implementation and supervision of systems of internal financial control; and

(c) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

SFI 1.19 All Directors and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming with the requirements of Standing Orders, the Schedule of Matters, Standing Financial Instructions (including Schemes of Delegation) and financial procedures.

SFI 1.20 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure, or who is authorised to obtain income, shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

SFI 1.21 For any and all Directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

## SFI 2. AUDIT, FRAUD, CORRUPTION, BRIBERY AND SECURITY

### Audit Committee

SFI 2.1 In accordance with Standing Orders the Board of Directors shall formally establish an Audit Committee, with clearly defined terms of reference, and following guidance from the NHS Audit Committee Handbook and in accordance with the Audit Code for NHS Foundation Trusts issued by NHS Improvement, which will provide an independent and objective view of internal control by:

(a) ensuring that there is an effective internal audit function established by management, that meets mandatory Public Sector Internal Audit Standards;

(b) reviewing the work and findings of the external auditors;

(c) reviewing financial and information systems, monitoring the integrity of the financial statements and any formal announcements relating to the Trust's financial performance, and reviewing significant financial reporting judgements;

(d) reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

(e) monitoring compliance with Standing Orders and Standing Financial Instructions;

(f) reviewing schedules of losses and special payments, making recommendations to the Board; and

(g) reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

SFI 2.2 Where the Audit Committee considers there is evidence of ultra vires transactions or improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board.

SFI 2.3 It is the responsibility of the Chief Finance Officer to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when/if an internal audit service provider is changed.

**Chief Finance Officer**

SFI 2.4 The Chief Finance Officer is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

(b) ensuring that the internal audit is adequate and meets the NHS foundation trust audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud, corruption or bribery;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

(e) a clear opinion on the effectiveness of internal control in accordance with the current Risk assessment framework issued by NHS England including, for example, compliance with control criteria and standards;

(f) major internal financial control weaknesses discovered;

(g) progress on the implementation of internal audit recommendations;

(h) progress against plan over the previous year;

(i) a strategic audit plan covering the coming three years; and

(j) a detailed plan for the next year.

SFI 2.5 The Chief Finance Officer or designated auditors are entitled, without necessarily giving prior notice, to require or receive:

SFI 2.6 access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

SFI 2.7 access at all reasonable times to any land, premises, members of the Board and Council of Governors or employees of the Trust;

SFI 2.8 the production of any cash, stores or other property of the Trust under a member of the Board or employee's control; and

SFI 2.9 explanations concerning any matter under investigation.

**Role of internal audit**

SFI 2.10 Internal audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data; and

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;

(ii) waste, extravagance, or inefficient administration; or

(iii) poor value for money or other causes.

SFI 2.11 Whenever any audit matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately.

SFI 2.12 The Director of Internal Audit/Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

SFI 2.13 The Director of Internal Audit/Head of Internal Audit shall be accountable to the Chief Finance Officer. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Director of Internal Audit in the form of an Internal Audit Charter. The Charter will comply with guidance on reporting contained in the Public Sector Internal Audit Standards. The Charter will be reviewed at least every three years.

**External audit**

SFI 2.14 The external auditor is appointed, through a formal process, by the Council of Governors following recommendation from the Audit Committee which should ensure that a cost efficient service is being provided. Where a problem arises in the provision of this service it should be raised with the external auditor and referred on to NHS England if the issue cannot be resolved.

SFI 2.15 It is for the Council of Governors to appoint or remove the external auditors at a general meeting of the Council of Governors, based on recommendations from the Audit Committee. The Trust must ensure that the external auditor appointed by the Council of Governors meets the criteria included by NHS England within the Audit Code for NHS Foundation Trusts, at the date of appointment and on an on-going basis throughout the term of their appointment.

**Fraud, corruption and bribery**

SFI 2.16 Under the NHS Standard Contract, all organisations providing NHS services must put in place and maintain appropriate counter fraud arrangements. In line with their responsibilities, the Trust Chief Executive and Chief Finance Officer shall monitor and ensure compliance on fraud, corruption and bribery as set out in NHS Counter Fraud Authority Standards for providers.

SFI 2.17 The Trust shall nominate a suitable person to carry out the duties of the Local Counter-Fraud Specialist (LCFS) as specified by the NHS Counter Fraud Manual and guidance.

SFI 2.18 The Local Counter Fraud Specialist shall report to the Chief Finance Officer and shall work with staff in NHS Counter Fraud Authority in accordance with the NHS Counter-Fraud Manual.

SFI 2.19 The Local Counter Fraud Specialist will be responsible for producing counter fraud progress reports and presenting these to the Audit Committee. In addition, a Counter Fraud Annual Report and work plan will be produced at the end of each financial year.

SFI 2.20 The Bribery Act (2010) came into force on 1st July 2011. Under the Bribery Act it is a criminal offence for organisations to fail to prevent bribes being paid on their behalf. Organisations which fail to take appropriate steps to avoid the risk of bribery taking place will face large fines and even the imprisonment of the individuals involved and those who have turned a blind eye to the problem.

SFI 2.21 The Act:

(a) makes it a criminal offence to give or offer a bribe, or to request, offer to receive or accept a bribe, whether in the UK or abroad (the measures cover bribery of a foreign public official);

(b) makes it an offence for a director, manager or officer of a business to allow or turn a blind eye to bribery within the organisation; and

(c) introduces a corporate offence of failure to prevent bribery by persons working on behalf of a commercial organisation.

**Security management**

SFI 2.22 Under the NHS Standard Contract, all organisations providing NHS services must put in place and maintain appropriate security management arrangements. In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance on NHS security management.

SFI 2.23 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management. The Chief Executive has overall responsibility for controlling and coordinating security.

## SFI 3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

**Preparation and approval of plans and budgets**

SFI 3.1 The appropriate Executive Director will compile and submit to the Board a Business Plan, which considers national and system planning guidance, capacity and demand, and workforce, estates and financial targets. The annual business plan will represent the target operating model for the financial year, operationalising the requirements and focus for the coming year to support the Trust's longer term strategic objectives. The Business Plan will contain:

(a) a statement of the significant assumptions on which the plan is based; and

(b) details of major changes in workload, delivery of services, or resources required to achieve the plan.

The Business Plan will be submitted to the Greater Manchester Integrated Care Board and NHS England in line with their deadlines, guidance, and requirements.

SFI 3.2 Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit income and expenditure plans for approval by the Board. Such plans will:

(a) be in accordance with the aims and objectives set out in the Business Plan;

(b) triangulate with workforce, activity and efficiency plans

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds; and

(e) identify potential risks.

SFI 3.3 The Trust shall submit information in respect of its financial plans to the Greater Manchester Integrated Care Board and NHS England, once approved by the Board of Directors.

SFI 3.4 The Chief Finance Officer will monitor actual financial performance against plan and report variances and risks to the Board.

SFI 3.5 All budget holders must provide information as required by the Chief Finance Officer to enable income and expenditure plans to be compiled.

SFI 3.6 Budget holders, with divisional responsibility, will electronically sign off their allocated income and expenditure plans at the commencement of each financial year via the Trust's devolved financial management system, DFM.

SFI 3.7 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders, to help them manage their delegated financial performance successfully.

**Budgetary delegation**

SFI 3.8 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the value of the delegated budget;

(b) the purpose(s) of each budget heading;

(c) whole time equivalents (WTEs) in respect of pay budgets;

(d) individual and group responsibilities;

(e) authority to exercise virement;

(f) achievement of planned levels of service; and

(g) the provision of regular reports.

SFI 3.9 The Chief Executive, Executive Directors, Clinical Directors and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

SFI 3.10 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

SFI 3.11 Non-recurring budgets shall not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Chief Finance Officer.

**Budgetary control and reporting**

SFI 3.12 The Chief Finance Officer will devise and maintain systems of budgetary control and reporting. These will include the following:

(a) Bi-monthly financial reports to Finance and Performance Committee and Board, including:

(i) Key performance indicators via the balanced score card;

(ii) income and expenditure to date showing trends and forecast year-end position;

(iii) income and expenditure

(iv) movements in working capital;

(v) movements in cash and capital;

(vi) capital project expenditure and projected outturn against plan;

(vii) explanations of any material variances from plan; and

(viii) details of any corrective action where necessary and the Chief Executive's and/or Chief Finance Officer's view of whether such actions are sufficient to correct the situation.

(b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible.

(c) Investigation and reporting of variances from financial, activity and manpower budgets.

(d) Monitoring of management action to address variances.

(e) Arrangements for the authorisation of budget transfers.

(f) Advice to the Chief Executive and the Board on the consequences and economic and financial impact on future plans and projects of a change in policy, pay awards and other events and trends affecting budgets.

SFI 3.13 Each budget holder is responsible for ensuring that:

(a) they remain within their budget allocation;

(b) any planned reduction in income or overspending on expenditure, which cannot be addressed by virement, are reported to the Board of Directors;

(c) the amount provided in an approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;

(d) all recruitment of fixed term or permanent employees must be approved via the Trust's current recruitment policy. Approval must be gained prior to engaging services of any and all agency workers;

(e) they remain within their funded establishment;

(f) they identify and implement cost improvements and income generation initiatives in accordance with the requirements of the approved budget; and

(g) any proposal to increase revenue spending has an appropriate funding stream identified and that this has been agreed by the Chief Executive. Proposals to increase revenue spending should also be signed off by the Chief Finance Officer. This applies to all revenue developments whether part of Annual Business Plan discussions or separate business case initiatives, however funded.

SFI 3.14 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Business Plan.

**Budget transfer - virement**

SFI 3.15 The facility of virement is available between budget holders/managers of different budgets. Virement can involve the following different types of transfers:

(a) Transfers between non-pay budgets;

(b) Transfers between staff budgets; and

(c) Transfers from staff to non-pay budgets. NB: Transfers from non-pay to staff budgets are not allowable unless agreed and documented, by the Executive Team or as part of the business planning process.

SFI 3.16 There is no financial ceiling limiting the amount of any one virement transfer. In all cases, the Divisional Finance Manager shall be consulted. It is paramount that virement changes do not undermine the integrity of the budgets.

SFI 3.17 To proceed with budget virements the agreement of both parties should be sought by the Divisional Finance Manager.

**Capital expenditure**

SFI 3.18 The general rules applying to delegation and reporting shall also apply to capital expenditure.

**Monitoring of performance**

SFI 3.19 The Chief Executive is responsible for ensuring that

(a) the appropriate monitoring returns are submitted to NHS England;

(b) financial performance measures have been defined and are monitored and reasonable targets have been identified for these measures;

(c) a robust system in in place for managing performance against the targets; and

(d) reporting lines are in place to ensure all performance is managed and arrangements are in place to manage/respond to adverse performance.

**Emergency expenditure**

SFI 3.20 In instances which are deemed as critical the Chief Executive can approve unbudgeted revenue expenditure up to a value of £10,000 (per instance) and with the additional agreement of the Chairman up to £20,000 (per instance). Applications for such an approval must be submitted to the 'Associate Director of Financial Services and Payroll' who will then forward to the Chief Finance Officer for final submission to the CEO and Chairman**.**

## SFI 4. ANNUAL ACCOUNTS AND REPORTS

SFI 4.1 The Chief Finance Officer, on behalf of the Trust, will

(a) keep accounts, and in respect of each financial year;

(b) prepare annual accounts, in such form as NHS England and Department of Health and Social Care may, with the approval of the Treasury, direct;

(c) ensure that, in preparing annual accounts, the Trust complies with any directions given by NHS England and Department of Health and Social Care with the approval of the Treasury as to:

(i) the methods and principles according to which the accounts are to be prepared; and

(ii) the information to be given in the accounts.

(d) ensure that a copy of the annual accounts, and any report of the External Auditor on them, are laid before Parliament and that copies of these documents are sent to NHS Improvement; and

(e) submit financial returns to NHS England for each financial year in accordance with NHS Improvement's timetable.

SFI 4.2 The Trust's audited annual accounts must be presented to the Board for approval and received by the Council of Governors at a public meeting.

SFI 4.3 The Trust's annual accounts must be audited by an auditor appointed by the Council of Governors. The Trust's audited annual accounts must be presented at a public meeting and made available to the public.

SFI 4.4 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health and Social Care Group Accounting Manual.

## SFI 5. BANK AND GBS ACCOUNTS

### General

SFI 5.1 The Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts.

SFI 5.2 The Chief Finance Officer is responsible for negotiating the Trust's banking contracts, establishing any associated mandates and naming personnel to be signatories for banking transactions.

SFI 5.3 No employee may open or hold a bank account in the name and/or address of the Trust or of its constituent hospitals/departments. Any employee aware of the existence of such an account shall report the matter to the Chief Finance Officer.

### Bank and GBS accounts

SFI 5.4 The Chief Finance Officer is responsible for:

(a) bank accounts and Government Banking Service (GBS) accounts;

(b) establishing separate bank accounts for the Trust's charitable funds;

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Board of any external borrowing requirements; and

(e) ensuring that procedures are maintained that document all transaction processing relating to Trust bank accounts.

**Banking procedures**

SFI 5.5 The Chief Finance Officer will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated;

(b) the limit to be applied to any overdraft; and

(c) those authorised to sign cheques or other orders drawn on the Trust's accounts.

SFI 5.6 The Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

**Banking tendering and review**

SFI 5.7 The Chief Finance Officer will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

SFI 5.8 Competitive tenders should be sought at least every five years, unless the Board determines otherwise. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

## SFI 6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

**Income systems**

SFI 6.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

SFI 6.2 Credit note authorisation will be determined for each manager depending on their role/responsibility and a list of managers who are set up to undertake such approvals is maintained within Oracle.

SFI 6.3 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

**Fees and charges**

SFI 6.4 The Trust shall follow NHS Improvement's guidance in setting prices for NHS Service contracts, where services are not covered by a mandatory National Tariff. The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by NHS England (such as Payment by Results National Tariffs), HM Treasury or by statute. Independent professional advice on matters of valuation shall be taken as necessary.

SFI 6.5 Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the NHS Commissioning Board – Standards of Business Conduct shall be followed.

SFI 6.6 All employees must ensure that an appropriate Service Level Agreement is in place in respect of all transactions which they may initiate or deal with that results in an income stream for the

Trust. This will include but is not limited to contracts, leases, tenancy agreements, private patient undertakings. Employees must also ensure that an appropriate mechanism is in place for raising timely invoices to recover income due on such transactions.

**Debt recovery**

SFI 6.7 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

SFI 6.8 Income which is deemed due, but possibly uncollectable, should be dealt with in accordance with debt recovery procedures, and reported as a write-off loss (SFI 14.5) where appropriate.

SFI 6.9 Overpayments should be detected (or preferably prevented) and recovery initiated.

**Security of cash, cheques and other negotiable instruments**

SFI 6.10 The Chief Finance Officer is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

SFI 6.11 Trust cash shall not under any circumstances be used for private transactions such as the encashment of private cheques, bank to bank transfers or temporary loans.

SFI 6.12 Trust accounts should not be used for ad hoc temporary banking of employee funds or other monies unrelated to Trust business and income, except patients' monies held in trust.

SFI 6.13 Trust credit cards should not be used for personal expenditure, even if there is an intention to reimburse the Trust.

SFI 6.14 Trust credit cards should not be used to pay employee expenses without prior approval, as these should be reimbursed via Payroll.

SFI 6.15 All cheques, postal orders, cash etc. shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

SFI 6.16 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

SFI 6.17 During the absence (whether sickness or annual leave etc.) of the authorised safe key holder, the officer who acts in their place shall be subject to the same controls as the normal holder of the key. There shall be a written discharge of the safe and/or cash box contents on the transfer of responsibilities, with the discharge document authorised by the relevant senior officer and retained for audit inspection.

SFI 6.18 The opening of incoming post shall be undertaken by two officers except where authorised in writing by the Chief Finance Officer. All cash, cheques, postal orders and other forms of payment received shall be entered in an approved form of remittance register. All cheques and postal orders shall be crossed "Not Negotiable Account Payee Only – Wrightington, Wigan and Leigh NHS Foundation Trust". The remittance register should be passed to the cashier from whom a signature should be obtained.

SFI 6.19 All unused cheques and GBS orders will be held as controlled stationery and issued in accordance with controlled stationery procedures.

SFI 6.20 Any loss or shortfall in cash, cheques or other negotiable instruments shall be reported immediately. Where there is prima facie evidence of fraud, corruption and bribery it will be necessary to follow the Trust's Counter Fraud Corruption and Bribery Policy and Response Plan. Where there is no evidence of fraud and corruption the loss shall be reported in line with losses procedures.

## SFI 7. TENDERING AND CONTRACTING PROCEDURE

### General

SFI 7.1 The procedure for making all contracts by, or on behalf of, the Trust shall comply with the Trust's Standing Orders and Standing Financial Instructions.

SFI 7.2 The approval of business cases prior to the procurement process is covered in SFI 23.

SFI 7.3 **In all instances, the intended expenditure should be reflective of the total life cycle costs of provision of the goods and / or services.**

### EU Directives governing public procurement

SFI 7.4 Directives by the Council of the European Union promulgated by the Department of Health and Social Care prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

### Competitive quotations

SFI 7.5 Competitive quotations are required where the intended expenditure or income is equal to, or is reasonably expected to exceed £10,000 but not exceed £50,000 ex VAT.

(a) Quotations should be obtained from at least three suppliers based on specifications or terms of reference prepared by, or on behalf of, the Trust.

(b) Quotations should be submitted by email or via electronic sourcing software, as deemed appropriate by the Procurement Department.

(c) All quotations should be treated as confidential and should be retained for inspection.

(d) The Chief Executive or his/her nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation (if payment is to be made by the Trust), or not the highest (if payment is to be received by the Trust), then the choice made and the reasons why should be recorded in a permanent record.

SFI 7.6 Contract and tendering procedures within these SFIs should be applied to quotations as best practice.

### Competitive tendering

SFI 7.7 Competitive tenders are required where the intended expenditure or income is equal to or is reasonably expected to exceed £50,000, but not exceed the relevant European Union threshold ex VAT.

SFI 7.8 The Trust shall ensure that competitive tenders are invited for:

(a) the supply of goods, materials and manufactured articles;

(b) the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);

(c) the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and

(d) disposals of Trust property or goods (unless specified in **Error! Reference source not found.**).

SFI 7.9 Formal tendering procedures need not be applied where:

(a) the estimated expenditure or income does not, or is not reasonably expected to exceed £50,000 excluding VAT;

(b) the supply is proposed under special arrangements negotiated by the DH, in which event the said special arrangements must be complied with;

(c) the Trust is disposing of Trust assets, as set out in SFI 7.71

(d) the requirement is covered by an existing contract (this includes contracts let by external agencies on behalf of the NHS e.g. NHS Supply Chain); or

(e) there is a national or regional sole supplier agreement in place.

**Non–competitive waivers**

SFI 7.10 In exceptional instances where competitive quotations and tenders are not deemed possible, Trust officers should seek the approval of the Trust to waive these requirements.

SFI 7.11 Requirements of a statutory nature, and/or services provided by other public sector organisations that are sole suppliers are excluded from these tendering procedures and will not require a non-competitive waiver.

SFI 7.12 Continued professional development and/or training courses that are either sole supplier, provided by another public sector organisation or selected on the basis of geographical location will not require a non-competitive waiver.

SFI 7.13 Contracts for the purchase or rental of land, existing buildings or other immovable property or concerning rights on such property are excluded from the Public Contract Regulations and as such will not require a non-competitive waiver

SFI 7.14 A waiver is not required where a repair is needed to equipment that is covered by an existing approved framework maintenance agreement, and the value of the repair is below £20,000 (ex VAT).

SFI 7.15 Quotation and tendering procedures may only be waived in the following circumstances:

(a) very exceptionally, where the Chief Executive decides that formal tendering procedures would not be appropriate, however in such instances the benefits and rationale must be clearly demonstrated;

(b) timescales - where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(c) sole supplier - where specialist expertise is required and is available from only one source;

(d) maintaining continuity – when there is a clear benefit to be gained from maintaining continuity with an earlier project and/or engaging a different supplier for the new task would be inappropriate. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering (financial evidence must be provided in support); or

(e) standardisation where the requirement is an addition to a previously tendered range of goods and services and clearly supports the Trust policy for standardisation.

SFI 7.16 The waiving of competitive quotation or tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

SFI 7.17 Where it is decided that a competitive quotation/ tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

**Authorisation of waivers**

SFI 7.18 Where competitive tendering or a competitive quotation process is to be waived, the authorisation limits stipulated are as follows.

| Amount | Authorisation |
|---|---|
| Less than £10,000 ex VAT | No waiver required |
| £10,001k - £50,000 ex VAT | Deputy Director of Operational Finance |
| £50,001 - £100,000 ex VAT | Director of Operational Finance |
| £100,001 to EU Threshold ex VAT | Chief Finance Officer |
| Up to and over EU Threshold ex VAT | Chief Executive (or Deputy) |

SFI 7.19 Expenditure exceeding the relevant European Union threshold may not be waived, unless specified in the European Regulations. The Trust Procurement Department will advise in these circumstances.

**Frameworks and approved supplier lists**

SFI 7.20 The Trust shall use contracts established by the Crown Commercial Service (CCS), NHS Supply Chain (NHSSC), Shared Business Service Collaborative Procurement Service (SBS) Health Trust Europe (HTE) or another applicable organisation with appropriate frameworks, for the procurement of goods and services unless the Chief Executive or nominated officers deem it inappropriate.

SFI 7.21 If the Trust does not use frameworks as mentioned in SFI 7.20, and where tenders or quotations are not required because expenditure is below £10,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Finance Officer.

SFI 7.22 The Trust shall ensure that the suppliers invited to tender for estates-related contracts (and where appropriate, quote) are among those on approved lists such as, ProCure22 or the latest DHSC framework providing design and construction services or those outlined in SFI 7.20.

SFI 7.23 All firms who have applied for permission to tender must satisfy the Trust as to their technical and financial competence. All suppliers must adhere, where appropriate, to the standard NHS Terms and Conditions.

**Exceptions to using approved contractors**

SFI 7.24 If, in the opinion of the Chief Executive and either the Chief Finance Officer or the Director with lead responsibility for clinical governance, it is impractical to use a potential contractor from the list of approved suppliers (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

**Contracting/tendering procedure**

SFI 7.25 The Trust has adopted an “e-tendering” system to issue and receive all tenders electronically.

SFI 7.26 All invitations to tender on a formal competitive basis shall state the date and time as being the latest time for the receipt of tenders, and no tender will be considered for acceptance unless submitted through the e-tender system, as instructed within the tender documentation.

SFI 7.27 Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

SFI 7.28 Every tender for goods and services shall embody the NHS Terms and Conditions and, as appropriate, the contract form required for the specific goods and services.

SFI 7.29 Where the Trust is tendering to undertake the provision of goods/services for another organisation then a full financial appraisal must be undertaken and approved by Executive Team Meeting (ETM) prior to any invitation to tender being submitted. Where approval has been granted a full business case must be completed and approved in accordance with the business case approval process during the period in which the contract is being agreed.

**Receipt and safe custody of tenders**

SFI 7.30 All tenders must be issued and managed via the Trust’s, or other approved, electronic tendering systems e.g. Crown Commercial Services. No hard copy tenders will be accepted.

SFI 7.31 Electronic tenders will be held and locked electronically until the allocated time and date for opening.

**Opening tenders**

SFI 7.32 The electronic tendering system is a fully automated, auditable system which seals bids until the response deadline has passed. Therefore, the originating Contract Manager will be deemed authorised to access the electronic tenders and release them once the sealed date and time has passed.

SFI 7.33 A full electronic record of the tenders received will be available in accordance with the agreed parameters of the system.

**Admissibility of tenders**

SFI 7.34 In considering which tender to accept, if any, the designated officer(s) shall have regard to whether value for money will be obtained and whether the number of tenders received provides adequate competition.

SFI 7.35 Tenders received after the due time and date may be considered only if the tenders received on the due date have not been opened and the designated officer(s) decide that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, being satisfied that there is no reason to doubt the bona fides of the tenders concerned.

SFI 7.36 The Chief Executive or the Chief Finance Officer shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition.

SFI 7.37 Technically late tenders (i.e. those dispatched in good time but delayed through no fault of the tenderer) will be regarded as having arrived in due time.

SFI 7.38 Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders.

SFI 7.39 Where examination of tenders reveals errors, which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing their offer.

SFI 7.40 Necessary discussions with a tenderer regarding the contents of their tender, in order to elucidate before the award of a contract, need not disqualify the tender.

SFI 7.41 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the Chief Executive.

SFI 7.42 Where only one tender/quotation is received, the designated officer(s) shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

SFI 7.43 A tender other than the most economically advantageous tender shall not be accepted unless for good and sufficient reason and a record of that reason be created and approved by the Chief Executive and held with the appropriate tender documentation.

SFI 7.44 Where the form of contract includes a fluctuation clause, all applications for price variations must be submitted in writing by the tenderer and shall be approved by either the Chief Executive or the Chief Finance Officer.

SFI 7.45 All Tenders should be treated as confidential and should be retained for inspection.

**Acceptance of tenders**

SFI 7.46 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender.

SFI 7.47 The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless the Chief Executive determines that there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

SFI 7.48 It is accepted that the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach; and

(d) ability to complete the project on time.

SFI 7.49 Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

SFI 7.50 Post tender negotiations on price shall not be entered into without the specific prior approval of the Chief Finance Officer in writing and must be in accordance with UK and EU Procurement Regulations. Such approvals shall not be given without prior consultation with the Chairman of the Audit Committee or the Chairman of the Finance & Performance Committee. Such negotiations are to be carried out by a senior manager specifically designated by the Chief Finance Officer, witnessed by a second manager, and approved by the Chief Executive. The range and scope of the negotiations are to be determined by the Chief Finance Officer on each and every occasion.

SFI 7.51 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions, except with the authorisation of the Chief Executive.

SFI 7.52 The use of these procedures must demonstrate that the award of the contract was not in excess of the going market rate/price current at the time the contract was awarded, and that best value for money was achieved.

SFI 7.53 All tenders should be treated as confidential and should be retained for inspection.

**Signing of contracts**

SFI 7.54 In all instances, the Trust's Procurement Team must be engaged in the tender procurement process prior to an official order being raised.

SFI 7.55 SFI 7.54 to SFI 7.58 refers specifically to circumstances where a contract needs to be signed (see DHSC guidance document available on the www.gov.uk website).

SFI 7.56 Contracts should be approved as follows:

| Amount | Contracts on NHS T&Cs | Contract on Non-NHS T&Cs |
|---|---|---|
| Less than £10,000 ex VAT | Associate Director of Procurement | Associate Director of Procurement |
| £10,001k - £25,000 ex VAT | Associate Director of Procurement | Deputy Director of Operational Finance |
| Up to £50,000 ex VAT | Director of Operational Finance | Director of Operational Finance |
| Up to EU Threshold ex VAT | Chief Finance Officer | Chief Finance Officer |
| Over EU Threshold ex VAT | Chief Executive (or Deputy) | Chief Executive (or Deputy) |

**Tender reports to the Board of Directors**

SFI 7.57 Reports to the Board of Directors will be made on an exceptional circumstance basis only.

**Fair and adequate competition**

SFI 7.58 The Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and, unless not practicable, in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

**Expenditure to be within financial limits**

SFI 7.59 No tender or quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Chief Finance Officer.

**Reverse e-auctions**

SFI 7.60 Where appropriate, the Trust will use e-auctions, and partner organisations to conduct e-auctions on its behalf, and will determine throughout the year the most appropriate product areas that will achieve the best value by being managed through an e-auction.

SFI 7.61 The results of the e-auction will be made available for scrutiny and ratification using a similar process to that of electronic tenders, and a record will be kept of the submissions in full.

**Health care services**

SFI 7.62 Where the Trust elects to invite tenders for the supply of health care services, these Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure.

**Items which subsequently breach thresholds after original approval**

SFI 7.63 Items estimated to be below the limits set in these Standing Financial Instructions for which formal tendering procedures are not used, which subsequently prove to have a value above such limits, shall be reported to the Audit Committee on a quarterly basis and be recorded in an appropriate Trust record.

**Authorisation of tenders and competitive quotations**

SFI 7.64 Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided in line with SFI 7.54.

SFI 7.65 In the case of authorisation by the Board of Directors, this shall be recorded in their minutes.

**Private finance for capital procurement**

SFI 7.66 When considering PFI funding the Trust should normally market-test. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) the Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;

(b) a business case must be referred to the Department of Health and Social Care, NHS Improvement, or as per current guidelines;

(c) the proposal must be specifically agreed by the Board of the Trust; and

(d) the selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

**Compliance requirements for all contracts**

SFI 7.67 The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) the Trust's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) any relevant directions including the Capital Investment Manual, Health Building Note 00-08: Estatecode and guidance on the Procurement and Management of Consultants;

(d) such of the NHS Standard Contract Conditions as are applicable; and

(e) appropriate NHS guidance regarding the form of contracts with foundation trusts.

SFI 7.68 Where appropriate, contracts shall be in, or embody, the same terms and conditions of contract as the basis on which tenders or quotations were invited.

SFI 7.69 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all available systems in place.

SFI 7.70 Commercial negotiations and the establishment of a contract management framework may only be undertaken by members of the Procurement Department, unless otherwise authorised by the Chief Executive or Chief Finance Officer.

**Disposals**

SFI 7.71 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his/her nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the relevant disposal policy of the Trust;

(c) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract; and

(d) land or buildings subject to compliance with DH guidance.

**In-house services and benchmarking**

SFI 7.72 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided in-house. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering. This will be undertaken adopting a two-stage process.

SFI 7.73 The process for undertaking the Best Value Review is set out below.

(a) Establish a cross-functional project team, to include senior representatives from the department which is the focus of the exercise, Finance, Procurement, staff-side and HR, with project management responsibility residing with the Associate Director of Procurement.

(b) The project team will be responsible for the scope and specifics of the departmental review. This should include quality targets and innovations, as well as cost analysis. Specific metrics would include the range of services offered, head count, and comparison of KPI data, with the aim of providing the Trust with a holistic view of the value received from the existing in-house service provider. For benchmarking, at least one comparator must be an external provider.

(c) The project team are responsible for the production of a report in which improvements/opportunities are identified. The department or service in question is then given a period of 3 months to make any necessary improvements to the in-house service provision, to align itself to the 'best in class' targets. Where improvements are not achieved, escalation to a full 'market testing' exercise is an executive decision.

SFI 7.74 On the basis of the outcome of the benchmarking exercise, the Trust may determine that in-house services should be market tested by competitive tendering.

SFI 7.75 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) specification group, comprising the Chief Executive or nominated officer(s) and specialist;

(b) in-house tender group, comprising a nominee of the Chief Executive and technical support; and

(c) evaluation team, comprising normally a specialist officer, a Procurement officer and a representative of the Chief Finance Officer.

SFI 7.76 All groups should work independently of each other, and individual officers may be a member of more than one group, but no member of the in-house tender group may participate in the evaluation of tenders.

SFI 7.77 The evaluation team shall make recommendations to the Board.

SFI 7.78 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

**Applicability of SFIs on tendering and contracting to funds held in trust**

SFI 7.79 These Instructions shall equally apply to expenditure from charitable funds.

## SFI 8. NON-PAY EXPENDITURE

**Delegation of authority**

SFI 8.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

SFI 8.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

(b) the maximum level of each requisition and the system for authorisation above that level.

SFI 8.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

**Authorisation levels for approval of purchase orders**

SFI 8.4 The below table details the internal approval levels and limits applicable for the procurement of goods and services through the Trust's procurement order processing system (Oracle).

| Approval Level | Approval Level - Posts | Approval Limit |
|---|---|---|
| 1 | Chief Executive/Deputy Chief Executive/Chief Finance Officer | £1,000,000 |
| 2 | Director of Operational Finance | £300,000 |
| 3 | Executive Director | £250,000 |
| 4 | Associate Director / Deputy Director | £150,000 |
| 5 | Head of Department or Service | £20,000 |
| 6 | Deputy Head of Department/Head of Service | £10,000 |
| 7 | Senior Department/Service Manager | £5,000 |
| 8 | Department/Service Manager | £2,500 |
| 9 | Department/Service Approver | £1,000 |
| 10 | Requestor Only | N/A |

SFI 8.5 In cases where expenditure is over £1,000,000, the Chief Executive's limit will be increased to allow electronic authorisation in instances where the business case has been approved by the Board and evidence can be shown of this.

SFI 8.6 The table below details the internal approval limits applicable within the Procurement Department for the approval of purchase orders once authorisation has been given to expenditure

| Position | PO Approval Limit |
|---|---|
| Associate Director of Procurement | £25,000,000 |
| Procurement Manager | £250,000 |
| Contracts Officers (Capital) | £100,000 |
| eProcurement Manager/Contracts Manager/Assistant Contracts Manager | £100,000 |
| Contracts/eProcurement Officer/Assistant | £50,000 |

SFI 8.7 The procurement process for goods, services or works depends upon whether expenditure is incurred from capital or revenue budgets, and refers to expenditure not already covered by existing NHS national or local contracts.

SFI 8.8 The limits below refer to whole life cost of the contract (i.e. an annual contract value of £70,000 over 3 years requires OJEU tender in respect of revenue) to incur non-pay expenditure (ex VAT):

SFI 8.8.1. Revenue expenditure

| | | |
|---|---|---|
| 1. | Below £10,000 | Purchase order |
| 2. | £10,001 to £49,999 | Official quotations |
| 3. | £50,000 to EU threshold for goods/services | Official tender exercise |
| 4. | Over current EU threshold for goods/services | OJEU tender exercise |

SFI 8.8.2. Capital

| | | |
|---|---|---|
| 1. | Below £10,000 | Purchase order |
| 2. | £10,001 to £49,999 | Official quotations |
| 3. | £50,000 to EU threshold for goods/services | Official tender exercise |
| 4. | Over current EU threshold for goods/services | OJEU tender exercise |

**Choice, requisitioning, ordering, receipt and payment for goods and services**

SFI 8.9 *Requisitioning:* To ensure best value for money all purchases of goods and services must be made utilising the advice and services of the Trust's Procurement Department. Where this advice is not acceptable to the requisitioner, the Chief Finance Officer (and/or the Chief Executive) shall be consulted. All requisitions shall be priced and include the relevant financial code.

SFI 8.10 *System of payment and payment verification:* The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms or otherwise in accordance with national guidance.

SFI 8.11 The Chief Finance Officer will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained. Once approved, the thresholds should be incorporated in these SFIs and regularly reviewed;

(b) prepare procedural instructions or guidance within these SFIs on the procurement of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, with the only exceptions set out in SFI 8.12 below; and

(e) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for the following:

(i) A list of Directors/employees authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct; and
- the account is in order for payment.

(iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

SFI 8.12 *Prepayments:* Prepayments are only permitted where exceptional circumstances apply.

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages.

(b) The appropriate authorised staff member must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is, at some time during the course of the prepayment agreement, unable to meet their commitments.

(c) The Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold).

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

SFI 8.13 *Official orders:* Official orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Chief Finance Officer;

(c) state the Trust's terms and conditions of trade; and

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

They may be transmitted by a system of Electronic Data Interchange (EDI) approved by the Chief Finance Officer.

SFI 8.14 *Duties of managers and staff:* Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and the relevant staff must ensure that:

(a) all contracts (except as otherwise provided for in these SFIs), leases, tenancy agreements and other commitments which may result in a liability are notified to the Procurement Department in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care;

(d) all intellectual property (IP) benefits, such as copyright, patents, design rights, trademarks and confidentiality are protected and applied in all cases via the Trust's authorised representatives, (as established in the Trust's Intellectual Property Policy);

(e) discussions with suppliers in respect of commercial terms must not be undertaken other than by members of the Procurement Department;

(f) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;

(g) all goods, services, or works are ordered on an official order except purchases from petty cash and purchases from suppliers identified on the agreed list of non-PO suppliers/services maintained by Financial Services and Procurement.

(h) verbal orders must only be issued very exceptionally and be accompanied by a purchase order number - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(i) requisitions/orders/petty cash requests are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(j) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(k) changes to the list of employees and officers authorised to certify invoices are notified to the Chief Finance Officer;

(l) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer;

(m) petty cash records are maintained in a form as determined by the Chief Finance Officer; and

(n) the Conflicts of Interest Policy (incorporating) Gifts and Hospitality Policy must be adhered to at all times, with no orders issued to or business transacted contrary to this policy.

SFI 8.15 The Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with current guidance.

SFI 8.16 In the case of contracts for building or emergency works which require payment made on account during progress of the works, the Chief Finance Officer shall make payment upon receipt of a certificate from the appropriate technical consultant or works officer appointed to a particular building or engineering contract.

## SFI 9. STORES AND RECEIPT OF GOODS

### General position

SFI 9.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take; and

(c) valued at the lower of cost and net realisable value, or a weighted average in the case of Pharmacy.

### Control of stores, stocktaking, condemnations and disposal

SFI 9.2 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of any pharmaceutical stocks shall be the responsibility of a designated pharmaceutical officer; the control of any fuel oil and coal shall be the responsibility of a designated estates manager.

SFI 9.3 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager. Wherever practicable, stocks should be marked as Trust property.

SFI 9.4 The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

(a) All goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification. A delivery note should be obtained from the supplier at the time of delivery/service and signed by the staff member receiving the goods/service.

(b) Particulars of all goods/services received shall be registered on the day of receipt, with unsatisfactory goods returned to the supplier within the set timescales.

(c) Stock shall only be issued/released upon receipt of an authorised requisition.

SFI 9.5 All stock records shall be in such form and shall comply with such systems of control as the Chief Finance Officer may require.

SFI 9.6 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

SFI 9.7 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

SFI 9.8 The designated manager/pharmaceutical officer shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer

shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI 14 Disposals and condemnations, losses and special payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

**Goods supplied by NHS Supply Chain**

SFI 9.9 For goods supplied via the NHS Supply Chain regional stores, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note ('priced advice note') before forwarding this to the Chief Finance Officer/Director of Operational Finance, depending on value, who shall satisfy him/herself that the goods have been received before accepting the recharge.

## SFI 10. CONTRACTING FOR PROVISION OF HEALTHCARE SERVICES

**Commissioner-related contracts**

SFI 10.1 The Chief Executive is responsible for negotiating contracts for the provision of services to patients in accordance with the Business Plan, and for establishing the arrangements for providing extra-contractual services. In carrying out these functions, the Chief Executive should take into account the advice of the Chief Finance Officer regarding:

(a) costing and pricing of services;

(b) payment terms and conditions; and

(c) amendments to contracts and extra-contractual arrangements.

SFI 10.2 Contracts should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income. Contract prices should comply with NHS Improvement's and NHS England's National Tariff Guidance.

SFI 10.3 The Chief Finance Officer shall produce regular reports detailing actual and forecast contract income with a detailed assessment of the impact of the variable elements of income.

**Non commissioner-related contracts**

SFI 10.4 Where the Trust enters into a relationship with a non-NHS body or another NHS organisation for the supply or receipt of other services, either clinical or non-clinical, or collaborative arrangements and non-financial contracts, the responsible contracting officer should ensure that an appropriate Service Level Agreement (SLA) is in place and has been signed by both parties. SLAs must be signed off as follows:

(a) For corporate SLAs, the Lead Executive (or nominated deputy)

(b) For divisional SLAs, the Divisional Director of Operations.

Plus, in all circumstances:

(c) Director of Operations and Performance (or nominated deputy)

(d) Chief Finance Officer (or nominated deputy)

(e) Either: Chief Nurse, or Medical Director (or nominated deputies)

SFI 10.5 This contract should incorporate:

(a) a description of the service and indicative activity levels;

(b) the term of the agreement including termination arrangements;

(c) the value of the agreement;

(d) the operational lead;

(e) performance and dispute resolution procedures; and

(f) risk management and clinical governance arrangements.

SFI 10.6 Non-commissioner contracts should be reviewed and agreed on an annual basis or as determined by the term of the agreement so as to ensure value for money and to minimise the potential loss of income.

SFI 10.7 Copies of signed SLAs should be retained on file by the contracting officer and, where the contract specifies financial information, a copy should be issued to the appropriate Divisional Management Accountant within Finance.

SFI 10.8 Electronic copies of the SLA and sign off schedule should be submitted to the Head of Legal Services with summary details of the SLA expiry date and any review dates which occur during the term of the SLA.

## SFI 11. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE BOARD OF DIRECTORS AND EXECUTIVE COMMITTEE AND EMPLOYEES

**Remuneration and terms of service**

SFI 11.1 The Board shall establish a Remuneration Committee comprised of non-executive directors. Such Committee shall have clearly defined terms of reference which specify which posts fall under its remit as well as its composition and the arrangements for reporting.

SFI 11.2 The Committee will undertake the following:

(a) Decide the remuneration and allowances, and the other terms and conditions of office, of the executive directors and any other senior employees under its remit, including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) payable expenses and compensation payments; and

(iv) arrangements for termination of employment and other contractual terms.

(b) monitor and evaluate the performance of the executive directors and any other senior employees under its remit; and

(c) oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

SFI 11.3 When deciding the remuneration, allowances and the other terms of service of the executive directors and any other senior employees under its remit, the Committee shall ensure that they are fairly rewarded for their individual contribution to the Trust, having proper regard to the

Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate.

SFI 11.4 The allowances paid to the non-executive directors shall be determined by the Council of Governors**.**

**Funded establishment**

SFI 11.5 The manpower plans incorporated within the annual budget will form the funded establishment.

SFI 11.6 The funded establishment of any department may not be varied without the approval of the Chief Executive unless in accordance with an establishment control procedure approved by the Board.

SFI 11.7 All budget holders must remain within their funded establishment unless prior consent has been granted by the Board.

**Staff appointments**

SFI 11.8 No Director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive; or

(b) unless the changes are within the limit of their approved budget and funded establishment; or

(c) the change is temporary and within the delegated powers of the Workforce Expenditure Panel.

SFI 11.9 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

**Processing payroll**

SFI 11.10 The Chief Finance Officer is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates; and

(d) agreeing method of payment.

SFI 11.11 The Chief Finance Officer will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the current Data Protection Legislation;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque or bank credit to employees and officers;

(i) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) segregation of duties in preparing records and handling cash; and

(m) a system to ensure the recovery of sums of money and property, from those leaving the employment of the Trust, due by them to the Trust.

SFI 11.12 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Chief Finance Officer's instructions and in the form prescribed by the Chief Finance Officer; and

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employees or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Chief Finance Officer must be informed immediately.

SFI 11.13 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

SFI 11.14 Advances of pay may only be given to staff to ensure timely remuneration of pay earned or reimbursement of legitimate expenses incurred in advance of normal pay processing. Loans may not be made to staff even if against potential future earnings.

SFI 11.15 Expenses should only be reimbursed via payroll. There should be no reimbursement for Trust purchases via payroll.

**Contracts of employment**

SFI 11.16 The Board shall delegate responsibility to the Director of Workforce for:

(a) ensuring that all employees are issued with a contract of employment in a form approved by the Board and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment. Local pay variations require the written approval of the Director of Workforce.

SFI 11.17 The Chief Finance Officer will be responsible for maintaining up-to-date procedures, to ensure that assurance can be obtained from off-payroll workers to determine that the correct tax and NI contributions are being paid to HMRC.

## SFI 12. EXTERNAL BORROWING AND INVESTMENTS

### Public Dividend Capital

SFI 12.1 On authorisation as a foundation trust, the public dividend capital (PDC) held immediately prior to authorisation continues to be held on the same conditions.

SFI 12.2 Additional public dividend capital may be made available on such terms the Secretary of State for Health (with the consent of HM Treasury) decides.

SFI 12.3 Draw down of additional public dividend capital will be authorised by the Chief Executive or Deputy Chief Executive, and by the Chief Finance Officer or the Director of Operational Finance.

SFI 12.4 The Trust shall be required to pay annually to the Department of Health and Social Care a dividend on its public dividend capital at a rate to be determined from time to time, by the Secretary of State.

### Commercial borrowing and investment

SFI 12.5 The Chief Finance Officer will advise the Board concerning the Trust's ability to pay interest on, or repay principal on, borrowings held, and will advise the Board on any proposed new borrowing. The Chief Finance Officer is responsible for reporting periodically to the Board concerning all loans and overdrafts.

SFI 12.6 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Chief Finance Officer.

SFI 12.7 The Chief Finance Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

SFI 12.8 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short-term borrowing requirement in excess of one month must be authorised by the Chief Finance Officer.

SFI 12.9 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Finance Officer.

SFI 12.10 All long-term borrowing must be consistent with the plans outlined in the current Business Plan and be approved by the Board of Directors.

### Investments

SFI 12.11 Temporary cash surpluses must be held only in such public or private sector investments as approved and authorised by the Board in line with the Trust's Treasury Management Policy.

SFI 12.12 The Chief Finance Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

SFI 12.13 The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

## SFI 13. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

### Capital investment

SFI 13.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon Business Plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) shall ensure that capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

SFI 13.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(iii) appropriate project management and control arrangements; and

(b) that the Chief Finance Officer has certified professionally the costs and revenue consequences detailed in the business case.

SFI 13.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of Health Building Note 00-08: Estatecode.

SFI 13.4 The Chief Finance Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HMRC guidance.

SFI 13.5 The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall delegate to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender; and

(c) approval to accept a successful tender.

SFI 13.6 The Chief Finance Officer shall issue procedures for the regular reporting of capital expenditure and commitment against authorised capital expenditure.

**Asset registers**

SFI 13.7 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a rolling programme of physical checks of assets against the asset register.

SFI 13.8 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Department of Health and Social Care Group Accounting Manual and IFRS accounting standards.

SFI 13.9 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architects' certificates, suppliers' invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) lease agreements in respect of assets held under a finance lease and capitalised.

SFI 13.10 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

SFI 13.11 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

SFI 13.12 The value of each asset shall be depreciated using methods and rates as specified in the Department of Health and Social Care Group Accounting Manual.

SFI 13.13 The Chief Finance Officer shall calculate and pay public dividend capital charges as specified in the Department of Health Group and Social Care Accounting Manual.

**Security of assets**

SFI 13.14 The overall control of fixed assets is the responsibility of the Chief Executive.

SFI 13.15 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset; and

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

SFI 13.16 The up-to-date maintenance and checking of asset records shall be the responsibility of designated budget holders for all items for which the initial purchase or replacement is within their service area. All discrepancies revealed by the verification of physical assets to the fixed asset register shall be notified to the Chief Finance Officer.

SFI 13.17 Whilst each employee has a responsibility for the security of Trust property, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

SFI 13.18 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

SFI 13.19 The Chief Finance Officer shall be the authorised officer to be responsible for the disposal of assets surplus to requirements.

SFI 13.20 Where practical, assets should be marked as Trust property and have a bar coded tag correlating to the record held on the asset register.

## SFI 14. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

### Disposals and condemnations

SFI 14.1 The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers.

SFI 14.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will notify the Chief Finance Officer to determine the asset's current valuation and the impact the disposal may have on the Trust's finances. Advice will be given as to the disposal procedure and obtaining the estimated market value of the item, taking account of professional advice where appropriate.

SFI 14.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer; and

(b) recorded by the condemning officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

SFI 14.4 The condemning officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

### Losses and special payments

SFI 14.5 The Chief Finance Officer must prepare procedural instructions on the recording of, and accounting for, condemnations, losses, and special payments, with regard to HM Treasury's Managing Public Money, and NHS-specific guidance and directions.

SFI 14.6 Any employee discovering or suspecting a loss of any kind, other than fraud, corruption or bribery, must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Finance Officer, or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then inform the Chief Finance Officer and/or Chief Executive.

SFI 14.7 Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the police if theft or arson is involved.

SFI 14.8 Where property loss/damage is suspected, including theft of or criminal damage (including burglary, arson, and vandalism) to staff, patient or NHS property or equipment, the Chief Finance Officer must immediately inform NHS Protect.

SFI 14.9 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify the Board.

SFI 14.10 Any employee discovering or suspecting fraud, corruption or bribery, or anomalies which may indicate fraud or corruption, must inform the Trust's Local Counter Fraud Specialist (LCFS).

SFI 14.11 The LCFS and/or Chief Finance Officer must report all frauds in accordance with the provisions of the Trust's Local Protocol on the Conduct of Investigations and Application of Sanctions and Redress in Respect of Fraud and Corruption.

SFI 14.12 The Chief Finance Officer will

(a) refer any novel, contentious or repercussive cases to the Department of Health and Social Care for approval, including extra-statutory and extra-regulatory payments, in accordance with HM Treasury direction; and

(b) refer severance payments on termination of employment (not including Treasury-approved MAS scheme payments) to NHS Improvement, who will deal directly with HM Treasury to get the necessary approval.

NHS England and the general public are informed of specific individual losses and special payments which exceed £250,000 via the Annual Reports and Accounts process.

SFI 14.13 The delegated limits approved by the Board for the approval of losses are set out below:

| Category of loss | Approval delegated to: | Nominated deputy |
|---|---|---|
| **1. Losses of cash**<br>(a) Theft, fraud, arson etc.<br>(b) Overpayments of salaries, wages, fees and allowances<br>(c) Other causes, including un-vouched or incompletely vouched payments, overpayments other than those included under 1(b), loss of cash by fire (other than arson), physical losses of cash, cash equivalents and stamps other than those covered by 1(a)<br>**2. Fruitless payments and constructive losses** (including abandoned capital schemes, except where work is purely exploratory)<br>**3. Bad debts and claims abandoned**<br>(a) Private patients<br>(b) Overseas visitors<br>(c) Cases other than 3(a) and 3(b)<br>**4. Damage to buildings, their fittings, furniture and loss of equipment and property in stores and in use**<br>(a) Culpable causes e.g. theft, fraud, arson or sabotage, whether proved or suspected, neglect of duty or gross carelessness<br>(b) Stores losses<br>(c) Other causes e.g. weather damage or accidental fire | ≤ £25,000: Chief Finance Officer<br>≤ £50,000: Chief Executive<br>> £50,000: Audit Committee and Board of Directors | For Chief Finance Officer: Director of Operational Finance or Deputy Director of Operational Finance<br>For Chief Executive: Executive Director |

SFI 14.14 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in respect of bankruptcies and company liquidations. This shall include the requirement for parent company guarantees or banker's bonds in circumstances where a review of company financial credit ratings requires further guarantees to be made prior to awarding contracts.

SFI 14.15 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

SFI 14.16 The delegated limits approved by the Board for the approval of special payments are set out below:

| Category of special payment | Approval delegated to: | Nominated Deputy |
|---|---|---|
| **5. Compensation payments made under legal obligation** (such as court order or arbitration award for personal injury, property damage or unfair dismissal)<br><br>**6. Extra-contractual payments to contractors** (such as payments for non-contractual obligations which might arguably have been upheld in court) | ≤ £25,000: Chief Finance Officer<br><br>≤ £50,000: Chief Executive<br><br>> £50,000: Audit Committee and Board of Directors | For Chief Finance Officer:<br>Director of Operational Finance<br>or Deputy Director of Operational Finance<br><br>For Chief Executive:<br>Executive Director |
| **7. Ex-gratia payments**<br>(a) Loss of personal effects<br>(b) Clinical negligence (negotiated settlements following legal advice) where the guidance relating to such payments has been applied<br>(c) Personal injury claims involving negligence where legal advice is obtained and relevant guidance has been applied<br>(d) Other clinical negligence cases and personal injury claims<br>(e) Other employment payments<br>(f) Patient referrals outside the UK and EEA guidelines<br>(g) Other<br>(h) Maladministration, such as bias, neglect, or delay | ≤ £10,000<br><br>Legal Services Department<br><br>≤ £50,000 Chief Nurse<br><br>> £50,000 Audit Committee and Board of Directors | Not applicable |
| **8. Severance payments on termination of employment** (beyond contractual | See SFI 14.12 | |

| | | |
|---|---|---|
| | obligations and not including Treasury-approved MAS) | |
| **9.** | **Extra statutory and extra regulatory payments** | |

SFI 14.17 The Chief Finance Officer shall maintain a Losses and Special Payments Register, which is completed on an accrual's basis.

SFI 14.18 All losses and special payments must be reported to the Audit Committee each quarter, as a minimum.

## SFI 15. INFORMATION TECHNOLOGY AND GOVERNANCE

**Responsibilities and duties of the Chief Finance Officer**

SFI 15.1 The Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware, for which the Chief Finance Officer is responsible, from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for current Data Protection Legislation;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system.

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment; and

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Chief Finance Officer may consider necessary are being carried out.

SFI 15.2 The Chief Finance Officer shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

**Responsibilities and duties of other directors and officers**

SFI 15.3 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of trusts in the region wish to sponsor jointly) all responsible directors and employees will send to the Chief Finance Officer:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirements; and

(c) support arrangements for the system including business continuity and disaster recovery plans.

**Contracts for computer services with other health bodies or outside agencies**

SFI 15.4 The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

SFI 15.5 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

**Risk assessment**

SFI 15.6 The Chief Finance Officer shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action is taken to mitigate or control risk.

**Requirements for computer systems, which have an impact on corporate financial systems**

SFI 15.7 Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) only appropriate staff have access to such data; and

(d) computer audit reviews are carried out, as considered necessary.

**Freedom of information**

SFI 15.8 The Trust shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

**Information governance "principle 7 compliance statement"**

SFI 15.9 The NHS holds the most sensitive and confidential information about individuals and is bound by current Data Protection Legislation. When sharing data with external parties or data processed by a third party, we must adhere to General Data Protection Regulations Article 5 (1) (f) which states that: " data must be processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures." Therefore, all data processors acting on behalf of the Trust or under instruction from the Trust must adhere to all current Data Protection Legislation and afford the appropriate security to the information they may hold/process where the Trust is the Data Controller. Measures include statements regarding information security; implementation of physical security and access controls, and business continuity measures; information governance training for staff; and incident reporting procedures. Failures may lead to the Trust seeking damages if a breach/data loss occurs.

## SFI 16. PATIENTS' PROPERTY

SFI 16.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

SFI 16.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are notified before or at admission that the Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

SFI 16.3 This notification is through:

(a) notices and information booklets;

(b) hospital admission documentation and property records; and

(c) the oral advice of administrative and nursing staff responsible for admissions.

SFI 16.4 The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of patient's money.

SFI 16.5 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

SFI 16.6 Patient lockers are available for use by patients, and those wishing to use these facilities may do so following an assessment of competence and capability. For patients who have property that needs to be handed in for safekeeping, and who are unable to use the lockers provided, a Patient Property Record, in a form determined by the Chief Finance Officer, shall be completed in respect of the following:

(a) property handed in for safekeeping by any patient (or guardian as appropriate); and

(b) property taken into safe custody having been found in the possession of:

(i) mentally ill patients;

(ii) confused and/or disoriented patients;

(iii) unconscious patients;

(iv) patients dying in hospital;

(v) patients found dead on arrival at hospital; or

(vi) patients severely incapacitated for any reason.

A record shall be completed in respect of all persons in category (b) including a nil return if no property is taken into safe custody.

SFI 16.7 The Patient Property Record shall be completed by a member of the hospital staff in the presence of a second member of staff and the patient or their personal representative, where practicable. The record shall then be signed by both members of staff and the patient, except where the latter is restricted by mental or physical incapacity.

SFI 16.8 Property and money handed over for safe keeping shall be placed immediately into the care of the cashier or designated member of the General Office staff except where there are no

administrative staff available, in which case the property shall be placed in the care of the most senior member of nursing staff on duty.

SFI 16.9 Except as provided in SFI 16.10 and SFI 16.11 below, refunds of cash handed in for safe custody will be dealt with in accordance with written instructions from the Chief Finance Officer. Property other than cash that has been handed in for safe custody shall be returned to the patient as required. The return shall be receipted by the patient (or guardian as appropriate) and witnessed. The receipts are then retained by the hospital cashier for audit inspection.

SFI 16.10 The disposal of the property of deceased patients shall be effected by the hospital cashier, or the staff member who has had responsibility for its security. Particularly where cash and valuables have been deposited, they shall only be released after written authority given by the Chief Finance Officer. Such authority shall include details of the lawful kin or other persons entitled the deceased's property.

SFI 16.11 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

SFI 16.12 In respect of a deceased person's property, if there is no will and no lawful kin, the property vests in the Crown and the Chief Finance Officer shall notify the Duchy of Lancaster.

SFI 16.13 Any funeral expenses necessarily borne by the Trust are a first charge on a deceased person's estate. No other expenses or debts shall be discharged out of the estate of a deceased patient.

SFI 16.14 Where patients' property or income is received for specific purposes and held for safekeeping, the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

## SFI 17. CHARITABLE FUNDS

**The charity framework and the applicability of standing financial instructions to the Charity**

SFI 17.1 The Trust's SFIs are equally applicable to the Trust's charitable funds with regards to procurement and transactions.

SFI 17.2 The Standing Financial Instructions state the Board of Directors responsibilities as a Corporate Trustee for the management of charitable funds and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, Corporate Trustee responsibilities must be discharged separately, and full recognition given to its accountabilities to the Charity Commission. The Trustee must ensure compliance with the Charity Commission's latest guidance and best practice, and charity law, including the Charities Act 2011.

SFI 17.3 The discharge of the Board of Directors Corporate Trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. The Charitable Trust Committee is a Committee of the Trust Board with delegated powers to administer charitable matters and authorise expenditure.

SFI 17.4 Within these Standing Financial Instructions, 'charitable funds' are defined as the total net assets of Wrightington, Wigan and Leigh Health Services Charity (also known as 'Three Wishes'), which is a registered charity in support of purposes relating to the National Health

Service. These chiefly represent the cumulative cash donated and bequeathed to the Charity, net of charitable expenditure to date. Management of the funds is governed by charity legislation.

**Approvals**

SFI 17.5 The Chief Finance Officer must prepare procedural guidance for raising, handling, and accounting for charitable income, and for the proper expenditure of charitable funds, and shall ensure that each charitable fund is managed appropriately with regard to its purpose, the Charity Commission's latest guidance and best practice, and charity law.

SFI 17.6 No new fund or fundraising activity (except those 'for the general purposes of the Charity', and not undertaken during work time) shall be established without first obtaining the written approval of the Charitable Trust Committee.

SFI 17.7 As Corporate Trustee, the Committee has delegated limits for the approval of expenditure as follows:

| Type of charitable fund | Nominated Deputy |
|---|---|
| Divisional funds and restricted funds (such as appeal funds) | ≤ £20,000 including VAT and carriage<br>Divisional Fund Committee<br>> £20,000<br>Charitable Trust Committee |
| Fundraising expenditure | ≤ £5,000 including VAT and carriage<br>Associate Director of Financial Services and Payroll<br>≤ £20,000 including VAT and carriage<br>Chief Finance Officer<br>> £20,000<br>Charitable Trust Committee |
| The Charitable Trust Committee reserves the right to veto expenditure approved by Divisional Fund Groups and to recharge divisional funds for administrative, governance or other costs. | |

**Fund management and expenditure**

SFI 17.8 All Divisional Fund Committees shall be responsible for the management of funds held within their areas of responsibility including the implementation of initiatives to increase donations.

SFI 17.9 Divisional Fund Committees will be responsible for ensuring that all expenditure incurred through charitable funds meets the public benefit test as outlined in the Charity Act 2011; and that such expenditure is timely, without the unnecessary accumulation of funds.

SFI 17.10 All expenditure must be for 'appropriate charitable purposes', in accordance with the Charity's Expenditure Guidance policy document. Exceptionally, strategic and governance expenditure is approved by the Charitable Trust Committee.

SFI 17.11 In the first instance, it is the responsibility of a Divisional Fund Committee or equivalent to ensure that all commitments against a charitable fund represent the best available value for money in terms of direct patient benefit, and are consistent with 'appropriate charitable purposes' as defined by

(a) the fund's objectives;

(b) Charity policies; and

(c) patient benefit criteria set out in charity law.

SFI 17.12 Under no circumstances shall a fund be allowed to go into deficit. It is a responsibility of the Divisional Fund Committee to ensure this does not occur.

SFI 17.13 Where possible, the use of exchequer funds to discharge charitable fund liabilities should be avoided, and any indebtedness to exchequer should be discharged by the charitable fund at the earliest possible time.

**Income**

SFI 17.14 All charitable gifts, donations and fundraising activities are governed by the Charity's Fundraising and Income Guidance policy document. All charitable proceeds must be handed immediately to the Chief Finance Officer via an authorised Cash/General Office, to be banked directly to the Charity's charitable fund bank account. All gifts received shall be confirmed to the donor in the Trust's authorised form of receipt that will ensure the donor's wishes are observed without unnecessarily creating new trusts.

SFI 17.15 Gifts which are intended to personally and directly benefit staff, such as 'thank-you' presents, flowers or contributions to staff recreation are not charitable donations, as they have no link to public or patient benefit, but are, rather, gifts to individuals. As such, they are expected to be modest, and are covered by the Trust's Conflicts of Interest Policy.

SFI 17.16 Under no circumstances shall any income (cash, cheques, or other forms of payment) be retained on any Ward or Department, excepting when a Cash/General Office is closed. Where a donation occurs at night or at weekends, the income shall be retained in a secure environment, with an internal receipt given to the donor at the time the donation is made. In the event of this occurring, the income shall be deposited with a Cashier at the next earliest opportunity.

SFI 17.17 All gifts and income accepted shall be administered in accordance with the relevant fund's charitable objectives, subject to the terms of specific trusts. As the Charity can only accept cash or non-cash donations for all or any purpose related to the Health Service, officers shall, in cases of doubt, consult the Chief Finance Officer before accepting gifts of any kind.

SFI 17.18 In respect of legacies and bequests, the Chief Finance Officer shall be kept informed of all enquiries regarding legacies and bequests, which should be filed on a case-by-case basis. Where required, the Chief Finance Officer shall:

(a) provide assistance covering any approach regarding the wording of wills and the receipt of funds/other assets from executors; and

(b) where necessary, obtain grant of probate, or make application for grant of letters of administration.

**Banking**

SFI 17.19 The Chief Finance Officer shall be responsible for ensuring that appropriate banking services are available in respect of administering the charitable funds.

**Investment management**

SFI 17.20 The Chief Finance Officer shall be responsible for all aspects of the management of the investment of charitable funds as delegated under the terms of the Charity's approved

Treasury Management Policy. The issues on which the Chief Finance Officer shall be required to provide advice to the Charitable Trust Committee include:

(a) the formulation of a Treasury Management Policy, which meets statutory requirements and Charity Commission guidance with regard to income generation and the enhancement of capital value;

(b) the appointment of advisers, brokers and, where appropriate, investment fund managers;

(c) pooling of investment resources in line with Charity Commission legislation;

(d) the participation by the Trust in common investment funds and the agreement of terms of entry and withdrawal from such funds; and

(e) the review of investment performance and of brokers and fund managers.

**Asset management**

SFI 17.21 Donated assets in the ownership of, or used by, the Trust as Corporate Trustee, shall be maintained along with the general estate and inventory of assets of the Trust. The Chief Finance Officer shall ensure that:

(a) appropriate records of all donated assets owned by the Trust are maintained, and that all assets, at agreed valuations are brought to account; and

(b) appropriate measures are taken to protect and/or to replace assets. These are to include decisions regarding insurance, inventory control, and the reporting of losses.

**Reporting**

SFI 17.22 The Chief Finance Officer shall:

(a) ensure that regular reports are made to the Charitable Trust Committee with regard to, inter alia, fund balances, investments, expenditure, expenditure approvals, and any policies in line with Department of Health and Social Care and Charity Commission guidance;

(b) prepare annual accounts in the required manner, which shall be submitted to the Charitable Trust Committee and Audit Committee within agreed timescales;

(c) prepare an annual Trustee's report and required returns for the Charity Commission for adoption by the Committee;

(d) prepare detailed procedural instructions concerning the receiving, recording, investment and accounting for charitable funds; and

(e) maintain such accounts and records as may be necessary to record and protect all transactions and funds of the charitable funds.

## SFI 18. ACCEPTANCE OF GIFTS HOSPITALITY AND COMMERICAL SPONSORHSIP BY STAFF

SFI 18.1 The Chief Finance Officer shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy, the Conflicts of Interest Policy, should follow the guidance contained in the NHS England model policy document. This policy guides officers and should be adhered to in all business dealings with organisations and people outside of the Trust.

SFI 18.2 The Trust will publish on its website, its Register of Interests and Register of Gifts and Hospitality on a bi-annual basis and Registers of Interests and Registers of Gifts and Hospitality will be discussed at each Audit Committee meeting.

SFI 18.3 Gifts to staff, including cash, intended to benefit individual staff members or teams, are not charitable donations to the Trust's charity.

SFI 18.4 Staff should not ask for or accept gifts, rewards or hospitality that may affect, or be seen to affect, their professional judgement. Gifts of cash or cash equivalent should always be declined.

SFI 18.5 Hospitality includes offers such as transport, refreshments, meals, accommodation etc, and should only be accepted where it is secondary to a business event i.e. there is a legitimate business reason. Hospitality must be appropriate and not out of proportion to the occasion i.e. subsistence only.

SFI 18.6 Commercial sponsorship agreements must always be declared. Before entering into a commercial sponsorship agreement written approval should be sought from the individual's line manager.

SFI 18.7 Sponsored post holders must not promote or favour the sponsor's products.

SFI 18.8 Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored post.

## SFI 19. RETENTION OF RECORDS

SFI 19.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health and Social Care guidelines NHS Records Management Part 1 and Part 2.

SFI 19.2 The records held in archives shall be capable of retrieval by authorised persons.

SFI 19.3 Records shall only be destroyed in accordance with latest Department of Health and Social Care guidance and a record shall be maintained of those records so destroyed, together with the date of their destruction.

## SFI 20. RISK MANAGEMENT AND INSURANCE

**Programme of risk management**

SFI 20.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with NHS Improvement's Risk Assurance Framework, which must be approved and monitored by the Board.

SFI 20.2 The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) promotion among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including internal audit, clinical audit, and health and safety review;

(f) a clear indication of which risks shall be insured; and

(g) arrangements to review the risk management programme.

SFI 20.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement within the Annual Report and Accounts as required by Department of Health and Social Care Group Accounting Manual.

SFI 20.4 The Chief Finance Officer shall ensure that appropriate insurance arrangements exist in accordance with Department of Health and Social Care guidance. This will be a mixture of NHS Resolution cover and, in some instances, commercial insurance.

SFI 20.5 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

SFI 20.6 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, exceptions when trusts may enter into insurance arrangements with commercial insurers. The exceptions are:

(a) insuring motor vehicles owned by the Trust including insuring third party liability arising from their use;

(b) private finance initiative (PFI) contracts where the other consortium members require that commercial insurance arrangements are entered into;

(c) pressure vessels such as boilers and other associated risks; and

(d) income generation activities – if not related to normal business activity, these should normally be insured using commercial insurance. If the income generation activity is an activity normally carried out by the Trust for an NHS purpose, the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution. .

SFI 20.7 All other commercial, or alternative insurance policies, are to be approved by the Chief Finance Officer.

**Arrangements to be followed by the board in agreeing insurance cover**

SFI 20.8 Where the Board decides to use the risk pooling schemes administered by NHS Resolution, the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

SFI 20.9 Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed to the Trust.

SFI 20.10 All the risk pooling schemes require scheme members to make some contribution to the settlement of claims (the ‘deductible’). The Chief Finance Officer should ensure documented

procedures also cover the management of claims and payments below the deductible in each case.

## SFI 21. INTELLECTUAL PROPERTY

### Intellectual property (IP)

SFI 21.1 The Trust has an approved Intellectual Property Policy.

SFI 21.2 It is appropriate therefore to include IP references in the Standing Financial Instructions.

### Definition of intellectual property

SFI 21.3 Intellectual Property can be defined as products of innovation and intellectual or creative activity and can include inventions, industrial processes, software, data, written work, designs and images. IP can be given legal recognition of ownership through intellectual property rights (IPR) such as patents, copyright, design rights, trademarks or “know how.”

SFI 21.4 Examples of IP that may be developed in the NHS include: training manuals, clinical guidelines, books and journal articles, PowerPoint presentations, inventions, new or improved designs, devices, equipment, new uses for existing drugs, diagnostics tests, and new treatments.

### Ownership of intellectual property

SFI 21.5 Ownership of IP will, in most cases, rest with the Trust. This applies to all IP produced by Trust employees in the course of their employment, specifically when undertaken on Trust premises, using Trust equipment and in contact with Trust patients. IP developed by an employee outside the course of their employment, not utilising Trust assets or Trust patients will usually belong to the employee, subject to agreement.

SFI 21.6 This is in accordance with the Patent Act 1977, and the Copyright, Designs and Patent Act 1988.

SFI 21.7 IP ownership can vary according to the circumstances under which the IP was generated. Such circumstances include:

(a) joint/honorary appointments/trainees;

(b) externally funded work;

(c) commissioned work; and

(d) collaborative projects.

### Disputes of ownership

SFI 21.8 If the ownership of IP is disputed, dated written records relating to the IP in question will be assessed to establish the inventor(s), and their proportionate contribution. If such material is not available, the Chief Executive of the Trust will make a final decision, taking professional advice if necessary.

SFI 21.9 Persons covered by the Intellectual Property Policy include:

(a) all staff that are full time or part time employees of the Trust;

(b) full-time or part-time staff who are self-employed (e.g. private practice);

(c) trainee professionals (e.g. Specialist Registrars);

(d) staff seconded to other organisations; and

(e) staff with joint or honorary contracts with another organisation.

**Intellectual property management**

SFI 21.10 The Trust should use an appointed NHS Innovation Hub as its IP expert company to give advice and assistance in the protection, management and commercial opportunities of IP initiatives.

**Staff obligations**

SFI 21.11 All employees, including those covered by the Intellectual Property Policy, have an obligation to inform the Trust's R&D manager about identified or potential IP activities, and must not, under any circumstances, sell, assign, license, give or otherwise trade IP without the Trust's approval.

SFI 21.12 The Trust brand and logos should not be used unless in connection with Trust business.

**Monitoring intellectual property**

SFI 21.13 The Research and Development Manager will provide to the Board updates with regards to:

(a) the risks and rewards in respect of approving IP initiatives; and

(b) potential and ongoing IP initiatives.

## SFI 22. DECLARATION OF INTERESTS

**General**

SFI 22.1 All staff are required to declare interests which are relevant and material. Staff should declare interests on appointment and when there are any changes.

SFI 22.2 Staff members at Agenda for Change band 8d and above, and any member of staff on any other salary scale at that level and above including all consultants and medical staff, will be asked to confirm on an annual basis that their entry on the register of interests is accurate and provide updates as required.

SFI 22.3 A declaration of interest must be submitted by any grade of employee in the event where a relationship exists when involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices and/or equipment.

**Bribery Act 2010**

SFI 22.4 Bribery is generally defined as giving or offering someone a financial or other advantage to encourage a person to perform certain activities and can be committed by a body corporate. Commercial organisations (including NHS bodies) will be exposed to criminal liability, punishable by an unlimited fine, for failing to prevent bribery.

SFI 22.5 The offences of bribing another person or being bribed carry a maximum sentence of 10 years imprisonment and/or a fine. In relation to a body corporate the penalty for these offences is a fine.

SFI 22.6 This Trust does not, and will not, pay bribes or offer improper inducements to anyone for any purpose; nor will it accept bribes or improper inducements. It is important that all employees,

contractors and agents are aware of the standards of behaviour expected of them contained in this policy.

SFI 22.7 It is the duty of Trust employees, including all agency and contracted staff, who have the powers to enter into transactions on behalf of the Trust, not to influence or enter into negotiations or purchases with an individual or entity where a relationship with the other party exists. For clarification relationships include, but are not limited to, spouse, parent, child, brother, sister (and relations of any of these). Relationships also include friendships, and are deemed to exist when the employee has any financial interest in the other party.

SFI 22.8 If in doubt, Trust employees and representatives must inform their line manager and in all circumstances should declare his/her interest by completing a declaration of interest form which can be found in the Trust's Code of Conduct Policy, and should not take any part in the negotiation process.

**Declaration of interest**

SFI 22.9 An annual completion of declarations of interest exercise will be undertaken as part of the Trust's annual accounts process and is mandatory for all staff on band 8 and above. Any disclosures not made and later discovered will be considered a breach of Trust Standing Financial Instructions, which could subsequently lead to disciplinary action being taken.

## SFI 23. BUSINESS CASE AND TENDER PROCESS

**Introduction**

SFI 23.1 The Trust's business case process has been established to ensure there is full involvement from any party within the organisation that could be affected by the intended direction of travel. Auditability, governance and financial principles are critical to ensure there is no unforeseen service, quality or financial consequences from our investment decisions.

SFI 23.2 All approved business cases must satisfy one of more of the investment criteria established by the Executive Team. Business cases must include key performance indicators for how the investment will be assessed or measured once implemented.

SFI 23.3 All business cases must have a reference number assigned by the finance department, referenced within the minutes of the meeting of the approving entity.

**Revenue and capital expenditure**

SFI 23.4 All revenue and capital investments must be submitted for a formal decision using the Trust's current business case process and template. Business cases for national funding should be on the appropriate NHSE template.

SFI 23.5 Should the Trust approve, it may also be necessary to seek approval from the Greater Manchester Integrated Care Board or NHS England.

SFI 23.6 Should the Trust approve, it may also be necessary to seek NHSE's approval.

SFI 23.7 Business cases will be approved in accordance with the following table:

| Type of Business case | Capital Medical Equipment Group | Executive Team Meeting | Finance and Performance Committee | Board of Directors |
|---|---|---|---|---|
| Capital medical equipment, within the delegated capital limit for Capital Medical Equipment and with no revenue implications. | £500k | N/A<br><br>(CME cases over £500k still require ETM endorsement before going to F&P) | £1m | >£1m |
| All other business cases | N/A | £500k | £1m | >£1m |
| *The value of a business case is defined as the total combined revenue and capital expenditure (calculated as total capital expenditure, plus recurrent revenue expenditure plus one-off revenue expenditure).* | | | | |

Appendix 1

As an organisation that is publicly funded with stringent financial duties to achieve, it is essential for the Trust to have robust financial controls in place. This will ensure that we are providing value for money, that our colleagues are working within this guidance framework and that we do not become vulnerable to the risk of fraud. A strong financial governance and control framework will contribute toward the Trust managing its finances on an effective and sustainable basis.

The Standing Financial Instructions (SFI's) form a key role in the Trust's financial governance and control framework, and it is important that employees are aware of their responsibilities for financial governance by understanding and working within the guidance of this policy.

To support the Trust's governance and control framework, a monitoring and reporting process has been implemented to ensure that employees are following the SFI's correctly and that processes and procedures are working effectively.

The following matrix highlights the key areas of the SFI's, how monitoring of compliance will be undertaken and when issues or incidents arise, how these will be managed. In some cases, where there are repeated occurrences of issues or disregard for the framework that put the Trust at risk of Fraud, these will be escalated formally.

It is acknowledged that in the majority of instances staff will have acted in good faith, and there may be situations where further training or guidance is required to support staff to ensure they are working in line with the framework, however, it is important that the Trust does not leave itself open to the risk of fraud. Exploring and understanding issues or incidents that don't comply with this framework will allow for a review of the procedures and controls in place.

We aim to work collectively with staff to understand the root cause of issues and learn from these to prevent future incidents. Whilst our priority is to support staff in following this framework, careless disregard for the processes within this framework or fraud related matters are unacceptable and will be addressed via a formal process.

| Chapter of SFI | **Areas for potential non-compliance** ***(This list is not exhaustive)*** | **How it will be monitored** | **Applicable to** | | **Monitoring by** | **Point at which breach will be escalated for review under Trust disciplinary policy.** |
|---|---|---|---|---|---|---|
| **Audit fraud corruption bribery and security** | • All instances of fraud, corruption or bribery ***(Section 2)*** | Referrals to Local Counter Fraud Specialist | All employees | | Local Counter Fraud Specialist | **Immediately** |
| **Business planning budgets budgetary control and monitoring** | • Exceeding budgetary total, or virement limits set by the board ***(3.2.2)*** | Monthly monitoring of budget statements | Budget holders | | Management Accounts | Clinical divisions report on their performance via bi-monthly divisional assurance meetings (DAMs) which are chaired by an Executive Director.<br><br>An escalation process called RAPID (recovery, action, planning, implementation and delivery) has been introduced where performance metrics can trigger the DAM meeting to convert to a RAPID meeting to provide further scrutiny and support on the financial position. |
| | • Use of non-recurring expenditure to fund recurring budget expenditure without authority ***(3.2.4)*** | | | | | |
| | • Use of approved budget for a purpose other than as specially authorised ***(3.3.2, c)*** | | | | | |
| | • Engaging services of agency workers without approval ***(3.3.2, d)*** | Budget statements<br>Review of agency invoices | Budget holders | | Financial Services | **After 3rd Notification** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Bank and GBS Accounts** | • Opening a bank account in Trust name ***(5.1.3)*** | As and when the situation arises. | All employees | | Financial Services | **Immediately** |
| **Income fees and charges** | • Employees must report income due on transactions which they initiate/ deal with including all contracts, leases and tenancy arrangements ***(6.2.3)*** | As and when the situation arises. | Budget holders | | Management Accounts | **Immediately** |
| | • Use of Trust cash for private transactions, encashment of cheques bank to bank transfers and loans ***(6.4.2)*** | As and when the situation arises. | Cash office | | Financial Services | **Immediately** |
| | • Use of Trust Credit card for personal expenditure ***(6.4.4)*** | Via monthly reviews of credit card statements | Credit card holders | | Financial Services | **Immediately** |
| | • Use of Trust credit card for expenses which should be reimbursed through payroll without prior approval ***(6.4.5)*** | | | | | **After 2nd notification** |
| | • Holders of safe keys should not accept unofficial funds for depositing in their safes without sealed envelopes or locked containers ***(6.4.7)*** | Audits of Cash Office | Cash office | | Financial Services | **Immediately** |
| | • Failure to report losses of cash cheques and other negotiable instruments ***(6.4.11)*** | As and when the situation arises. | Cash office | | Financial Services | **Immediately** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Tendering and contracting procedure** | • Failure to obtain competitive quotes for expenditure expected to exceed £10,000 but not exceed £50,000 ***(7.3.1)*** | Requisition entered onto Oracle and checked by buyer | Oracle users | | Procurement | **After 2nd notification** |
| | • Failure to undertake competitive tendering exercise for expenditure that is equal to or reasonably expected to exceed £50,000 ex VAT ***(7.4.1)*** | Requisition entered onto Oracle and checked by buyer | | | | **After 2nd notification** |
| | • Waivers unsupported by procurement ( 7.6.1) | As and when the situation arises. | | | | **After 2nd notification** |
| | • Failure to involve procurement in the tender process ***( 7.14.1)*** | As and when the situation arises. | | | | **After 2nd notification** |
| | • Unauthorised approval of NHS and Non NHS Contracts ***(7.14.3)*** | As and when the situation arises. | | | | **After 2nd notification** |
| | • Failing to ensure that all items received under a prepayment agreement have been received ***(8.3.4,d)*** | As and when situation arises | | | | **After 2nd notification** |
| | • Failing to comply with requisitioning and ordering processes ***(8.3.6, a- n)*** | Monthly reviews of invoice process via Non PO route. | Oracle users | | Procurement | **After 2nd notification** |
| **Contracting for provision of healthcare** | • Failure to ensure that a SLA is in place for the supply or receipt of services either clinical or non- clinical ***(10.4)*** | | Legal Team | | Legal team | **Immediately** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Terms of services allowances and pay** | • Failure to remain within funded establishment without prior consent to changes ***(11.2.3)*** | Monthly monitoring of budget statements | Budget holders | | Management Accounts | Escalated through divisional internal reporting structure and review meetings with finance managers, Directorate Managers and Directors of Performance.<br><br>Ultimate outcome is representation at the divisional assurance review with members of the executive team and then Finance and Performance Committee.<br><br>Finance reports to include details of breaches." |
| | • Engagement, re-grade, hire of agency staff or changes to any employees remuneration unless authorised to do so ***(11.3.1)*** | Monthly monitoring of budget statements | Budget holders | | Management Accounts/Payroll | **Under review pending update to temporary staffing policy (Aug 2021)** |
| | • Late submission of time records to payroll ***(11.4.3,a)*** | Monitoring of payroll related information | Payroll authorised signatories | | Payroll | **After 3rd Notification** |
| | • Failure to submit termination forms to the payroll department immediately on | | | | | **After 2nd notification** |

| | | | | | | |
|---|---|---|---|---|---|---|
| | knowing the effective date of the an employee's resignation, termination or retirement ***(11.4.3, c)*** | | | | | |
| | • Changing an individual's pay outside of agenda for change terms and conditions without the appropriately authorised Local Pay Variation form ***(11.5.1)*** | | | | | **Controls in place to prevent this happening**. |
| | • Damage to premises, vehicles and equipment or any of equipment stores or supplies must be reported. ***(13.3.5)*** | As and when the situation arises. | All employees | | Financial Services | **After 2nd notification** |
| **Disposals and condemnations, losses and special payments** | • Failure to dispose of assets in accordance with disposal policies. ***(14.1.2)*** | As and when the situation arises. | Budget holders | | Financial Services | **After 2nd notification** |
| | • Any employee discovering or suspecting a loss of any kind, other than fraud, corruption or bribery must immediately inform their head of department. ***(14.2.2)*** | As and when the situation arises. | All employees | | Financial Services | **Immediately** |
| **Patients Property** | • Failure to complete patient property record in respect of patient property handed in for safekeeping ***(16.6)*** | As and when the situation arises. | Ward Staff | | Financial Services | **After 2nd notification** |

| | | | | | | |
|---|---|---|---|---|---|---|
| | • Failure to hand patient property into the Cash office ***(16.7)*** | | | | | |
| **Charitable Funds** | • Undertaking fundraising activity for the Trust Charity without appropriate approval ***(17.2.2*** | As and when the situation arises. | All employees | | Financial Services | **After 1st notification** |
| | • Commitment to expenditure which does not meet charitable purposes and public benefit test ***(17.3.2, 17.3.3)*** | Monthly review of expenditure purchases | Charitable Fund Managers | | Financial Services | **After 1st notification** |
| **Acceptance of gifts and hospitality** | • Failure to disclose commercial sponsorships & Gifts and Hospitality ***(18.6, 8.3.6.n, 17.4.2)*** | Gifts and hospitality register | All employees | | Local Counter Fraud Specialist/Company Secretary | **After 1st notification** |
| **Risk management and insurance** | • Entering in to commercial insurance arrangements without authorisation ***(20.1.6)*** | As and when the situation arises. | All employees | | Financial Services | **After 2nd notification** |
| **Intellectual property** | • Selling, assign license or trade IP without approval ***(20.1.6)*** | As and when the situation arises. | All employees | | Financial Services | **After 1st notification** |
| **Declarations of interest** | • Influencing or entering into negotiations or purchases with an individual or entity where a relationship with the other party exists ***(22.2.4, 22.2.5 & 22.3.1)*** | Via MES software | All employees | | Local Counter Fraud Specialist /Company Secretary | **After 1st notification** |
| **Business case and tender process** | Incurring expenditure where the business case process has not been followed. **(S23)** | Via monthly budget statements and capital to revenue approvals | Budget holders | | Management Accounts and Capital Accountant | **After 1st notification** |

# Maternity Incentive scheme 2023

## Safety Action 8 Training plan

From September 2023 the Maternity Service commenced an amended 4-day training programme for Midwives and 2 and a half days for Maternity support workers, to cover all elements of CNST and the core competency framework. Annual training has remained ongoing for Core competencies 2 3and 6.

To ensure compliance attendance from Obstetricians is required annually on both PROMPT and on fetal surveillance training.

It is also compulsory that any anaesthetist on the obstetric rota attend PROMPT training annually. The new schedule for both Midwives and support workers is detailed below: -

**Time frame for compliance of the above competencies is 1st December 2022 until 1st December 2023**

To meet all six core modules within the 3-year time frame as detailed in the core competency framework 2 extra days training days have been facilitated for Midwives and Maternity support workers (maternity safety day and specialist services updates)

**The training requirements set out in the core competency framework require 90% attendance of relevant staff groups by the end of the 12-month period for each core competency.**

## Saving babies lives care bundle (core competency Module 1 )

This includes updates on all elements of the bundle, except fetal monitoring in labour as this is covered as a separate session. Sessions commenced September 2023 so 90% compliance will be achieved by August 2024.

- Topics include: -
  - * Smoking in pregnancy
  - * Fetal growth restriction with face-to-face fundal height measurement assessment
  - * Reduced fetal movements
  - * Pre-term birth
  - * Diabetes in pregnancy

### Current compliance

| Topic | Number attended September | | %age compliance | |
|---|---|---|---|---|
| | Midwives | MSW | Midwives | MSW |
| Smoking in pregnancy | 24 | 2 | 16% | 5% |
| Fetal growth restriction | 24 | 2 | 21% | 5% |
| Reduced fetal movements | 24 | 2 | 21% | 5% |

| | | | | |
|---|---|---|---|---|
| Preterm birth | 24 | 2 | 21% | 5% |
| Diabetes in pregnancy | 24 | 2 | 16% | 5% |

**By July 2024 compliance will be over 90% in all topics**

## Fetal surveillance in labour (core competency Module 2)

A full day session compulsory for all Midwives and obstetricians, minimum required attendance is 90% for both groups. Topics discussed include: -

- Fetal Physiology
- Fetal physiology and sepsis
- Fetal physiology and meconium
- Intelligent intermittent auscultation
- Dawes Redman and antenatal CTG's
- Local case reviews
- Human factors
- Risk assessment in labour

| | Midwives | Obstetric consultants | Obstetric registrars |
|---|---|---|---|
| September<br>Number attended<br>%age compliance | <br>17<br>98.6% | <br>2<br>91% | <br>0<br>89% |

## Multi-professional PROMPT Day (core competency Module 3)

At present face to face PROMPT multidisciplinary emergency training days have been in place since June 2021. Sessions are delivered monthly 9-5pm in the education centre with theory sessions in the morning and emergency drill simulations in the afternoon. The sessions covered from September 2023 until August 2024 are as follows: -

- Antepartum haemorrhage and uterine rupture
- Postpartum Haemorrhage
- Impacted fetal head
- Maternal Collapse
- Shoulder Dystocia
- Anaesthetic emergencies

All sessions are multidisciplinary including midwives, maternity support workers, Obstetric trainees, obstetric consultants, and anaesthetic consultants with optional participation from maternity theatre staff. To achieve 90% compliance, we need a minimum attendance of 14 midwives, 1 obstetric consultant, 1-2 obstetric registrars, 1-2 anaesthetists and 3-4 Maternity support workers to attend each month.

PROMPT compliance to date is detailed in the table below

| | Midwives | Maternity support workers | Obstetric consultants | Obstetric registrars | Anaesthetists |
|---|---|---|---|---|---|
| September<br>Number attended<br>% rolling compliance | <br>21<br>85% | <br>3<br>78% | <br>2<br>75% | <br>2<br>79% | <br>1<br>68% |

| | | | | | |
|---|---|---|---|---|---|
| October projection Number to attend<br>% compliance | 17<br>91% | 5<br>78% | 3<br>83% | 2<br>86% | 5<br>68% |
| November projection Number to attend<br>% compliance | 13<br>93% | 4<br>83% | 1<br>92% | 0<br>86% | 3<br>79% |

**There is a plan to have the staff who are not compliant trained within the next 3 sessions. Final session will be 1st December 2023, which is the deadline for completion. (Email sent to Divisional leads to emphasise the importance of attendance for each of the staff members to ensue attendance is facilitated)**

## Equality, equity, and personalised care. (core competency Module 4 )

This includes updates on the following topics: -

*Maternal mental health
* Bereavement care
* Care of vulnerable women
* Equality and diversity with cultural competence
* Governance updates including learning from incidents

**Current compliance**

| Topic | Number attended September | | %age compliance | |
|---|---|---|---|---|
| | Midwives | MSW | Midwives | MSW |
| Maternal mental health | 14 | 2 | 45% | 5% |
| Bereavement care | 24 | 2 | 50% | 5% |
| Vulnerable women | 14 | 2 | 46% | 5% |
| Equality and diversity | 14 | 2 | 10% | 5% |
| Governance update | 26 | NA | 17% | NA |

**By July 2024 compliance will be over 90% in all topics**

## Care during labour and the postnatal period. (core competency Module 5 )

This includes updates on the following topics: -

*Management of labour (Covered on fetal surveillance training)
* VBAC (covered on PROMPT training)
* GBS in labour
* Management of epidural anaesthesia (workshops in the clinical area)
*Perineal trauma (workshops in the clinical area)
* Infant feeding
* ATAIN
* Multiple pregnancy

**Current compliance**

| Topic | Number attended September | | %age compliance | |
|---|---|---|---|---|
| | Midwives | MSW | Midwives | MSW |
| GBS in labour | 16 | NA | 11% | NA |
| Management of epidural | NA | NA | 28% | NA |
| Perineal trauma | NA | NA | 54% | NA |
| Infant feeding | 14 | 2 | 10% | 5% |
| ATAIN | 14 | 2 | 10% | 5% |
| Multiple pregnancy | 24 | 2 | 21% | 5% |
| Operative delivery | 16 | NA | 11% | NA |

**By July 2024 compliance will be over 90% in all topics**

## Neonatal life support (core competency Module 6)

The annual update is delivered on the maternity safety days with a resuscitation council presentation and a practical demonstration followed by assessment of resuscitation techniques in line with CNST standards.

The NLS algorithm is used during training, and it is highlighted that all steps must be followed correctly and in order to achieve the best outcome.  It is advised during training that any neonatal resuscitation should action a call for help either by emergency call bell in the unit or by 999 if at home.

Current compliance for NLS annual update is 91% for midwives and 81% for Maternity support workers. The compliance for MSW's will be 90% over the next couple of months as new starters and staff returning from long term sick will be attending training.

# CNST Year 5 Progress Form

| | | |
|---|---|---|
| Name of provider: | | Wrightington Wigan. And Leigh Teaching Hospital NHS Foundation Trust |
| Name of Person completing the form: | | Cathy Stanford Divisional Director of Midwifery and Child Health |
| Date form completed: | | 20.09.2023 |
| Date due to Trust Board for final Sign off of declaration form: | | 01/12/2023 |
| Do you submit your CNST progress to the Trust Board as per the Perinatal Quality Surveillance Model?: | | Yes |
| Date of update to Trust Board: | | October -2023 |

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. The MIS applies to all acute Trusts that deliver maternity services and are members of the CNST.

The scheme incentivises **ten** maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved all ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

**To be eligible for payment under the scheme, Trusts must submit the completed Board Declaration form to NHS Resolution nhsr.mis@nhs.net by 12 noon on 1 February 2024.**

The LMNS is expected to have oversight and assurance that providers are meeting the ten safety actions leading up to the submission on 1st February 2024.

In line with section 4.7 of the Three-Year Plan for Maternity and Neonatal Services is for ICBs to oversee and be assured of trust's declarations to NHS Resolution for the maternity incentive scheme (CNST). This document supplements the Standard Operating Procedure document for CNST Year 5 Returns.

The proposed process for oversight and assurance allows for overall compliance of the ten safety actions. The process includes three elements:

A. The submission of evidence to the LMNS/ ICB stated in the CNST document.
B. The development of an assurance process to have oversight and gain assurance of the ten safety actions.
C. The process of sign off by NHS GMEC ICB CEO

**The submission of evidence to the LMNS/ ICB stated in the CNST document.**

**In order to meet the CNST requirements for sign off the Board declaration form and presentation will need to be presented to the Board in December and any outstanding actions for Training completion communicated for assurance to the Board Members in January 2024**

**The CNST document outlines that the LMNS, or in some instances the ICB require sight of or 'sign off' of certain pieces of evidence. A list of the evidence required, and dates required to be submitted to the LMNS, are presented in the table within the next slides:**

| Safety Action | Evidence | Submission to LMNS Date | Evidence presented at: | |
|---|---|---|---|---|
| | | | LMNS Maternity and Neonatal System Board Date | Clinical Effectiveness Group Date |
| 1 | N/A | | | |
| 2 | N/A | | | |
| 3 | Transitional Care and ATAIN Audits & Action plans | Q4 22-23<br>(Jan-Mar 23)<br>1st June 2023 | 12 September 2023 | 27 September 2023 |
| | | Q1 23-24<br>(Apr- Jun 23)<br>1st September 2023 | 14 November 2023 | 29 November 2023 |
| | | Q2 23-24<br>(Jul-Sept 23)<br>1st December 2023 | 16 January 2024 | TBC |
| **4A Obstetric Workforce** | | | | |
| 4Ai | Meet criteria for short term locums, if not met inform LMNS | October 2023<br>CNST Assurance Checkpoint | 14th November 2023 | |
| 4Aii | Compliance to Royal College of Obstetricians and Gynaecologists (RCOG) long term Locums action plan if required to be signed off by LMNS | October 2023<br>CNST Assurance Checkpoint | 14th November 2023 | |
| 4Aiii | Compliance to RCOG guidance compulsory rest action plan if required to LMNS | October 2023<br>CNST Assurance Checkpoint | 14th November 2023 | |
| 4Aiv | Compliance to consultant attendance for the clinical situations listed in RCOG workforce document, to share with LMNS | October 2023<br>CNST Assurance Checkpoint | 14th November 2023 | |
| **4C Neonatal Medical workforce** | | | | |
| 4C | Neonatal unit meets British Association of Perinatal Medicine (BAPM) national standards<br>Action plan if required shared with LMNS and Neonatal Operational Delivery Network (NNODN) | October 2023<br>CNST Assurance Checkpoint | 14th November 2023 | |

| 4D Neonatal Nursing workforce | | | | |
|---|---|---|---|---|
| 4D | Neonatal unit meets BAPM national standards Action plan if required shared with LMNS and NNODN | October 2023<br>CNST Assurance Checkpoint | 14th November 2023 | |
| 5 | Birth rate plus- where deficits in staffing levels have been identified, share with local commissioners | August 2023 | 12 September 2023 | 20 September 2023 |
| 6 | SBL New implementation tool to be shared | Quarterly quality improvement discussions between Trust and ICB utilising implementation tool (September & December 2023 – dates TBC) | 14th November 2023 | January (Date TBC) |
| 7 | Action plan coproduced with the MNVP following annual CQC Maternity Survey data publication | 20th October 2023 | 14th November 2023 | |
| | MNVP Work Plans | September 2023 | 12 September 2023 | |
| 8 | Core Competency V2 TNA signed off by Trust board and LMNS / ICB | 2 Weeks Before CNST Assurance Checkpoint Meeting | 14th November 2023 | 29th November 2023 |
| | Core Competency V1 Reporting May - August | Submission Date<br>29th September 2023 | 14 November 2023 | |
| | Core Competency V2 Reporting September – December | Submission Date<br>11th January 2024 | TBC | |
| 9 | N/a | | | |
| 10 | N/a | | | |

## **Safety Action 1**: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

| Requirements number | Safety action requirements | Likely to be compliant for submission date ? (Yes/ No /Not applicable) | Actions for compliance |
|---|---|---|---|
| A | All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death. | Yes | |
| B | For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards. | Yes | |
| C | For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months. | Yes | |
| D | Quarterly reports should be submitted to the Trust Executive Board from 30 May 202 | Yes | |
| | | | |

# **Safety Action 2**: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

| Requirements number | Safety action requirements | Confident / Requirement met? (Yes/ No /Not applicable) | Actions for compliance |
|---|---|---|---|
| 1 | Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics 2023. Final data for July 2023 will be published during publication October 2023. | Yes | |
| 2 | July 2023 data contains valid ethnic category (Mother) for at least 90% of women booked in the month. (Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances). | Yes | |
| 3 | Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the " Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics: Midwifery Continuity of carer (MCoC) Note: If maternity services have suspended all MCoC pathways, criteria ii is not applicable. | Not applicable | This will be completed once provisional score card is received, and no amendments are necessary. |
| | i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. | Yes | |
| | ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. These criteria are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks' gestation. | Yes | |
| **4** | Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023. | Not applicable | Submission will be made at end of August, Provisional score card will be received at end of September |
| **5** | Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust. | Yes | |

## **Safety action 3**: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

| Requirements number | Safety action requirements | Requirement likely to be met by Submission date? (completed /Yes/ No /Not applicable) | Actions for compliance |
|---|---|---|---|
| A | Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care. | Yes | |
| B | A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. | Yes | |
| | An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB. | Yes | Action plan shard with Safty Champions, needs to be shared with Quadumverite and locality lead |
| C | Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway. | Yes | Included in updated policy . Will be actioned from October 2023 |

# **Safety action 4**: Can you demonstrate an effective system of clinical workforce planning to the required standard?

| Requirements number | Safety action requirements | Likely to be compliant by submission date? (Yes/ No /Not applicable) | Actions for compliance |
|---|---|---|---|
| **Obstetric medical workforce** | | | |
| A | 1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:<br>a. currently work in their unit on the tier 2 or 3 rota or<br>b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or<br>c. hold an Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums. | Yes | Need evidence of compliance |
| | Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. | Yes | Need evidence of compliance |
| | 2) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. | Yes | implemented and risk assessment in place, need evidence that is happening |
| | 3) Trusts/organisations should monitor their compliance<br>of consultant attendance for the clinical situations 27 listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further nonattendance. | Yes | WILL BE SUBMITTED IN December . Ongoing audit in place |
| | 4) Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS. | | WILL BE SUBMITTED IN December . Ongoing audit in place |

| | | | |
|---|---|---|---|
| **Anaesthetic medical workforce** | | | |
| B | A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) | Yes | |
| **Neonatal medical workforce** | | | |
| C | The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing. | No | Action plan ongoing |
| | If the requirements have not been met in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies. | Yes | Action plan ongoing |
| | If the requirements had been met previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies. | Not applicable | |
| | Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN). | Yes | Action plan ongoing |

## **Safety action 5**: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

| Requirements number | Safety action requirements | Requirement met or likley to be met for the submission date? (Yes/ No /Not applicable) | Actions for compliance |
|---|---|---|---|
| A | A systematic, evidence-based process to calculate midwifery staffing establishment is completed. | Yes | |
| B | Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. | Yes | |
| C | The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. | Yes | |
| D | All women in active labour receive one-to-one midwifery care. | Yes | |
| E | Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period | Yes | |

## **Safety action 6:** Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

| Requirements number | Safety action requirements | Requirement met or likely to be met for the submission date? (Yes/ No /Not applicable) | Actions for compliance |
|---|---|---|---|
| A | Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024. | No | See SBL Paper |
| | implementing 70% of interventions across 6 elements overall and implementing at least 50% of interventions in each individual element. | No | See SBL Paper |
| B | Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool. | No | In Progress |

## **Safety action 7**: Listen to women, parents and families using maternity and neonatal services and coproduce services with users

| Requirements number | Safety action requirements | Likely to meet requirement by submission date? (Yes/ No /Not applicable) | Actions for compliance |
|---|---|---|---|
| A | Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023).Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group. | Yes | |
| B | Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board. | No | not completed yet |
| C | Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions. | Yes | Ongoing action plan in place. |

## **Safety action 8**: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

| Requirements number | Safety action requirements | Requirement likley to be met by submission date? (Yes/ No /Not applicable) | Actions for compliance |
|---|---|---|---|
| A | A local training plan is in place for implementation of Version 2 of the Core Competency Framework. | Yes | |
| B | The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB. | No | Not completed yet |
| C | The plan is developed based on the "How to" Guide developed by NHS England. | Yes | Not completed yet |

## **Safety action 9**: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

| Requirements number | Safety action requirements | Requirement likely to be met prior to submission date ? (Yes/ No /Not applicable) | Actions for compliance |
|---|---|---|---|
| A | All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded. | Yes | |
| B | Evidence that quarterly discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings. | Yes | |
| C | Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures. Meeting are to be quarterly and 2 in the reporting period. | No | not yet. Need to arrange. |

## **Safety action 10**: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6th December 2022 to 7 December 2023?

| Requirements number | Safety action requirements | Requirement likely to be met prior to submission date? (Yes/ No /Not applicable) | Actions for compliance |
|---|---|---|---|
| A | Reporting of all qualifying cases to HSIB/CQC//MNSI from 6th December 2022 to 7 December 2023. | Yes | |
| B | Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 6th December 2022 until 7 December 2023. | Yes | |
| C | For all qualifying cases which have occurred during the period 6th December 2022 to 7 December 2023, the Trust Board are assured that: | Yes | |
| | i. the family have received information on the role of HSIB/CQC/MNSI and NHS Resolution's EN scheme | Yes | |
| | ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour. | Yes | |

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

# CQC Action Plan September 2023

**Overall Rating for the service**

| | | |
|---|---|---|
| Are services Safe? | Requires Improvement |  |
| Are services well-led? | Good |  |

Date of inspection: 16th May 2023

The national maternity inspection program was held in May 2023, which is part of the programme to review maternity services and provide an up-to-date view of hospital maternity care across the country. The short, announced visit to the Royal Albert Edward Infirmary, reviewed only safe and well-led key lines of enquiry.

Our two offsite antenatal clinics at Thomas Linacre and Leigh were not inspected during this visit.

Its important to note the overall feedback was predominantly positive particular around the governance structure, maternity environment, and a positive culture.

Below is the action plan to address the issues raised.

| Complete | Partially complete/ Ongoing | Overdue | Not due |
|---|---|---|---|

| Recommendations | Action | Lead | Timeframe | Rag Rating | Evidence | Comments |
|---|---|---|---|---|---|---|
| **Moving and handling training to incorporate pool evacuation training** | **To review the moving and handling training agenda and introduce pool evacuation training** | Keeley Jones (KJ) | June 2023 | | TNA | |
| | • Meet with trust lead for moving and handling | KJ | June 2023 | | | |
| | • Devise training program and visual aids to be incorporated | Kelly Christie (KC) | August 2023 | | TNA and training program | |
| | • Pool evacuation emergency drills to be initiated in the clinical area for all staff | KJ | September 2023 | | | Video completed for dissemination to staff to supplement drill training |
| | • To maintain training register as evidence of compliance | KJ | September 2023 | | | |
| | • To develop competency assessment for pool evacuation training | KC | August 2023 | | Competency document | |
| **Perinatal mental health training** | **To review training needs analysis** | KJ | August 2023 | | | |
| | • Introduction of specialist training day to be inclusive of perinatal mental health update delivered by | Lyndsey Banks (LB) | September 2023 | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | specialist perinatal mental health midwife | | | | | |
| | • Case scenarios to be discussed in training presentation | LB | September 2023 | | | |
| | • Perinatal mental health course to be completed by lead midwife | LB | July 2024 | | | Perinatal lead midwife place secured |
| **Regulation 15 in line with reviewing supply and demand of emergency equipment and in date** | **To review current process of emergency equipment and daily safety checks** | Audrey Livesey (AL) | August 2023 | | | |
| | • New daily checklist to be updated to be definitive to equipment checked | AL | September 2023 | | | |
| | • Additional training for all band 7's coordinator and ward managers on the use of the electronic system to report faulty equipment | AL | September 2023 | | | |
| | • Equipment issues or concerns to be identified in safety huddles | Band 7 coordinators and ward managers | September 2023 | | | |
| | • Matron audit to be inclusive of safety checks audit | AL | September 2023 | | | |
| **Regulation 12 – additional support for black Asian and ethnic minority women in pregnancy** | **To review current guidance and update in line with equality, diversity, and inclusion guidance** | Ashely Gwinnett (AG) | July 2023 | | | |
| | • Introduction of NES pass for non-English-speaking women | AG | July 2023 | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | • Enhanced team midwifery to caseload all women who require additional support. | AG | July 2023 | | | |
| **Maternity practical obstetric multi-professional training compliance** | **Review training needs analysis** | KJ | September 2023 | | | Awaiting ratification |
| | • Review and update prompt training package. | KJ | September 2023 | | | Completed and in place |
| | • Train additional prompt trainers to facilitate training. | KJ | August 2023 | | | In progress |
| | • Revise and update training spreadsheet to improve visual for training compliance. | KJ | September 2023 | | | In progress almost complete |
| | • Overview of training compliance to be item on agenda at maternity senior leaders monthly meeting | KJ | September 2023 | | | In place |
| **Statutory requirements for safeguarding level 3 adults and children** | **Review training needs analysis and update requirements** | KJ | September 2023 | | | |
| | • Introduction of tea @ 10 in clinical areas to facilitate bitesize sessions | AL | September 2023 | | | Commenced but not fully embedded |

| | | | | | | |
|---|---|---|---|---|---|---|
| | • Specialist training day to include session delivered by safeguarding lead | Kerry Ryan (KR) | September 2023 | | | |
| | • Evidence of attendance to be held by safeguarding team and monitored by education team | KR/KJ | September 2023 | | | |
| **Fetal monitoring policy adhered to as per GMEC policy** | Fetal monitoring training standards to be reviewed | Joanne Birch (JB) | June 2023 | | | |
| | • Gmec policy to be disseminated to all staff | JB | July 2023 | | | |
| | • Maternity spotlight to be disseminated to inform staff of correct method to review CTG classification | JB | July 2023 | | | |
| | • Fetal monitoring training to include and raise awareness of policy and correct categorisation of CTG findings | JB | July 2023 | | | |

## Saving Babies Lives Compliance update, September 2023

Saving Babies Lives V3 was launched in June 2023, the care bundle is designed to tackle stillbirth and early neonatal death and a significant driver to deliver the ambition to reduce the number of stillbirths, bringing several elements of care together.

Version 3 saw the introduction of element 6, the management of pre-existing diabetes in pregnancy.

The successful achievement of SBL is essential as it also incorporated into element 6 of the Maternity Incentive Scheme. (MIS).

Trusts must evidence adequate progress against this deliverable by the submission deadline, and providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element.

These percentages will be calculated within the national implementation tool which is submitted to the LMNS for validation and approval of evidence submitted.

**Elements 3&4 have been validated for July (summary table below). 1,2 5&6 have been submitted on 22/09/23 for validation**

| Intervention Elements | Description | Element progress Status (self-assessment) | % of Interventions Fully Implemented (self-assessment) | Element Progress (LMNS validated) | % of Interventions Fully Implemented (LMNS Validated) | Narrative for partially Implemented elements: |
|---|---|---|---|---|---|---|
| Element 1 | Smoking in pregnancy | Partially Implemented | 70% | | 0% | Action plan submitted for training % for CO & VBA Training, trajectory forecast to be on target for deadline |
| Element 2 | Fetal growth restriction | Partially Implemented | 85% | | 0% | Action plan regarding the purchasing of digital BP monitors for all areas & specific audits required |
| Element 3 | Reduced fetal movements | Partially Implemented | 50% | Partially Implemented | 50% | Action plan for increasing % number of women who receive next working day scan. Midwife sonographer hours now agreed and to be made available – x2 MUP expressions of interests offered |
| Element 4 | Fetal monitoring in labour | Fully Implemented | 100% | | 20% | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Element 5 | Preterm birth | Partially Implemented | 81% | | 0% | Action plan for employment of SBL Pre-term Lead and clinic to be introduced |
| Element 6 | Diabetes | Partially Implemented | 50% | | 0% | New post for diabetes specialist lead, Trust to appoint Diabetic specialist Nusre and action plan for continuous glucose monitoring training |
| All Elements | TOTAL | Partially Implemented | 79% | Partially Implemented | 3% | |