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

Agenda

13:45 - 13:47
2 min

11. Declarations of Interest

Information *Mark Jones*

Verbal item

13:47 - 13:50
3 min

12. Minutes of Previous Meeting

Approval *Mark Jones*

12.Minutes_Board of Directors Public meeting_070623.pdf (4 pages)
12a. Public Board Action Log - June 2023.pdf (1 pages)

13:50 - 14:00
10 min

13. Chair's Opening remarks

Information *Mark Jones*

Verbal Item

14:00 - 14:15
15 min

14. Chief Executive's report

Information *Mary Fleming*

14. Board Report_CEO_August_2023 FINAL.pdf (3 pages)

14:15 - 14:45
30 min

15. Committee chairs' reports

Information *Non Executive Directors*

15.1. Finance and Performance

Information *Julie Gill*

Report to follow due to close proximity of the meeting.

15.2. People

Information *Lynne Lobley*

15.2 AAA _ People - Jul 2023.pdf (2 pages)

15.3. Quality and Safety

Information *Francine Thorpe*

15.3 AAA QSjune23.pdf (3 pages)

15.4. Audit

Information *Ian Haythornthwaite*

15.4 AAA - Audit Committee - 19 Jun 2023.pdf (2 pages)

15.5. Research

Information *Clare Austin*

15.5 AAA - Research - June 2023.pdf (2 pages)

14:45 - 15:00
15 min

16. Board assurance framework

Discussion *Paul Howard*

16. BAF Report Board August 2023v3.pdf (26 pages)

15:00 - 15:15
15 min

17. Integrated performance report

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

17. Board of Directors M3 2324 Scorecard.pdf (7 pages)

15:15 - 15:25
10 min

18. Finance Report

Discussion *Tabitha Gardner*

18. Trust Financial Report 23-24 June Month 3 Board.pdf (11 pages)

15:25 - 15:45
20 min

19. Maternity

Information *Rabina Tindale*

19.1. Maternity Dashboard

19.1 Maternity Dashboard report June 2023.pdf (4 pages)
19.1a MaternityDashboard June 2023.pdf (6 pages)
19.1b Neonatal Dashboard.pdf (4 pages)

19.2. Perinatal quality surveillance report

19.2 Maternity Perinatal Quality Surveillance Q1 (For Board).pdf (25 pages)
19.2a. Copy of June 2023 Perinatal Monthly Surveillance Dashboard.pdf (2 pages)

19.3. Neonatal staffing report

19.3 NNU STAFFING PAPER July 2023 for TB.pdf (10 pages)

19.4. Maternity Safety Report

19.4. Maternity Safety update report may-june 23.pdf (7 pages)

19.5. ATAIN action plan CNST

19.5. ATAIN ACTION PLAN CNST YEAR 5 June 2023 (002) For TB.pdf (8 pages)

15:45 - 16:00
15 min

20. IPC board assurance framework

Information *Rabina Tindale*

20. IPC BAF, Version 1.0. To 30 June 2023. 9.7.2023.pdf (29 pages)

16:00 - 16:10
10 min

21. Consent Agenda

21.1. Guardian of Safe Working Hours resport

Information *James Baker*

21.1. Quarter 3 Report GoSWH Feb 2023.pdf (8 pages)
21.1a. Quarter 4 Report GoSWH May 2023.pdf (7 pages)
21.1b. Annual Report GoSWH 2023.pdf (7 pages)

21.2. Freedom to Speak Up Guardian's report

Information *James Baker*

21.2. FTSU Update - ETM 20.07.23.pdf (2 pages)
21.2a. WWL Annual FTSU Guardian Report 2022-2023.pdf (21 pages)

21.3. Medical revalidation report

Information

21.3 2022-2023 Annual Submission to NHS England North West Final updated.pdf (14 pages)

21.4. Review of statutory and mandatory recommended posts

Information

21.4 Report - statutory, mandatory and recommended posts - Aug 2023.pdf (9 pages)

16:10 - 16:15
5 min

22. Date, time and venue of next meeting

Information *Mark Jones*

Wednesday 04 October 2023, 1:15 - 4.15pm

Board of Directors Public meeting

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

Boardroom, Trust Headquarters

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Attendees

Board members

Mark Jones (Chair), Rabina Tindale (Chief Nurse), Tracy Boustead (Chief People Officer), Sanjay Arya (Medical Director), Julie Gill (Non-Executive Director), Clare Austin (Non-Executive Director), Rhona Bradley (Non-Executive Director), Paul Howard (Director of Corporate Affairs), Francine Thorpe (Non-Executive Director), Tabitha Gardner (Chief Finance Officer), Richard Mundon (Director of Strategy and Planning), Mary Fleming (Deputy Chief Executive), Silas Nicholls (Chief Executive)

In attendance

Nina Guymer (Deputy Company Secretary (Minutes)), Two members of the public were also in attendance

Meeting minutes

13. Declarations of Interest

Information

No declarations of interest were made.

Mark Jones

14. Minutes of Previous Meeting

Approval

Mark Jones

It was clarified once again that the Deputy Chief Executive had been present at the previous meeting.

It was further clarified that the previous year's corporate objective which had been impacted by the issue with the national booking database, referred to at minute 49, was CO11.

The Deputy Chief Executive wished to clarify that, following the discussion set out at minute 52, WWL have now taken responsibility for the additional community beds as part of the Heathier Wigan Partnership discharge and flow programme but that no additional staffing has been provided, as was hooped for.

The minutes were **AGREED** as a true and accurate record subject to these amendments.

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

15. Chair's Opening remarks

Information

Mark Jones

The Chair was pleased to announce that WWL would be celebrating several birthdays relating to its sites and its radio station during the following week and that Lisa Nandy MP would be attending to unveil a commemorative mural at the Wigan site.

He reported back on recent meetings with Sir Richard Lees, and Cllr K Cuniffe, the latter to be scheduled moving forwards to occur circa every six weeks.

He advised that Dr T Hankin would imminently join WWL in a non-executive director post on an interim basis, following approval of the appointment by the Council of Governors. He added that throughout the recruitment process, considerations would be given as to initiatives which could support the raising of the diversity of the board, such as appointing associate non-executive directors and utilising the Shadow Board Programme.

16. Chief Executive's report

Information

Silas Nicholls

The Chief Executive presented the report which had been shared in advance of the meeting. He highlighted a marked improvement in urgent and emergency care since the board's last meeting but acknowledged that much progress is still to be made and that the issue will be a addressed through a system wide effort with primary and social care colleagues.

The board recieved and noted the paper.

16. Board Report_CEO_June_2023_FINAL.pdf

17. Committee chairs' reports

Information

Non Executive Directors

The non-executive chairs of the board's committees presented the reports which had been shared in advance of the meeting.

17.1. Finance and Performance

Julie Gill

The board recieved and noted the paper.

AAA F&P - 31 May 2023.pdf

17.2. People

Lynne Lobley

The Medical Director added that junior doctors' had ballotted in agreement to holding further strikes. In response to a query from the Chair he advised that WWL would pay the rate as agreed at the Greater Manchester Integrated Care Partnership Medical Directors' meeting to be paid during periods of strike action.

The board recieved and noted the paper.

17.2 AAA _ People - May 2023.pdf

17.3. Quality and Safety

Francine Thorpe

The board recieved and noted the paper.

17.3 AAA QSapril23.pdf

17.4. Audit

Ian Haythornthwaite

The Chief Finance Officer added that to ensure that governance processes around internal audits have been correctly followed the list of completed audits and actions required will be reviewed by the divisional leaders at their upcoming meeting.

The board recieved and noted the paper.

17.4 AAA Audit - May 2023.pdf

18. Board assurance framework

Decision

Paul Howard

The Director of Corporate Affairs advised that a second report was issued due to an error in the numbering of one corporate objectives but that the content is the same. He explained how the document should be used to inform discussions and invited questions to be directed to the lead executives in each area. No queries were raised.

All committee chairs agreed that the corporate objectives which their committees monitor have been appropriately scored, aside from the Finance and Performance Committee, which had elected to increase the score of the risk to C010, being PR9, from 8 to 12.

The board recieved and noted the paper.

18. BAF Report Board June 2023.pdf

19. Integrated performance report

Discussion

Sanjay Arya/Tracy Boustead/Mary Fleming

The executive directors presented the relevant sections of the report, respective to their portfolios.

Quality and safety

The Chief Nurse noted that the complaints to the medical divisions had increased by circa 30% but noted that there had been better success in resolving complaints at an earlier stage as a result of taking an informal approach to contacting patients in the first instance. Additional measures such as addressing matters with patients and relatives on the ward are also expected to assist in the further reduction of complaints.

The report was noted.

People

The report was summarised and noted.

Performance

The Deputy Chief Executive added that WWL have achieved the 75% target against the two hour urgent response rate during the reporting period. She summarised that there is now a much lower rate for readmissions and also improvement in the reablement model and the ability of the trust to assist more patients to return home. This would be the basis for the model of care moving forwards and is a positive first step for WWL.

The report was noted.

Finance

The report was summarised and noted.

19. Board of Directors M1 23 24 M12 2223 Scorecard.pdf

20. Finance Report

Discussion

Tabitha Gardner

The Chief Finance Officer presented the report for month one, which had been shared in advance of the meeting.

The Chair commented that himself and the other non-executives found it useful to be advised on the figure for Greater Manchester wide efficiency savings.

The importance of agreeing upon realistic financial targets was noted and the board heard that a cash management strategy is under development at both local and system level.

20. Trust Financial Report 23-24 April Month 1 Board.pdf

21. Consent Agenda

The Chair emphasised that the reports included within the consent agenda have all been reviewed in the first instance by either the executive team or one of the board's committees. The board **RESOLVED** as follows, having previously consented to items appearing on the consent agenda:

21.1. Committee terms of reference - Quality and Safety

Decision

Nina Guymer

The board **APPROVED** the terms of reference as set out.

21.1. ToR - QSCommittee 2023.pdf

21.2. Board self-certification - Licence condition FT4

Decision

Paul Howard

The board **APPROVED** the self-declaration of compliance with licence condition FT4, as set out.

21.2 FT4 self-certification 2023.pdf

21.3. Review of well-led action plan

Decision

Paul Howard

The board **APPROVED** the closure of actions associated with recommendations 4, 5 and 10. The board discussed that this piece of work had now been concluded however, it was agreed that executive team would carry out a deep dive in respect of one of the key lines of enquiry .

ACTION: Executive Team

21.3 Well-led action plan - May 2023.pdf

22. Date, time and venue of next meeting

Information

Mark Jones

The Chair expressed thanks to Mrs T Boustead for the time spent in her interim post, whilst advising that this would be her last board meeting at WWL, with newly appointed Chief People Officer, Juliette Tait, coming in to post in mid August 2023.

The next meeting will be held on Wednesday 2 August 2023, 1:15 - 4.15pm.

Action log

Date of meeting	Minute ref.	Item	Action required	Assigned to	Target date	Update
5 Apr 2023	56/23	Annual sustainability report	Schedule an update on the Wigan Galleries masterplan at a future Board workshop	N Guymer	TBC	Council colleagues scheduled to attend board workshop on 19 Jul 2023.

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	02/08/23
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

June and July were important months for colleagues past and present during 'Our Big Birthday Month', involving a series of celebrations to mark 150 years of Royal Albert Edward Infirmary (RAEI), 90 years of Wrightington Hospital and 50 years of WWL Radio, culminating in the NHS's 75th birthday on Wednesday 5th July. It was excellent to see so many people celebrating the heritage of the NHS and of our Trust, remembering the roots of our organisation and those who paved the way and were pioneers in healthcare before us. We witnessed a lot of activity across our sites, including the installation of a visual timeline of RAEI, which was developed with support from one of our former porters, Councillor George Davies. At Wrightington Hospital we saw the celebrations continue with parties, bake offs, tours of the site and an open day in the WWL Radio studio thanks to our dedicated volunteers. Staff at Leigh Infirmary hosted a fun day in honour of Our Big Birthday Month, before our colleagues were showcased and celebrated during for NHS75. Five of the Trust's 2022 STAR (Staff Thanks and Recognition) Awards winners were chosen to represent WWL at a special ceremony at Westminster Abbey in London, whilst two colleagues had their photographs shortlisted in a national photography competition dedicated to the NHS's birthday.

Despite the backdrop of celebration, our teams have been working extremely hard across WWL to create balance in our operational and financial challenges. We are still seeing very high attendance figures and a high acuity of patients, which unfortunately in turn creates prolonged waits for our patients. We are actively addressing this with our system partners and improvement plans we have in place to create better flow and safe discharges. Our ambulance handover times are steadily improving, and we are seeing more patients going through our Same Day Emergency Care unit, which helps to divert patients away from the Emergency Department. In addition to this, we recently had the official opening of the Makerfield Suite, a dedicated space for patients experiencing a mental health crisis who present at the Emergency Department. We are working in partnership with Greater Manchester Mental Health NHS Foundation Trust on this assessment area, which will improve the experience for our patients and help to provide the right care, in the right place and with the right health professionals.

Further challenges relating to industrial action periods have continued across June and July, with action being taken against the Government by Junior Doctors and Consultants from the British Medical Association. The latest strike provided us with a new challenge, in that it was the longest period of disruption for our Trust, running from Thursday 13th July to Saturday 22nd July and involving Consultants for the first time. Although there was a 48-hour gap between the end of the Junior Doctors industrial action and the start of the Consultants' strike, our services remained under pressure and regretfully a number of non-urgent operations and clinics were postponed ensuring patient safety at all times.

WWL colleagues and services continue to gain significant peer and sector recognition, with our First Contact Practitioners at Wrightington Hospital awarded the regional title for the Excellence in Primary and Community Care category at the prestigious NHS Parliamentary Awards, receiving the backing of all three of the Wigan Borough's Members of Parliament. This is a huge testament to an innovative group of specialist physiotherapy clinicians, who have created a more streamlined patient journey across the locality. At the Greater Manchester Health and Care Champion Awards, long-serving volunteer Barbara Lambert was presented with the Mayor's Special Recognition Award, and the late Karen Downs was posthumously recognised for her outstanding contribution and lasting legacy in digital care, with a GM Health and Care Champion Award provided to her family.

Colleagues withing our digital teams received a High Commendation at the HSJ Digital Awards for their work in Digital Literacy, Education and Upskilling, and two teams have been named finalists at the HSJ Patient Safety Awards, in the 'Harnessing a Human Factors Approach to Improve Patient Safety' category, and the 'Maternity and Midwifery Initiative of the Year' category. Congratulations also go out to clinical audit colleagues, who were named Clinical Audit Team of the Year for 2023 by the Clinical Audit Support Centre during Clinical Audit Awareness Week, and to colleagues

involved in two successfully shortlisted entries at the National Orthopaedic Alliance Excellence in Orthopaedics Awards. WWL's Paediatric Hip Arthroplasty Service has been shortlisted in the Partnerships and Integration category, whilst our innovative and creative work in digital therapy recruitment has been named as a finalist in the Workforce and Recruitment Campaign category.

Development progress continues at Leigh Infirmary with the construction of a new Clinical Diagnostic Centre and Laminar Flow Theatre all on track. The new buildings, recovery area, MRI and CT scanners are now in place, and work continues on the existing radiology department, cardiorespiratory department and phlebotomy department in order to provide a one-stop shop for diagnostic testing. This will be a huge improvement for thousands of patients every year, and from staff feedback it will also provide an equally as important boost for those working at Leigh Infirmary. Further developments at Leigh will also see a significant investment into our endoscopy service from the National Endoscopy Programme. This will help us increase the number of endoscopy rooms at Leigh infirmary from three to six, as well as upgrading the current facilities at RAEI to support the achievement of the Royal College of Physicians Joint Advisory Group accreditation.

Finally, I would like to welcome Juliette Tait, our new Chief People Officer to WWL, who joins the Trust this month. WWL has a strong focus on staff experience and Juliette will be leading on how we continue to create an inclusive and peopled-centred experience for all our colleagues. Juliette has a vast amount of experience within the Human Resources (HR) and Organisational Development (OD) sector, with previous roles at other Greater Manchester provider Trusts, Greater Manchester Police and more recently at Greater Manchester Mental Health NHS Foundation Trust as Executive Director of HR and OD. I'd like to also take this opportunity to thank our Interim Chief People Officer Tracy Boustead for her excellent contribution to WWL and wish her the very best in the future.

Committee report

Report from:	People Committee
Date of meeting:	11 July 2023
Chair:	Lynne Lobley

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

ALERT
▪ There was a lack of assurance noted in respect of medical e-rostering and an update was requested for the next meeting to set out the work which had taken place to improve in this area. ▪ The A&E medical staffing report was noted to highlight several issues which have been recurring during the twelve months following the last report (see risks below). ▪ Some areas of concern around corridor care were noted, following complaints made by the junior doctors reviewed through the Guardian of Safe Working report.
ASSURE
▪ The board assurance framework (BAF) provided assurance that the committee's corporate objectives have been refreshed for the year ahead, to include the workforce sustainability objective, which encompasses the three people corporate objectives. ▪ The workforce sustainability programme was endorsed by the committee and it was noted that this addresses key concerns highlighted by the committee at this and previous meetings, through its four streams of work. The committee took assurance that the programme is aligned with the newly released national NHS long term workforce plan. ▪ The people dashboard was presented, providing assurance in several key areas including the reduction of sickness absence and turnover and that WWL is in a good position in terms of recruitment, time to hire and efficiency. ▪ The committee were advised upon the plans in place for the upcoming doctors' strikes and took assurance from the plans outlined. ▪ The Trauma Risk Management Programme was received and noted to compliment existing interventions which WWL has in place, providing immediate access to support for staff following a traumatic incident. ▪ Assurance was provided by the medical revalidation report. ▪ The Guardian of Safe Working report showed how effectively the role is currently carried out, the value of these reports was noted and discussions clarified how the new guardian would be supported to take over the position.
ADVISE
▪ The Staff Story provided an account of the experience of a Ward Leader and her team, who were involved in the nursing strike. Key themes highlighted were the loyalty of staff, WWL's just culture and leadership and the public (patient) support for the trust

- Staff's aversion to being redeployed and the negative feelings around this were also noted - the committee empathised and it was explained that consideration is being given as to how this challenge may be overcome on a trust wide basis.
- The Committee noted that industrial action will continue and that the both junior doctors and consultants are to strike before the end of July 2023.
- An update was provided around how the Shadow Board Programme will be taken forwards for both previous participants and any future co-horts. This would be reported back to the Board of Directors which had set this as a task for the committee.
- The integrated working between junior doctors and ICT colleagues in relation to automation was noted.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- Two risks from the BAF have been closed down as at the end of the year and two additional risks have been escalated, with one being an overarching risk covering workforce.
- A risk around unfilled shifts due to the current ongoing escalation was noted and lack of the necessary established or temporary workforce was highlighted through the A&E medical staffing report.

Committee report

Report from:	Quality and Safety Committee
Date of meeting:	14th June 2023
Chair:	Francine Thorpe

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

ALERT

- Year – end reports for 2022/23 corporate objectives confirmed that:
  - Whist the Trust sustained the reduction in mortality related to acute kidney injury (AKI) from the previous year; we have seen an increase in mortality related to sepsis (C01)
  - The Q4 complaints report confirmed that significant progress has been made in complaints response times (68% responded to within agreed timescales); we did not achieve the 85% target (C05)
- Executive sponsors confirmed that the revised actions being taken within the 2023/24 corporate objectives aim to address the areas where targets were not met for last year.
- Recognition and appropriate intervention for patients who deteriorate was highlighted as an issue within a number of reports received. The Deteriorating Patient Group continues to meet to oversee actions being taken to secure improvement. A full report to include actions and measures being used to track progress has been requested for the next meeting to seek further assurance.
- The infection prevention control (IPC) report confirmed that the Trust had exceeded the clostridium difficile trajectory for 2022/23, reporting 70 cases against a trajectory of 53. Benchmarking information was provided that indicated this is consistent with a regional and national picture and that WWL is not an outlier.

ASSURE

- A presentation was received from the medical division that provided assurance on actions being taken to maintain the safety and comfort of patients being cared for in the A&E corridor. These include:
  - A revised and regularly audited standard operating procedure (SOP)
  - Regular audits to evidence compliance with the Emergency Department's safety checklist
  - Agreed staffing ratios to care for patients within the corridor
  - 3 x daily huddles to deploy staff according to patient need
  - Use of assessment cubicles where required to maintain privacy & dignity

- Changes implemented as a result of serious incident investigations
- The Community Division Deep Dive highlighted:
  - Improvement work leading to a reduction in falls on the Community Assessment Unit
  - A range of quality improvement projects including the inroduction of a model of co-production
  - Low numbers of complaints and acheivement of 85% response rate
- The Q4 Learning from Deaths report provided assurance that national guidance in relation to learning from deaths is being adhered to and we are compliant with any external reporting requirements. Regular structured judgement reviews are undertaken and any potentially preventable deaths fully scrutinised. The Trust has not received any Prevention of Future Deaths Notices from the Coroner.
- A draft version of the Trust's Quality Accounts was received and committee members confirmed that the data included was consistent with reports received during the year.
- The IPC report confimred that the Trust has not reported any MRSA bacteraemia cases during 2022/23.
- The Safe Staffing paper highighted that four wards (CCU, CDW, IDA, JCW) had not reported any acquired pressure ulcers during 2022/23.
- The Aspire Accreditation report provided assurance that 14 wards achevied bronze and 6 achieved silver by the end of 2022/23.

ADVISE

- A report providing initial feedback on the recent CQC inspection of maternity services highlighted several areas for improvement including:
  - Training around better cardiotocography interpretation;
  - No notable systems in place to ethnic minority backgrounds giving birth
  - Risks associated with ligatures
  - Completion of documentation in some areas
    Positive feedback included:
  - Detailed and comprehensive verbal handovers
  - Staff were welcoming and felt confident in the management team
  - Hourly rounding demonstrating a commitment to patient safety
    The formal report from the CQC is expected within the next few weeks
- Work remains ongoing in relation to the theme of patients being lost to follow up. The outcome of 2 further deep dives had not been signed off in time for this meeting and will be presented in August 2023.
- The Q4 Safe Staffing paper highlighted an increase in the total number of hospital acquired pressure ulcer's with a marked peak in January 2023. The significant staffing pressures during this time were cited as a contributory factor. Pressure ulcer prevention work remains a key objective for the Trust.
- A paper in relation to medical staffing within A&E was received that highlighted the challenges associated with the expansion of the the A&E footprint and the reliance on the use of locum doctors. The committee noted that further work is being undertaken to address this.
- A maternity staffing paper was received that highlighted a number of challenges in relation to current vacancies and projected retirements. Nationally mandated recommendations were outlined that impact quality and safety. The Committee

suported the paper in principle whist recognising that work is ongoing to develop a business case for approval elsewhere.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
• The 3 high risks relating to potential safety issues within the emergency department were highlighted as part of the urgent care governance update along with the mitigating actions being taken • No new risks were identified

Committee report

Report from:	Audit Committee
Date of meeting:	19 June 2023
Chair:	Ian Haythornthwaite

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

ALERT
▪ The internal auditors briefed the Committee on the internal audit programme and noted that there were currently six audits from 2022/23 outstanding. Two of these reports are at reporting stage; drafts having been received by WWL; management responses are being prepared; and the final report is currently being finalised. Three of the outstanding audits have, or will have, limited assurance, although it was noted that this was due to management focusing audits on areas of known weakness rather than the weaknesses being discovered. Management has agreed to circulate the final reports to the Committee immediately on conclusion. Consideration will be given to convening an extraordinary Committee meeting if needed, as the next scheduled meeting is not until September 2023.
ASSURE
▪ The Committee received the ISA260 (report to those charged with governance) and the auditors' annual report in advance of its presentation to the board, and noted the high level of assurance provided within it. ▪ The Committee reviewed the annual report, annual accounts and the associated representation letter and recommended them to the board for approval
ADVISE
▪ The Committee received an update from the Deputy Chief People Officer in relation to the medical e-roster internal audit which received limited assurance. The committee noted that the medical rostering team had now been established on a permanent basis through divisional funds without the need for an additional business case, and noted the intention to standardise medical rostering through one common piece of software. The recent reintroduction of Empactis absence management software was also noted to be a benefit. A follow-up audit of the matters raised in the original internal audit will be undertaken by the internal auditors in July and August 2023, with progress reported back to the Committee in September 2023. ▪ The Committee approved a Service Level Agreement Standard Operating Procedure, designed to strengthen the control environment. The audit of service level agreement is

scheduled to take place in Q2 2023/24 and the findings will be reported to the November 2023 meeting of the Committee.

- The board approved the updated Fit and Proper Person standard operating procedure
- The Committee met with the internal and external auditors without management present, as is best practice

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- The Committee undertook a deep dive into three pharmacy-related risks and was not able to obtain assurance. It has therefore requested that the Risk Management Group focuses on these at its next meeting and the Director of Pharmacy will also consider additional mitigations that could be put in place; particularly as there is a known challenge around the availability of the qualified pharmacy workforce.

Committee report

Report from:	Research Committee
Date of meeting:	6 June 2023
Chair:	Clare Austin

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

ALERT

- The current Research Assurance Framework (RAF) will be refined to support better reporting against research objectives annually.
- Currently the Service Level Agreement documentation for the work being undertaken via Christies is not in place.

ASSURE

- The joint strategy between Edge Hill University and WWL was approved, subject to minor changes to highlight the focus on patients.
- The committee received an overview of research activities in specialist services and were assures of the growth of research activities, number of principal investigators and specialities involved.
- Recruitment numbers to trials continues to increase and currently exceeds NIHR recruitment targets.
- The committee were assured that there are a broader number of specialties undertaking research.
- The committee were assured that progress is being made against the research strategy and the objectives set out.
- Engagement with Greater Manchester Applied Research Collaboration is firmly established, and collaboration is in progress.
- The committee viewed a video from a research participant which highlighted the benefits of taking part and the ease of participation.
- The sponsorship program is being audited through MIAA and a specific report will be produced. The committee were assured that this process has been constructive, and they are awaiting the outcome.
-

ADVISE

- The committee discussed that the involvement of nursing staff in research is challenging.
- The committee discussed that consideration should be given for different models of working to ensure that any nursing colleagues interested in undertaking a research role are supported and able to.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED
▪ None noted

Title of report:	Board Assurance Framework (BAF)
Presented to:	The Board
On:	2 August 2023
Presented by:	Director of Corporate Affairs
Prepared by:	Head of Risk Director of Corporate Affairs
Contact details:	E: paul.howard@wwl.nhs.uk

Executive summary

The latest assessment of the trust's thirteen 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:** Current risks have been reviewed and updated in line with the 2023/24 corporate objectives prior to the Quality and Safety Committee meeting on 9 August 2023. One new risk has been created and two risks closed since the last Board meeting:-

- ID 3805 - Sepsis Recognition, Screening and Management – new BAF risk.
- ID 3268 - Recognition, screening and treatment of the deteriorating patient – risk closed.
- ID 3647 – Preferred Place of Death – risk closed.

2.3 **People:** The People Committee met on 11 July 2023. One new risk has been created which is aligned to the 2023/24 corporate objectives and risk appetite statement. Two risks relating to last year's people objectives have been closed and two risks de-escalated to the corporate risk register:-

- ID 3783 – Workforce Sustainability – new BAF risk which relates to all three people objectives.
- ID 3532 – Person Centred People Management – risk closed.
- ID 3287 – Fairness and compassion – workforce EDI expertise and supporting infrastructure – risk closed.
- ID 3279 - Participation in preventative and restorative wellbeing activities – risk de-escalated from BAF to corporate risk register.
- ID 3283 - Personal Development - risk de-escalated from BAF to corporate risk register.

2.4 **Performance:** Current risks have been reviewed and updated in line with the 2023/24 corporate objectives prior to the Finance and Performance Committee meeting on 26 July 2023 and the following risks have been revised:-

2.4.1 Risk ID3292 Financial Performance: Failure to meet the agreed I&E position – the likelihood risk score has been increased from possible (3) to likely (4) and the overall assurance level has been reduced from high to medium since the last Board meeting.

2.4.2 Risk ID3291 Financial Sustainability: Efficiency targets & Balance Sheet – the likelihood risk score has been increased from unlikely (2) to possible (3) since the last Board meeting.

2.4.3 Risk ID3533 Urgent and Emergency Care – the likelihood risk score has been increased from possible (3) to likely (4) since the last Board meeting.

2.5 **Partnership:** Current risks have been reviewed and updated by risk leads.

2.5.1 The Board are asked to note one horizon scan risk relating to corporate objective 14: To improve the health and wellbeing of the population we serve. Given pressures on the Trust's financial position, access to funding to support initiatives which support widening access to employment for local residents is less certain, which may impact on delivery of the objective. This horizon scan risk will be developed into a BAF risk for the next Board meeting.

3. New Risks Recommended for Inclusion in the BAF

3.1 Two new risks have been added to the BAF since the last Board meeting in June 2023:

3.1.1 ID 3805 - Sepsis Recognition, Screening and Management – new BAF risk.
3.1.2 ID 3783 – Workforce Sustainability – new BAF risk which relates to all three people objectives.

4. Risks Accepted and De-escalated from the BAF

4.1 ID 3268 - Recognition, screening and treatment of the deteriorating patient – risk closed.
4.2 ID 3647 – Preferred Place of Death – risk closed.
4.3 ID 3532 – Person Centred People Management – risk closed.
4.4 ID 3287 – Fairness and compassion – workforce EDI expertise and supporting infrastructure – risk closed.
4.5 ID 3279 - Participation in preventative and restorative wellbeing activities – risk de-escalated from BAF to corporate risk register.
4.6 ID 3283 - Personal Development - risk de-escalated from BAF to corporate risk register.

5. Review Date

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

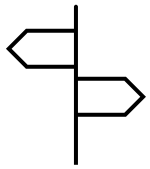
2023/24

The content of this report was last reviewed as follows:

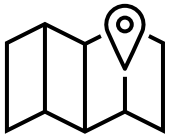
Board of Directors	June 2023
Quality and Safety Committee:	June 2023
Finance and Performance Committee:	July 2023
People Committee:	July 2023
Executive Team:	July 2023

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

How the Board Assurance Framework fits in

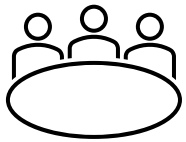


Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how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

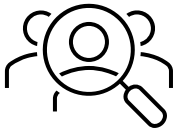


Corporate objectives: Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives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

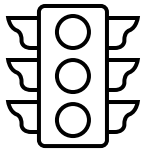
Board Assurance Framework: The board assurance framework provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains risks that are most likely to materialise and those that are likely to have the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



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



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



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

Understanding the Board Assurance Framework

RISK RATING MATRIX (LIKELIHOOD x IMPACT)

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

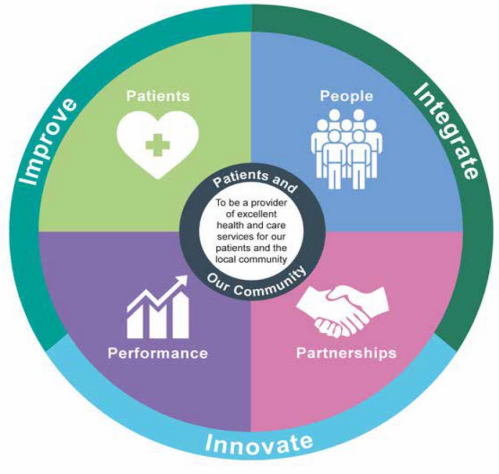
DIRECTOR LEADS

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

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

Our approach at a glance

Our Strategy 2030



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

Patients:	To be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience
People:	To ensure wellbeing and motivation at work and to minimise workplace stress
Performance:	To consistently deliver efficient, effective and equitable patient care
Partnerships:	To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

FY023/24 Corporate Objectives

Patients

We will…
- Improve the safety and quality of clinical services
- Ensure patients and their families receive personalised care in the last days of life
- Improve diabetes care for our population
- Improve the delivery of harm-free care
- Promote a strong safety culture within the organisation
- Improve the quality of care to our patients
- Listen to our patients to improve their experience

People

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

Performance

We will…
- Deliver our financial plan, providing value for money services
- Minimise harm to patients through delivery of our elective recovery plan
- Improve the responsiveness of urgent and emergency care

Partnerships

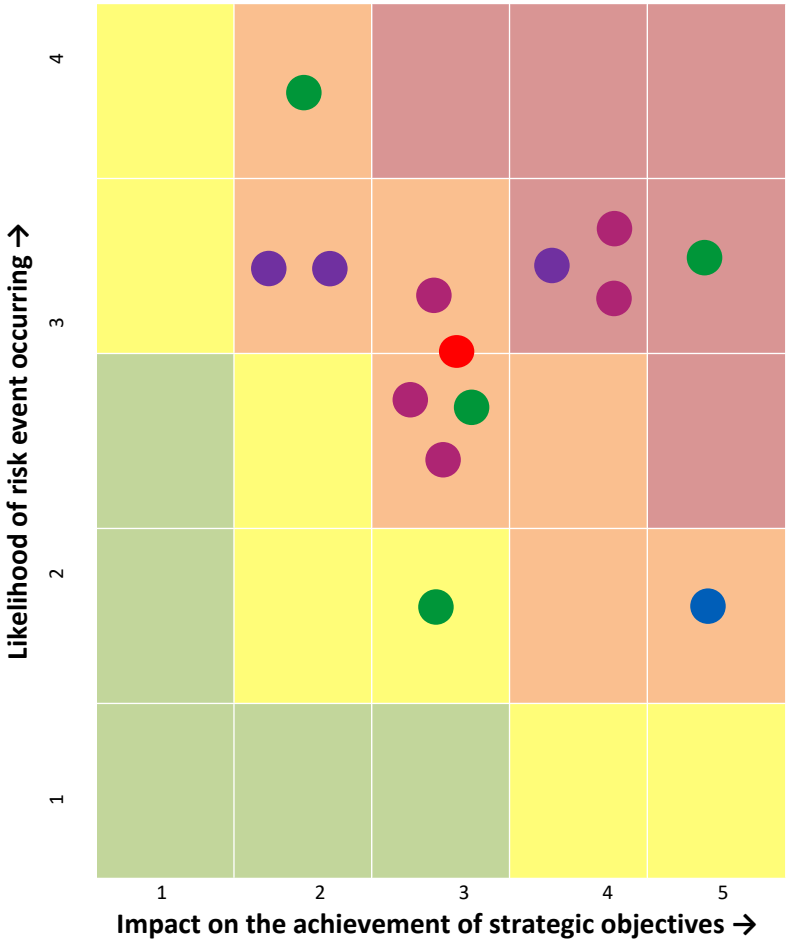
We will…
- Improve the health and wellbeing of the population we serve
- Develop effective partnerships within the new statutory environment
- Make progress towards becoming a Net Zero healthcare provider
- To increase research capacity and capability at WWL and in collaboration with EHU plan to make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

Risk management

Our risk appetite position is summarised in the following table:

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

The heat map below shows the distribution of all 13 strategic risks based on their current scores:



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

Patients

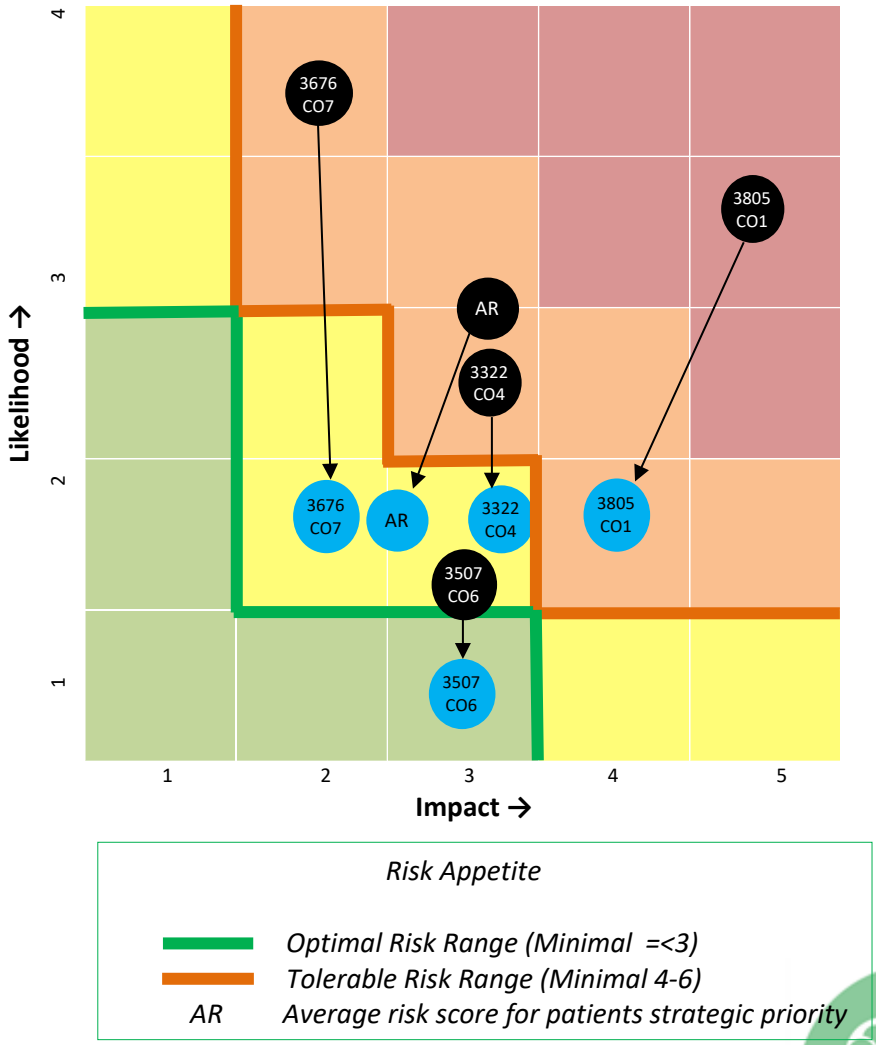
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

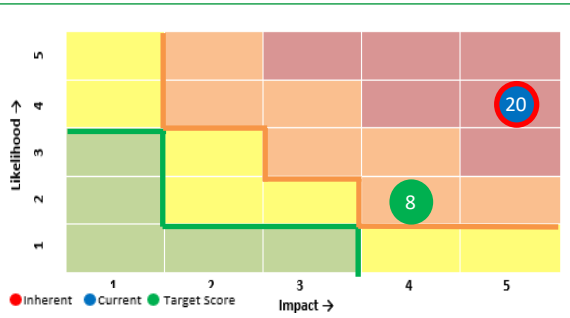
Monitoring: Quality and Safety Committee

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

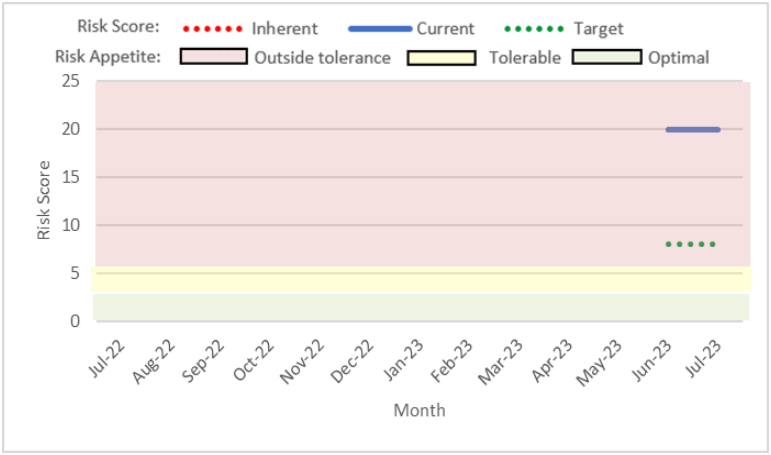
Ref.	Purpose of the objective	Scope and focus of objective
CO1	To improve the safety and quality of clinical services	To improve the compliance of Sepsis-6 care bundle as per Advancing Quality Audit, with aim to reduce mortality from sepsis.
CO2	To ensure patients and their families receive personalised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

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

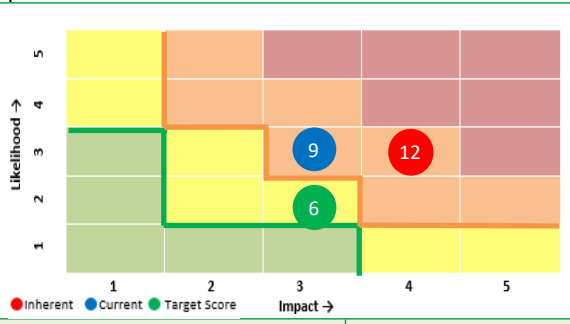


Corporate Objective: **CO1** To improve the safety and quality of clinical services					**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 1: Sepsis Recognition, Screening and Management**				
	Risk Statement:	There is a 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		

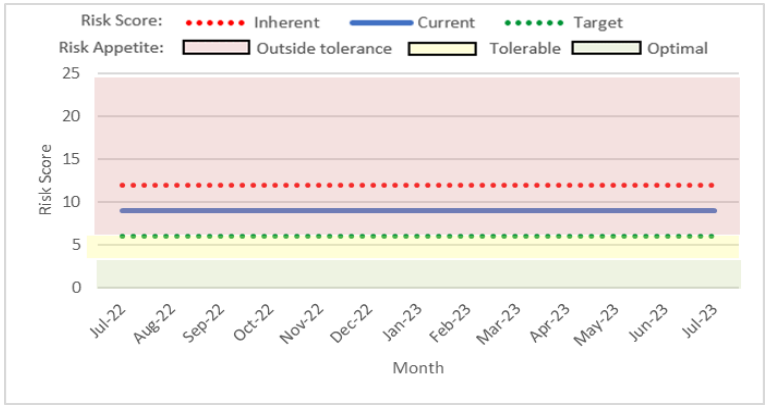
Risk Score Timeline



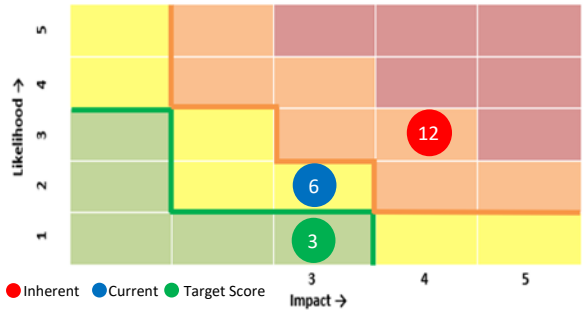
Strategic Opportunity / Threat Linked risk	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3805)**	• Ward walk rounds recommenced by current Sepsis Lead Nurse. • Link Nursing in all wards and department have been reinstated. • Training and Education - Corporate Induction, E-learning Sepsis, Sepsis in HIS. • Health Care Professionals - All staff are encouraged to maintain high standards of nursing care. • Sepsis nurse has recommenced reviewing Sepsis incidents on Datix. • Single Nurse Led Service • 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. • AQ (Advancing Quality as per Trust objectives) has now recommenced and we have data from January to May. • AMAT auditing for the Ward/Clinical areas.	• In process of recruiting band 6 Sepsis/AKI specialist nurse • 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:** • Quality & Safety Committee June 2023	**2nd Line:** • Sepsis Group to be established reporting into Deteriorating Patient Group.	1. Review Sepsis SOP 2. To recommence Sepsis training 3. Sepsis E-Learning review	Aug 2023 Sepsis Lead July 2023 Complete 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	

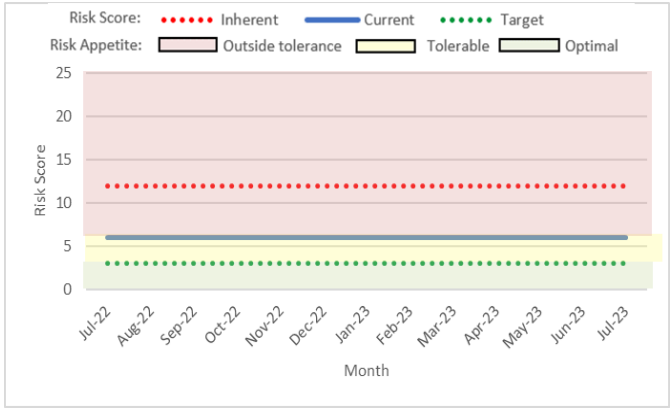
Risk Score Timeline



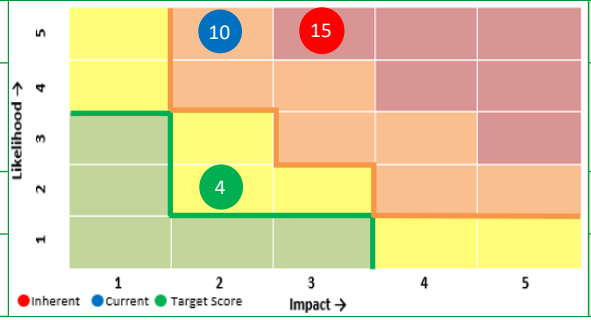
Strategic Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3322)** **Linked risk:** 3323 – Tissue viability team capacity	• Pressure ulcer link nurses trained within all areas and extended to community care homes.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

Corporate Objective: **CO6** To improve the quality of care for our patients					**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective.	**Risk Title:**	**PR 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	

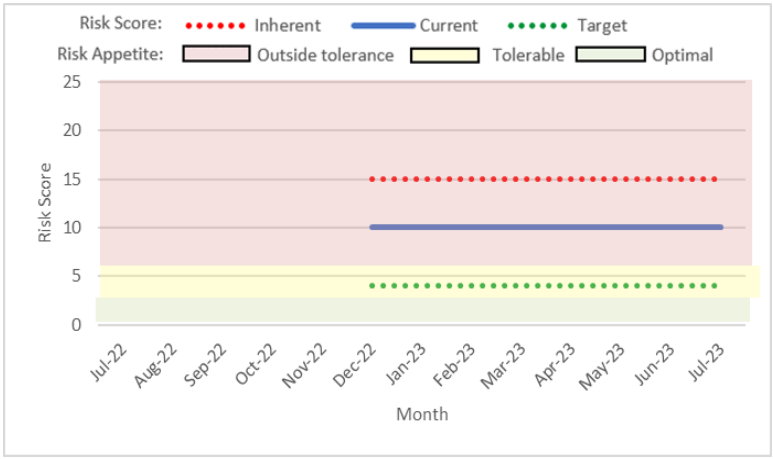
Risk Score Timeline



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3507)**	• Introduced the ASPIRE ward accreditation programme and have accredited 6 wards as silver status. • Weekly QA audits which have a greater focus on the quality/accuracy of clinical documentation, not just the timeliness. • 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. • At least one ward to achieve gold: SAL is pending their gold application. • 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). • 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:** • Quality & Safety Committee June 2023 • Monthly ASPIRE QSSG	**2nd Line:** • 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 What could prevent us achieving our strategic objective	**Risk Title:**	**PR 4: Complaint response rates**			
	Risk Statement:	There is a risk that complaints received may not be responded to and acted upon within our agreed timeframes, due to operational pressures and COVID backlog resulting in missed targets, unresolved complaints and adverse publicity.			
Lead Committee	**Quality and Safety**		**Risk 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	

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 3676)**	• Complaints SOP in place with defined roles, processes and timescales. • How to respond to a complaint training is being delivered with further sessions planned. • Patient relations team provide support and guidance.	• Releasing staff to attend training.	**2nd Line:** • Quality & Safety Committee June 2023	**2nd Line:** • No gaps currently identified.	1. Complaints backlog to be addressed. 2. Further training for staff to be arranged with staff given time to attend the training.	March 2024 CN March 2024 CN

People

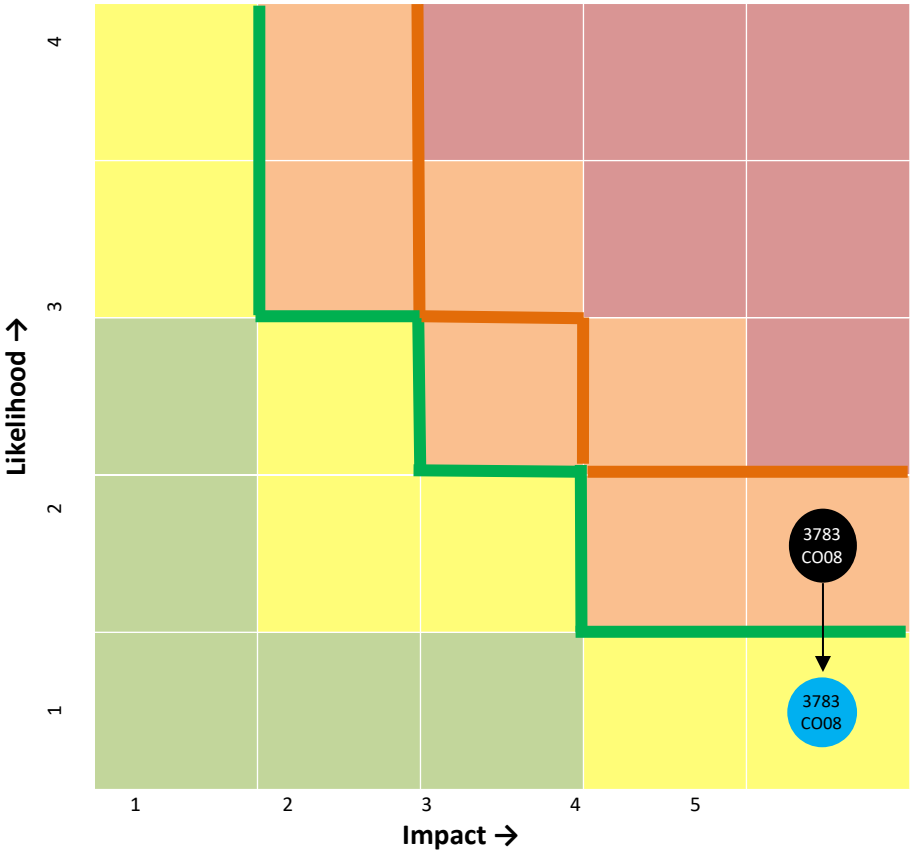
To ensure wellbeing and motivation at work and to minimise workplace stress.

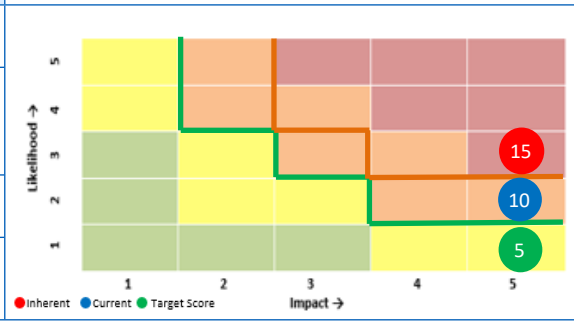
Monitoring: People Committee

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

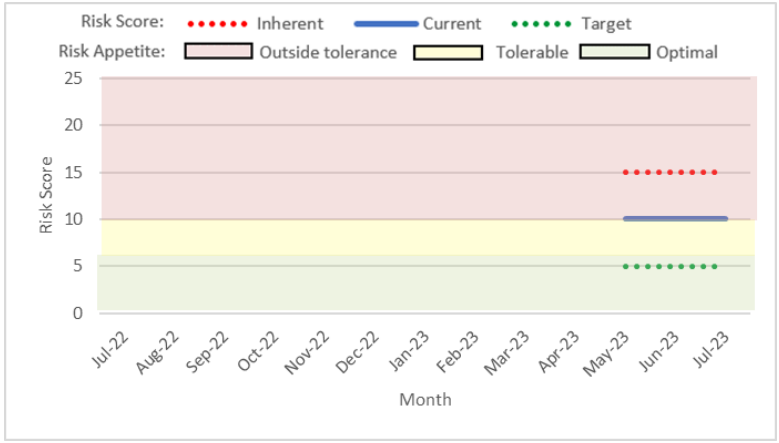
Ref.	Purpose of the objective	Scope and focus of objective
CO8	To enable better access to the right people, in the right place, in the right number, at the right time.	As part of our workforce sustainability agenda we will deliver the HR fundamentals brilliantly to: ✓ Reduce sickness absence from 6.58%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

The heat map below sets out the current risk score (black shading) and the target risk score (blue shading) for 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 Appetite**	Cautious		
Lead Director	**CPO**		**Risk category**	Staff Capacity & Capability, Staff Engagement Staff Wellbeing.		
Date risk opened	**19.06.23**		**Linked risks**	3572, 3229, 3227		
Date of last review	**26.06.23**		**Risk treatment**	Treat / Tolerate		

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 3783** Linked risks to corporate risk register: **ID 3572** Industrial action **ID 3229** Staff absence wellbeing **ID 3227** Maintaining safe staffing levels	• Workforce planning 2023/24 • Empactis relaunch • Civility Programme (just & learning culture) • People Dashboard refresh • Newton Europe Commission (pending) • National Staff Survey (October 2023 go live) • Launched start of year events – new appraisal season and route plan appraisal approach.	• Lead for people dashboard refresh and reporting mechanisms	**2nd Line:** • The sustainable workforce programme aims to implement robust trust wide workforce planning methodology and plans. • Empactis relaunch reports to Transformation Board monthly under sustainable workforce workstream • Civility Programme reports to Our Family, Our Future, Our Focus under the culture and leadership workstream. • Newton Europe Commission updates via ETM • Our Family, Our Future, Our Focus oversees National Staff Survey. • 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

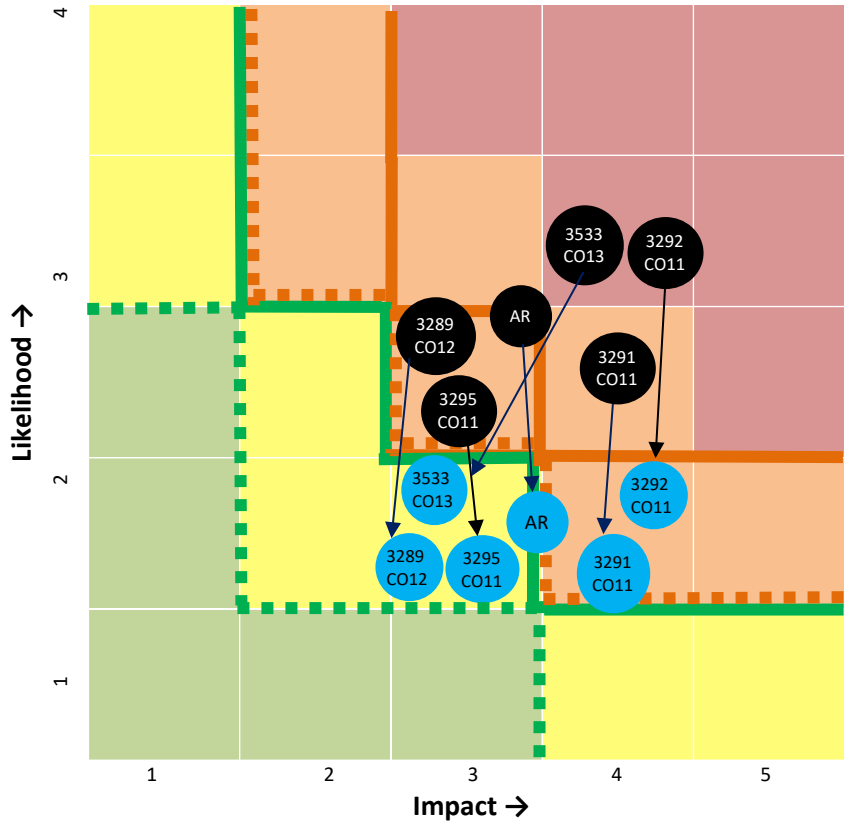
Our ambition is to consistently deliver efficient, effective and equitable patient care

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

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



Risk Appetite

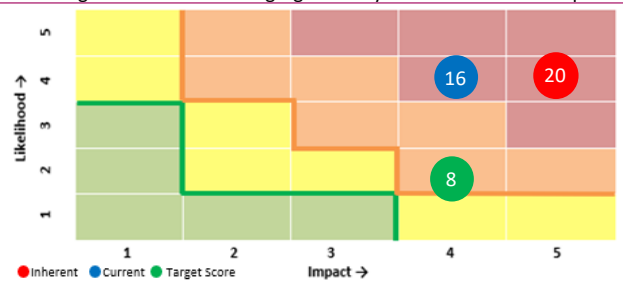
Optimal Risk Range (Financial Duties: Minimal ≤ 3)

(Other: Cautious ≤ 6)

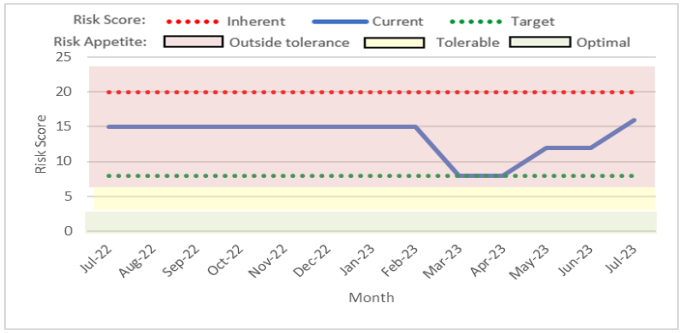
Tolerable Risk Range (Financial Duties: Minimal 4-6)

(Other: Cautious 8-10)

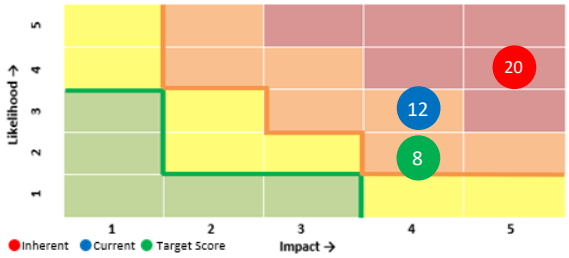
AR — *Average risk score for performance strategic priority*

Corporate Objective: **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	**14.07.23**		**Risk treatment**	Treat	

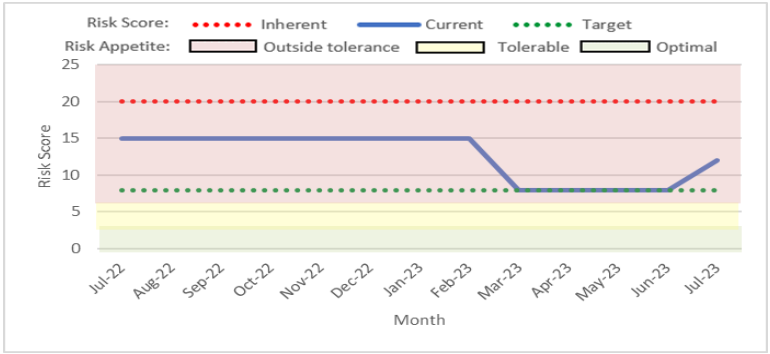
Risk Score Timeline



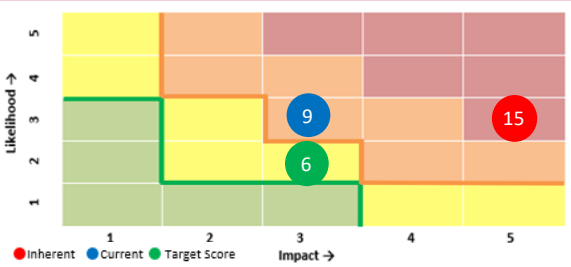
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3292)**	• Final plan signed off by Board and submitted to NHSEI – 4th May 23 • Work is ongoing with NHSE GM ICB and locality to manage the £11.9m funding gap from the withdrawal of locality support. Shortlist of options identified, although in year gap remains. • All divisions accepted budgets in April 23 • CIP target agreed with programme for delivery and actions. • Continued lobbying via Greater Manchester in respect of additional funding which is appropriate for current clinical capacity and operational and inflationary pressures (Ext.) • Robust forecasting including scenario planning for worst, most likely and best case. • Executive oversight and challenge of CIP & Financial performance through RAPID, Transformation Board & Divisional Assurance Meeting • Pay control group established with scrutiny and rigour over agency spend in line with national agency controls. • Stringent business case criteria to ensure only business critical investments are approved. • Escalation meeting held with NHSE in April 23 to review financial plan. • Full review of financial position by locality partners • RAPID meetings held for all divisions monthly in Q1. • Additional funding agreed to cover escalation costs in first half of 2023/24 • Escalation reduction plan agreed through ETM. • PWC concluded diagnostic into the drivers of financial and operational performance and key actions being progressed. • GM standardised financial controls has been shared by GM and are being implemented across WWL. • NHSE oversight of GM financial position including regular meetings with National NHSE CFO (Ext)	• System and locality support withdrawn. • Current plans to mitigate do not cover the gap currently. • No additional funding available for NRTR, additional beds and escalation in H2. • No additional funding expected to cover increased costs associated with industrial action. • No medium to long term resource confirmation or financial planning • Limited guidance on ERF arrangements.	**1st Line:** Monthly RAPID meetings for applicable divisions **2nd Line:** Finance & Performance Committee July 23	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Locality discussions ongoing around reducing escalation costs over H1 23/24 2. GM System PMO established to support delivery of I&E position (Ext)	Sept 23/ CFO 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 Tolerance**	Minimal	
Lead Director	**CFO**		**Risk category**	Financial Duties	
Date risk opened	**19.10.21**		**Linked risks**	-	
Date of last review	**14.07.23**		**Risk treatment**	Treat	

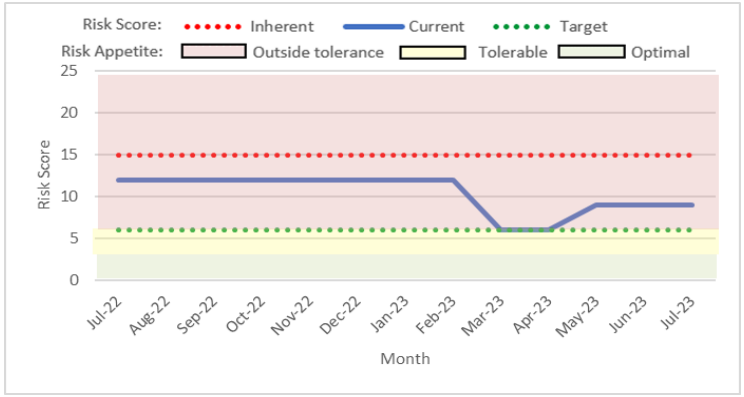
Risk Score Timeline



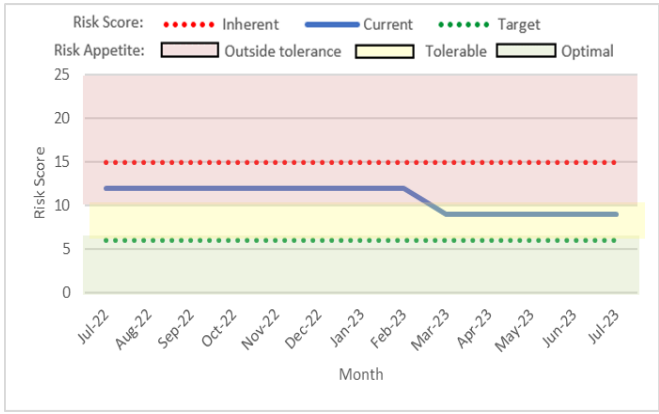
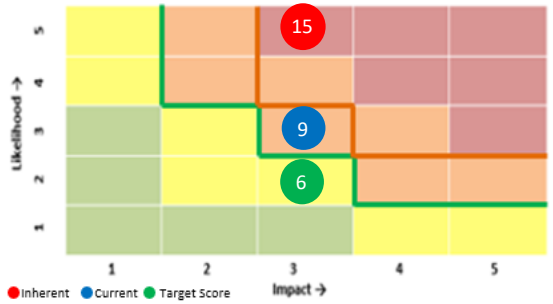
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3291)**	• Robust CIP divisional delivery approach and governance. • Work is ongoing to identify a bridge for the locality funding included in CIP. • Monitored via Divisional Assurance Meetings, with additional escalation through RAPID if Divisional delivery is off plan. • Further oversight at Executive Team, Transformation Board, F&P Committee and Board of Directors. • Work is ongoing across the GM system on developing a joint approach to productivity and cross cutting efficiency (Ext). • Transformation Board input & oversight of strategic programmes. • Effective credit control including monitoring debtor and creditor days and liquidity with oversight through SFT. • Effective monthly cash flow forecasting reviewed through SFT. • RAPID recovery metrics include recurrent CIP delivery. • Release of potential balance sheet flexibility included within 2023/24 financial plan. • Enhanced balance sheet reporting including cash metrics to SFT and within monthly finance report. • Clinical leadership established reviewing benchmarking opportunities for quality improvements through model hospital and GIRFT and reported through CAB, ETM and Divisional Assurance Meetings. • GM Cash management group being established from Q2 with WWL representation (Ext) • Internal cash management strategy being developed. • Cash forecast reviewed with no support required in Q2. • Cash position assessment, risks and mechanisms for accessing cash support shared with Finance and Performance Committee (July 23)	• Limited mechanisms to facilitate delivery of system wide savings. • GM system efficiency requirement with no plan • Unidentified divisional CIP 12% in year and 2% recurrently • GM Cash Management Strategy not yet developed (Ext)	**1st Line:** Monthly RAPID meetings for applicable divisions **2nd Line:** Finance & Performance Committee July 2023	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Monthly updates on CIP presented to Executive Team, with regular updates to Divisional Teams. 2. GM PMO established leading on system efficiency target £130m (Ext) 3. Cash management strategy developed.	Throughout 2023/24 CFO/DCEO Throughout 2023/24 CFO/DCEO Q2 CFO

Corporate Objective: C11 Deliver our financial plan, providing value for money services				**Overall Assurance level**	**High**
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 8: 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	**14.07.23**		**Risk treatment**	Treat	

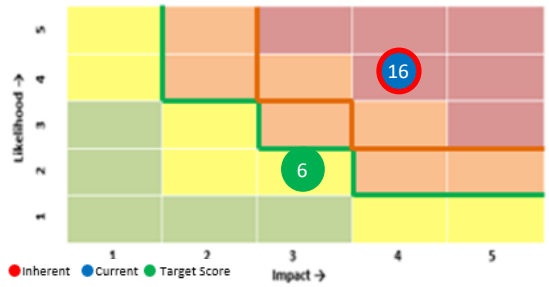
Risk Score Timeline



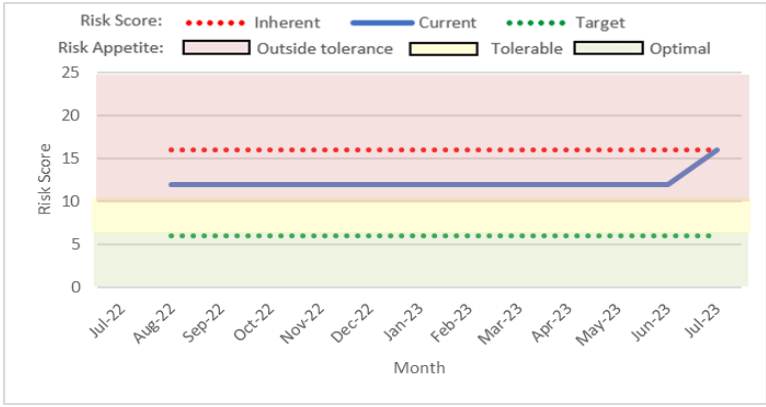
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3295)**	•Lobbying via Greater Manchester (Ext) •Capital Priorities agreed by Executive Team & Trust Board. •Cash for Capital investments identified within plan. •Reprioritisation of additional capital schemes to ensure the capital programme is reflective of organisational priorities. •3 year capital allocations available to inform more longer term system planning. •Strategic capital group established with oversight of full capital programme. •Operational capital group established to manage the detailed programme. •Attendance at GM capital leads group (Ext) •Programme Boards established for major capital schemes. •Work ongoing to bid for additional PDC funding •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). •Accelerated timescale for endoscopy required to secure national PDC funding – approved at national panel. •Theatre 11PDC funding approved at national panel (July 23) in line with WWL capital strategy. •Exploring options with commercial partners to facilitate capital investments outside of CDEL in line with strategy. •Exploring opportunities to lease rather than purchase in line with IFRS 16	• Impact of inflation in terms of project costs and timescales • GM overcommitment on CDEL plan with agreement not yet reached with NHSE – potential further reductions to CDEL limit expected. • Cash for capital investments identified is subject to achievement of I&E position including CIP delivery.	**1st Line:** Monthly Capital Strategy Group **2nd Line:** Finance & Performance Committee - July 2023	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Close monitoring of Capital spend in line with trajectory. 2. Development of capital reporting through the refreshed DFM App 3. Discussions ongoing with national team re. additional capital funding to support the £40m GM bespoke transaction and contingency (Ext)	Throughout 2023 CFO Q2 2023/24 CFO Q2 CFO

Corporate Objective: **CO12** To minimise harm to patients through delivery of our elective recovery plan				**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective?	**Risk Title:**	**PR 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	**19.07.23**		**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) Linked risks on corporate risk register: **3572** Industrial action **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. • Received notification from National team that our elective activity plan will be reduced to take into consideration activity lost due to industrial action. • Divisions have re-evaluated activity plans due to National choose and book system and capacity reducing from the Junior Doctors and Consultants industrial action. • On track to eliminate waits over 65 weeks. • Continue to exceed the trajectory for the cancer faster diagnosis standard. • Implementation of Community Diagnostic Centres which will provide more capacity without waiting list initiatives. • Monitor through divisional assurance meetings with clear escalation protocols to exec team meetings and F&P Committee - developed into an app. • Transformation Plan - elective productivity and capacity aims to increase diagnostics and support delivery of electives and develop elective capacity. • Providing and receiving mutual support from GM and region for high volume high complexity work.	• Elective activity below planned levels year to date primarily attributed to lost activity due to industrial action. • Lost 207 electives, 554 day cases, 515 procedures and 1082 new patients lost due to industrial action this year. • National team have not yet informed us what the elective activity plan reduction will be. • Demand for patients on cancer pathways exceeds capacity and impacts on delivery of non-cancer elective work. • Diagnostic capacity insufficient to deliver elective waiting times. • Reduce follow ups. • DNAs. • Increase productivity to meet organisational targets	**2nd Line:** • Integrated performance report through Finance & Performance Committee.	•No gaps in assurance currently identified.	1. Implementation of Transformation Programme 2. Funding from national team and reprofiling of activity plan.	March 2024 DCE March 2024 DCE

Corporate Objective: CO13 Improve the responsiveness of urgent and emergency care				**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective?	**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 Tolerance**	Cautious	
Lead Director	**DCE**		**Risk category**	Performance Targets	
Date risk opened	**05.09.22**		**Linked risks IDs**	3423	
Date of last review	**24.07.23**		**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 3533)** Linked risk on corporate risk register: **3423** ED – Increase in attendances and insufficient patient flow	• A&E performance on track. • 2 hour urgent care performance on track. • Delay in ambulance handovers within 60 mins has reduced. • Wigan locality system has been strengthened by the appointment of the Director of Integration across the Acute Trust and Wigan Council leading the Home First and Integration Programme. • Hospital Discharge and Flow Programme led by DCE. • Wigan system partners have re-instated the urgent and emergency care transformation board to support system wide change. • National team due to visit on 3rd August as part of GM Tier 1 allocation to experience challenges first hand and discuss flow with system partners. • Number of no right resides reduce from May to June 2023. • De-escalated an area. • Virtual hub optimisation. • Increase utilisation of the SDEC – Medical and frailty. • Ward improvement. • Mental Health alternations to Emergency Department.	• Insufficient capacity with 99% occupancy rate. • Corridor care • 12 hour waits have reduced slightly but remain a concern. • Number of no rights to reside patients. • Work required further upstream regarding higher acuity of patients in borough.	**2nd Line:** • Integrated performance report through Finance & Performance Committee – July 2023	**3rd Line:** • Visit from NHS England National Team - due 3rd August 2023.	1. Work closely with colleagues in Wigan locality to progress WWL Transformation Plan and Hospital Discharge and flow programme.	March 2024 DCE

Partnerships

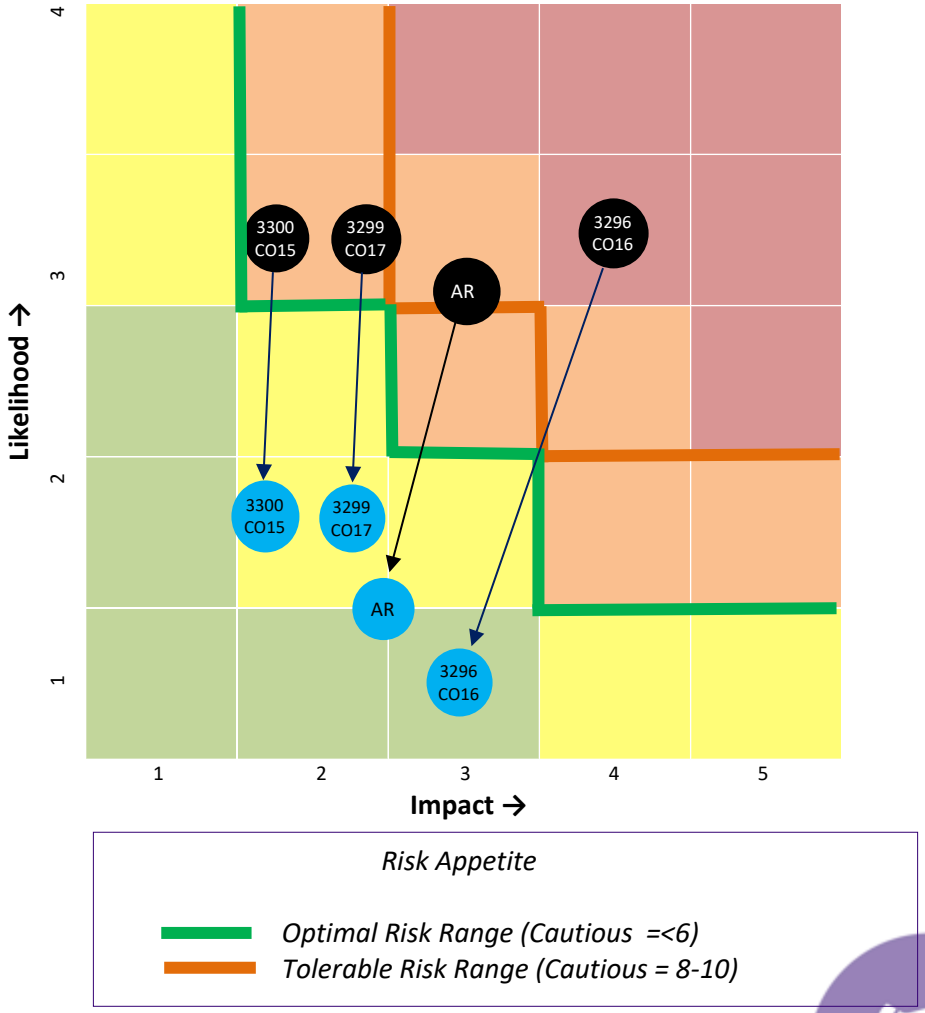
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

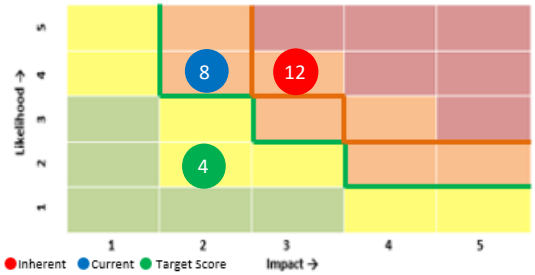
Monitoring: Board of Directors

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

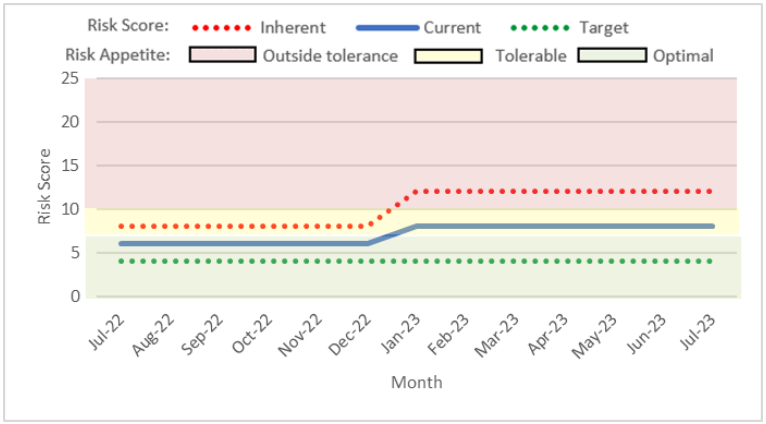
Ref.	Purpose of the objective	Scope and focus of objective
CO14	To improve the health and wellbeing of the population we serve	✓ As an Anchor institution we will work with partners to improve the health of the whole population we serve, supporting development of a thriving local economy and reducing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

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

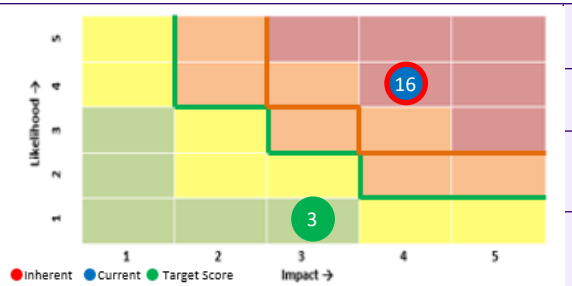


Corporate Objective: **CO15** To develop effective partnerships within the new statutory environment				**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic	**Risk Title:**	**PR 11: Partnership working - CCG changes**			
	Risk Statement:	There is a risk 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	**17.07.23**		**Risk treatment**	Treat	

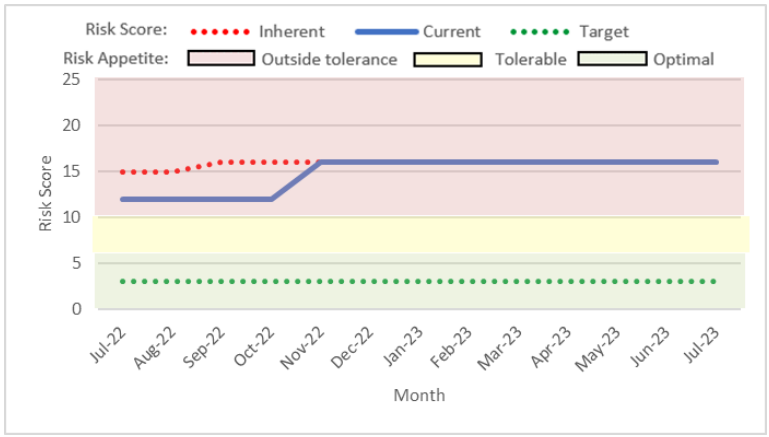
Risk Score Timeline



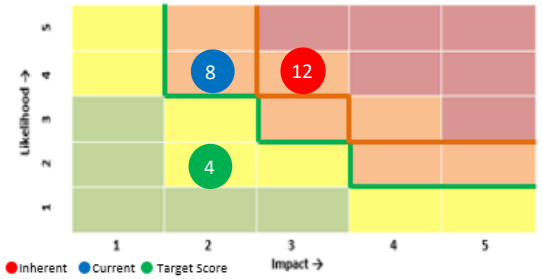
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3300)**	• Locality meeting structures in place to support lasting corporate knowledge.	• Uncertainty around CCG changes.	**2nd Line:** • Board of Directors June 2023 • **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 What could prevent us achieving our strategic objective	**Risk Title:**	**PR 12: Estate Strategy - net carbon zero requirements**				
	Risk Statement:	There is a risk that Net Zero may not be delivered, due to investment not being available, resulting in failure to deliver the Green Plan and legislative requirements				
Lead Committee	**Finance & Performance**			**Risk Appetite**	Cautious	
Lead Director	**DSP**			**Risk category**	Sustainability /Net Zero	
Date risk opened	**19.10.21**			**Linked risks**	-	
Date of last review	**29.06.23**			**Risk treatment**	Treat	

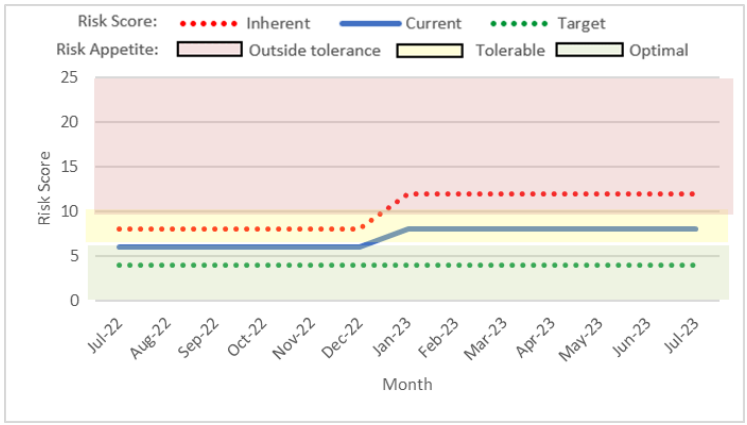
Risk Score Timeline



Strategic Opportunity /Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3296)**	• Sustainability Manager in post. Recruited band 4 support. Band 7 Energy Manager OBC submitted to ETM. • Greener WWL comms commenced, supported by recruiting to the Ambassadors programme. • Completed baseline assessment, developed prioritised investment plan, Net Zero Strategy and updated the Trust's Green Plan. • Net Zero and sustainability e-learning programme rolled out. • Governance structures set up to address divisional net zero issues. • Sustainability and Net zero included in corporate objectives process for 2023-24.	• Recurrent baseline emissions assessment • Climate Change Adaptation plan • Sustainable Travel Plan • Comms and Engagement strategy • Sustainability Impact Assessment (developed not integrated into QIA) • Capital funds should PSDS not be secured	**2nd Line:** • Finance & Performance Committee Sept 23 • Sustainability Assurance Framework (F&P Sept 23) • Ricardo progress briefing (Board Jul & Sept 2023) • Business planning process commenced. • Net Zero oversight group – bimonthly	• No substantive sustainability workforce resource to support delivery against strategic aims set out in the Net Zero NHS guidance document. • Investment schedule aligned to capital programme (based on Ricardo outputs)	1. Complete recurrent baseline assessment annually. 2. Estates Net Zero High level. Investment Plan to be integrated into capital planning 3. Further develop governance structures to ensure all areas captured.	

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 13: 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	**18.07.23**		**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 3299)**	• Project documentation including action log in place. • 1 colleague confirmed as meeting the minimum criteria of 0.40wte affiliation to EHU.	•A core number of university 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. •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:** • Board of Directors – June 2023	• None currently identified.	1.The key actions for increasing University employed research Principal Investigators: The Head of Research identified 1 substantive EHU clinician with Honorary Consultant status in WWL, however this individual is not a Principal Investigator in research. The CD for Research presented the Joint Clinical Academic Workforce Strategy (JCAW) to the Research Committee in March 2023 and following approval, this was shared with the Trust Board at the Away Day in April 2023. A Research Financial Strategic Plan is also at the stage of consultation prior to approval to support investment in such roles. On approval of the latter, the principles in the JCAW strategy will be employed, and discussed with EHU to increase the number of EHU substantive/WWL Honorary PIs with HR advice on contractual options for this individuals. 2. Our target for 2023/24 is to submit a minimum of 3 NIHR grant applications to be able to attract another NIHR award, which should enable achieving the £200k in 2025/26 to achieve this target.	MD March 2024 MD March 2024

Agenda item: [17]

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	WWL M3 23/24 Balanced Scorecard
Presented to:	Board of Directors
On:	2 August 2023
Presented by:	Director of Strategy & Planning
Prepared by:	Data Analytics and Assurance Team
Contact details:	DAASupport@wwl.nhs.uk

The WWL Way

Executive summary

M3 23/24, June position of the current iteration of the Trust's Balanced Scorecard and associated commentary is presented to the Board of Directors.

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

The DAA team have improved the printed version of the report; the interactive version on the Balanced Scorecard remains available and allows you to view trend, Statistical Process Control (SPC) and year on year comparison (where data available) charts for each KPI.

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

Or

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

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

Link to strategy
Patient
Partnership
Workforce
Site and Service

Risks associated with this report and proposed mitigations
None highlighted.

Financial implications
None currently highlighted.

Legal implications
None identified.

People implications

None identified.

Wider implications

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

Report: M3 WWL Balanced Scorecard: June 2023

Quality and Safety (Chief Nurse & Medical Director)

KPI Title	Period Covered	Total	Target	On Target	Trend	YTD
SHMI Rolling 12 Months	Feb-23	111.84	100	●	▼	111.84
HSMR Rolling 12 months	Mar-23	93.20	100	●	▼	93.20
Never Events	Jun-23	0	0	●	▼	2
Number of Serious Incidents	Jun-23	8	0	●	↔	21
STEIS Reportable Category 3, 4 & Unstageable Pressure Ulcers	Jun-23	1	0	●	↔	2
STEIS Reportable Serious Falls	Jun-23	0	0	●	↔	0
Methicillin-Resistant Staphylococcus Aureus (MRSA)	Jun-23	0	0	●	↔	0
Methicillin-Susceptible Staphylococcus Aureus (MSSA)	Jun-23	6	0	●	▲	10
Clostridium Difficile (CDT)	Jun-23	5	0	●	▲	11
Complaints Responses	Jun-23	55.88%	85%	●	▼	62.07%
Patient Experience (FFT)	Jun-23	92.86%	N/A	N/A	▼	91.77%

People (Chief People Officer)

KPI Title	Period Covered	Total	Target	On Target	Trend	YTD
Leaders Forum reach (Number of Leaders attending the Forum)	Jun-23	244	110	●	▲	478
FTSU contacts	Jun-23	6	N/A			27
Number of outputs per month (LF, ASTB, Executive Vlogs, CEO Vlog / Blog)	Jun-23	5	6	●	▼	18
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	Jun-23	95.93%	95%	●	▲	95.79%
Rostering timeliness	Jun-23	86.49%	75%	●	▲	79.28%
Appraisal	Jun-23	81.20%	90%	●	▲	80.61%
Usefulness of Trust wide communication	Nov-22	81.00%	70%	●		N/A
Rate card adherence (Medical)	Jun-23	48.20%	80%	●	▼	51.27%
% Turnover Rate	Jun-23	9.56%	10%	●	▲	9.56%
Vacancy rate	Jun-23	6.01%	5%	●	▼	6.19%
Sickness - %age time lost	Jun-23	4.39%	5%	●	▼	4.70%

Performance (Deputy Chief Executive)

KPI Title	Period Covered	Total	Target	On Target	Trend	YTD
Ambulance handovers 60+ minutes delay	Jun-23	72	0	●	▲	289
Reduce 12-hour waits in EDs	Jun-23	13.99%	10%	●	▲	14.08%
A&E waiting times : patients seen within 4 hours	Jun-23	70.60%	70.04%	●	▼	69.94%
G&A Bed Occupancy - Acute Adult Inpatient Wards	Jun-23	99.28%	95%	●	▲	99.13%
85% Paediatric Bed Occupancy (IN DEV)	Jun-23	45.15%	85%	●	▼	48.21%
85% Critical Care Bed occupancy for Adults and Children	Jun-23	68.27%	85%	●	▲	63.12%
Virtual ward patients	In Dev.					
No Right to Reside Patients (excluding Discharges)	Jun-23	138	50	●	▼	137
Cancer - waits longer than 62 days	May-23	70	83	●	▼	70
Patients waiting over 78 weeks (except patient choice and clinically complex)	Jun-23	3			▼	3
Total patients waiting over 65 weeks (except patient choice and clinically complex)	Jun-23	975			▲	975
Reduce waits of over 52 weeks by 50% by March 2024	Jun-23	3,741			▲	3,741
Number of diagnostics received completed within 6 weeks	Jun-23	80.27%	87%	●	▼	81.19%
Diagnostic activity compared to 19/20 levels	Jun-23	14,659	14,316	●	▼	44,867
Meet the cancer faster diagnosis standard by March 2024	May-23	72.27%	67.5%	●	▼	73.49%
Reduction in outpatient follow-ups	Jun-23	17,173	17,189	●	▼	49,187
Day case rate	Jun-23	85.09%	84%	●	▲	84.73%
Elective Theatre Utilisation	Jun-23	81.08%	85%	●	▼	81.54%
Elective Recovery Plan	Jun-23	92.87%	100%	●	▼	94.34%
2-hour urgent community response	Jun-23	75.61%	70%	●		75.61%

Finance (Chief Finance Officer)

KPI Title	Period Covered	Total	Target	On Target	Trend	YTD
Cash (£'000s)	Jun-23	35,234	31,958	●	▲	103,076
Cost Improvement Programme (CIP) (£'000s)	Jun-23	2,407	2,152	●	▲	5,123
Capital Expenditure (£'000s)	Jun-23	1,448	2,780	●	▲	2,946
Agency Expenditure (£'000s)	Jun-23	862	1,055	●	▲	2,626
Better Payment Practice Code (BPPC)	Jun-23	94.00%	95%	●	▼	94.36%
Agency % of Total Pay	Jun-23	3.02%	3.7%	●	▲	2.96%
Adjusted Financial Performance (£'000s)	Jun-23	(376)	195	●	▲	(1,565)
Surplus /Deficit (£'000s)	Jun-23	(388)	179	●	▲	(1,558)

Quality and Safety (Chief Nurse & Medical Director)

Patient Safety

During the month of May there were 8 incidents escalated to StEIS; these included x2 delayed diagnosis, x2 Never Event, X1 unstageable pressure Ulcer, x2 treatment delays and x1 surgical invasive procedure complication following cataract surgery. The never events reported were in relation to wrong site injection (orthopaedic) and wrong site drain insertion (medicine). Both incidents are being urgently investigated but immediate learning was implemented to reduce the risk of recurrence. Treatment delays continues to be a recurring theme during May; there is a lost to follow-up risk on the Corporate Risk Register. This risk is currently scoring a risk of 15 (risk 3652). A Task and Finish Group has been set up, facilitated by the Director of Corporate Affairs. This month has also seen an increase in Never Events reported, on the 26 June 2023 a themes SIRI meeting was held which focussed on these incidents and the learning identified, this learning was communicated across a wide audience for all professions across the Trust.

Complaints

The complaints response performance for May was 62%. There was a notable variation in response rates across the Divisions, with several achieving the target of 85% or higher, however further work is required. A further complaints workshop is being scheduled in August to review what can be changed, a triage process is being trialled within the Division of Medicine to see if any complaints can be responded to quicker via phone calls from the local teams and the quality checking process has also been streamlined.
In addition, the Patient Relations team have a further 2 sessions of how to respond to a complaint training scheduled for July and September which have had good uptake, although historically the attrition rate has been quite high. The aim of the training is to explain the process, highlight responsibilities and the importance of a timely response, whilst also providing the tools and confidence to respond sensitively and transparently.

People (Chief People Officer)

Wellbeing:

Salary finance offers now being shared with staff to their home address – worked with IG to find an approach for this as many staff are reluctant to do this via work channels.
TRiM Pilot Training Programme launched in July training - 20 staff to become TRiM Practitioners who will then be able to support staff across the trust following trauma related incidents.
Refresh of the OFOFOF Wellbeing Pillar – new objectives for 2023/24
Notice given to formally end EAP service as service is massively underutilised – contract to end Sept 2023. EAP have agreed to continue supporting staff that are currently accessing their counselling service.
Wellbeing Champions CPD - Andy's Man Club joined to promote their men's peer to peer support group across GM – further info at www.andysmanclub.co.uk
Staff Physio Educational Sessions - increased awareness of MSK issues and advice and guidance from physiotherapists. Supports plans to reduce MSK related absences.
Empactis absence manager relaunch underway having re-appointed the project coordinator and agreed re-implementation plan with Empactis. Monitored and supported through sustainable workforce transformation scheme.
Retention group established under sustainable workforce transformation scheme, with initial focus on the nursing and AHP professions.
Leadership & teams:
Culture & Engagement programme evaluation complete and proposal for launch of redesign programme in August 2023 shared with ETM 20th July.
Launch of OD Support Model shared with ETM July 2023 to outline OD support available to teams and interventions on offer.
Route Plan Appraisal – 80.7% staff had appraisal conversation (not all fall into new appraisal season as some staff already had an appraisal).
Objectives cascade and goal setting - Route Plan Appraisal data shows 12.4% of staff have taken part in goal setting & objectives cascade in their teams (775 out of 6269 staff – work still to be done here).
HEE Compassionate Leadership training for Junior Doctors – proposal to be shared with ETM on roll-out of the programme & evaluation of pilot with FY2's this yr.
Objectives cascade & goal setting - 12.4% of staff have taken part in goal setting & objectives cascade in their teams (775 out of 6269 staff). Lunch & Learn sessions available to support leaders in objectives cascade - book via Learning Hub.
eLearning available (Learning Hub) for staff and leaders to support them in goal setting. The Staff Experience team available to join team meetings to help leaders with their cascade.
Plans in discussion for triangulating the people data with performance, quality and finance.
Culture:
Guardian Service to cease providing external FTSUG on 31st August 2023. WWL FTSUG to be appointed reporting directly to the CPO. Measures to evaluate the changes in service will come from FTSU reports, frequency and themes of concerns raised and NSS scores attributed to staff feeling able to raise concerns.
True Colours network - underway with preparations for Wigan Pride. Also hosting a pronouns event on Monday 24th July in the well-being lounge – would be nice if Exec Members can drop-in.
Disability network - accessible signage project and sunflower scheme underway
Fame network - start of South Asian heritage month. Canteens will be promoting new South Asian food options each week for the month.
Comms and visibility: Five Executive Vlogs - plus CEO vlog, ASTB and LF. 155 on ASTB. Exec decision to stand down Leaders Forum Reach and replace with Start of the Year event.
Personal development:
Mandatory Training – National 95.9% target compliance exceeded by 0.4% since last month. Local compliances are steadily increasing 90%
Oliver McGowan Mandatory learning now live for all staff.
Coaching development programme launched for WWL Coaches with a programme of coaching CPD and coaching supervision to continually develop our internal coaching expertise.
EDI Lead role – vacancy now live.
Working in partnership with Wigan Council to develop a strategy for optimising Apprenticeship Levy funds and gifting of these for organisations who don't have access to a levy. Supports smaller organisations in locality to develop their staff.

Performance (Deputy Chief Executive)

UNSCHEDULED CARE

Despite significant challenges, including highest occupancy rate in the Northern Region, overall A&E performance was 70.6% and is online with trajectory against the 4-hour standard which is just below the National average of 73.3%. The last time England hit the target was July 2015

The 2-hour urgent community response national rate has been exceeded. Unimpeded flow (discharges and bed availability) aids an improved A & E performance, a contributing factor to flow is the number of no right to reside (NRTR) patients. Over the month of June 2023, the number of patients with no right to reside peaked at 138. However, on average 110 patients waited to leave the hospital, an improvement from 121 patients in April 2023.

The number of people waiting over 12 hours in the emergency department reduced slightly in June but remains a concern. The Ambulance handover transformation programme continues to deliver an improving performance, delays reduced from a peak of 433 in November 2022 to 72 in June. The Trust aims to achieve the target of 0% delays of over 60 minutes by the end of this year. Furthermore, the average ambulance handover time continues to improve from 38 minutes in April 2023 to 20 minutes in June 2023.

The Trust achieved successful de-escalation of an area whilst also managing junior doctor's strike during June. Members of the National team are scheduled to visit the Trust in August as part of the Greater Manchester Urgent and Emergency Care Tier 1 process. The purpose of the visit is to obtain an overview of the key challenges, to experience firsthand the challenges faced by the A&E team and to discuss whole system patient flow with system partners. Wigan system partners have reinstated the Urgent Emergency Care transformation board with plans to support system wide change. System support has been strengthened with appointment of a Director of Integration across the Acute Trust and Wigan Council to lead the Home First and Integration programme.

SCHEDULED CARE

The Trust is making good progress with clearance of long waits for elective care. All patients beyond 78 weeks who were impacted by the national e-referral system have now been treated in accordance with national guidance. As a Trust we continue to plan to deliver clearance of 65 week waits by March 2024, however divisional trajectories are currently being revised to account for the e-referral drop off patients and lost capacity due to ongoing industrial action which has affected delivery of the activity plan. The Trust has received notification from the national team that the elective activity plan for the year will reduce to consider periods of industrial action, we await further details.

Cancer performance continues to improve, with the 14-day target being met in May (latest validated position) and the highest 62-day performance in almost 2 years 83.5% against a target of 85%. As at the end of May, there were 70 patients waiting beyond 62 days against a plan of 83. The Trust continues to exceed its trajectory against the Cancer 'faster diagnosis standard'.

Diagnostic activity remains on plan; however, the challenge is reduced capacity due to low uptake of additional sessions and lack of capacity for specialist procedures. Longer term plan will be to provide the required capacity within the Community Diagnostic Centres.

The elective productivity and capacity transformation scheme is performing well, 'did not attend' are reducing but reappointments are high, the roll out of further technology will help validate waiting lists. Theatre productivity is largely driven by lost capacity due to strike action, over 180 patients each day are cancelled and re-booked as a direct result of strike action, this is having a significant impact on booking teams' ability to manage capacity. The Trust has submitted a bid to the GM ICB to provide support to deliver activity targets.

It should be noted that the operational reality is still not in line with NHSI/e key planning assumptions to support delivery of Urgent and Elective Care - significant pressures are still seen in urgent care demand, cancer referral rates and bed occupancy levels. The Trust continues to work with system partners both at locality and Integrated care Board levels to safely manage both urgent and planned care.

Finance (Chief Finance Officer)

Surplus/Deficit

The Trust reported an actual deficit of £0.4m in month 3 (June 2023), which is an adverse variance of £0.6m to the plan. Year to date, the Trust is reporting an actual deficit of £1.6m which is £2.1m adverse to plan. As reported previously, the income position does not reflect the potential underperformance against the Aligned Payment and Incentive scheme (API) which is estimated at £1.7m year to date against the internal plan.

Adjusted Financial Performance

The adjusted financial performance is a deficit of £0.4m which is £0.6m adverse to the plan of £0.2m surplus.

Agency Expenditure

Agency expenditure is £0.9m in month 3, which is comparable to previous months. This is £0.3m below the NHSE agency ceiling year to date, which is set at 3.7% of total pay expenditure.

Agency % of Total Pay

Agency expenditure as a percentage of the Trust total pay bill is 3.0%, which is lower than the NHSE ceiling of 3.7%.

Capital Expenditure

Expenditure against the capital plan was £2.8m which is £1.3m below plan in month 3. Year to date, capital expenditure is £3.9m below the internal CDEL plan. This is primarily due to the Community Diagnostic Centre (CDC) and Leigh Theatre 4. This is expected to be recovered during the financial year.

Cash

Cash is £35.2m at the end of month 3 which is £0.3.3m above plan due to the time of the pay award cash flows.

Cost Improvement Programme (CIP)

In month 3, £1.3m has been delivered against a plan of £2.2m, therefore there is a favourable variance of £0.3m. Year to date, CIP delivery is £1.0m below plan. As at the end of month 3, there is an unidentified gap of £4.5m (18%) in year and £8.0m (40%) recurrently, which whilst challenging is a better position than compared to this time last year.

Better Payment Practice Code (BPPC)

BPPC for month 3 is 94.0% by volume and 92.7% by value. Performance by volume has reduced marginally from the previous month (94.3%) and improved by value (92.8%). An action plan is being developed to improve the BPPC to the target of 95.0%.

Change log:

Ref	ID	Metric	Change	Date	Requested by:
23/24 01	21	Sickness Absence	Change target from 4% to 5%	22/05/2023	Deputy Chief People Officer
23/24 02	59	Ambulance Handovers under 30 minutes	Remove metric	13/04/2023	Deputy Chief Executive
23/24 03	58	Ambulance Handovers under 15 minutes	Remove metric	13/04/2023	Deputy Chief Executive
23/24 04	75	Cancer referrals - 115& of pre-covid average	Remove metric	13/04/2023	Deputy Chief Executive
23/24 05	24	Patients waiting over 104+ weeks (except patient choice or clinically complex)	Remove metric	13/04/2023	Deputy Chief Executive
23/24 06	28	Outpatient utilisation (In Dev)	Remove metric	13/04/2023	Deputy Chief Executive
23/24 07	68	Outpatient DNA rates	Remove metric	13/04/2023	Deputy Chief Executive
23/24 08	67	Virtual Outpatient Consultations	Remove metric	13/04/2023	Deputy Chief Executive
23/24 09	76	Total Waiting List - RTT position	Remove metric	13/04/2023	Deputy Chief Executive
23/24 10	80	A&E waiting times : patients seen within 4 hours	Add metric	13/04/2023	Deputy Chief Executive
23/24 11	90	85% Paediatric Bed Occupancy	Metric added	13/04/2023	Deputy Chief Executive
23/24 12	91	85% Critical Care bed occupancy for Adults and Children	Metric added	13/04/2023	Deputy Chief Executive
23/24 13	88	Patients waiting over 65+ weeks (except patient choice or clinically complex)	Add metric	13/04/2023	Deputy Chief Executive
23/24 14	89	Patients waiting over 52+ weeks by 50% by Mar 24	Add metric	13/04/2023	Deputy Chief Executive
23/24 15	81	Virtual ward patients - add placeholder whilst metric under development	Add metric	13/04/2023	Deputy Chief Executive
23/24 16	86	Number of diagnostics received completed within 6 weekd	Add metric	13/04/2023	Deputy Chief Executive
23/24 17	87	Diagnostic activity compared to 19/20 levels	Add metric	13/04/2023	Deputy Chief Executive
23/24 18	85	Meet the cancer faster diagnosis standard	Add metric	13/04/2023	Deputy Chief Executive
23/24 19	83	Reduction in outpatient follow - ups	Add metric	13/04/2023	Deputy Chief Executive
23/24 20	84	Day case rate	Add metric	13/04/2023	Deputy Chief Executive
23/24 21	82	2 hour urgent community response	Metric added	13/04/2023	Deputy Chief Executive
23/24 22	3	Sespis - 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

Agenda item: [18]

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Monthly Trust Financial Report – Month 3 (June 2023)
Presented to:	Board of Directors
On:	2nd August 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 £1.6m YTD, which is £2.1m adverse to plan. The final plan for 2023/24 included an income assumption of £11.9m from Wigan Council, based on £7.0m to support escalation and £4.9m for unfunded bed capacity, with a plan of £4.7m year to date. On the 19th June 2023, Wigan Council notified the Trust that they are now unable to provide funding in 2023/24 due to their own financial position. This has been reflected within the month 3 position with an assumption of reduced income of £1.0m year to date based on live discussions about redirection of other funding. The Trust is working on bridging the gap within the WWL financial plan with various options being considered within the locality and with GM ICB, who have been fully briefed on the situation. The loss of the Council income has been mitigated in month by non-recurrent benefits of £2.8m following a review of the balance sheet. At present, the Trust is forecasting to deliver the full year planned deficit of £6.5m. There are multiple 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. As advised by NHSE, the year to date position does not include any reduction in income associated with an underperformance on the activity plan for the Aligned Payment and Incentive (API) payment mechanism.

Activity	Achieve the elective activity plan for 2023/24.	Red	The month 3 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 and June, with further action planned for July by both junior doctors and consultants.
Cash & liquidity	Effective cash management ensuring financial obligations can be met as they become due.	Amber	Cash is £35.2m at the end of month 3 which is £3.3m above plan. This has increased by £2.9m from the previous month. The increase is due to timing of payments from customers and payments to suppliers. The receipt of the pay award funding has contributed to the improvement as the Pay as You Earn (PAYE) deductions are paid to HM Revenue & Customs (HMRC) one month in arrears. This will be an additional £6.2m to be paid in July. Taking this into account, the cash balance would be £2.9m below plan.
Capital expenditure (CDEL)	Achieve CDEL for 2023/24.	Green	Capital expenditure against internal CDEL was £0.9m in month 3 against a plan of £2.0m, which is £1.1m below plan. Year to date, capital expenditure is £2.6m below the internal CDEL plan. This is primarily due to the 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, £2.4m has been delivered against a plan of £2.1m, which is a favourable variance of £0.3m. Year to date, CIP delivery is £1.0m below plan. At the end of month 3, there is an unidentified gap of £5.5m (23%) in year and £5.2m (26%) recurrently, which whilst challenging is an improved position on previous years. The unidentified gap relates predominantly to the centralised CIP and council income.

Temporary expenditure	To remain within the agency ceiling set by NHSE and reduce bank expenditure.	Amber	The divisional agency expenditure is £0.9m in month 3, slight increase from last month. The Trust is operating within the agency ceiling with agency representing 3.0% of the total pay bill year to date (compared to the ceiling of 3.7%). Bank expenditure within the divisions was £2.6m in month 3, a reduction of £0.1m on last month.
Business conduct	Comply with the Better Payments Practices Code (BPPC) of paying 95% of invoices within 30 days.	Amber	BPPC for month 3 is 94.0% by volume and 92.7% by value. Performance by volume has reduced marginally from the previous month (94.3%) and improved by value (92.8%). An action plan is being developed 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. The loss of funding support by Wigan Council presents a material risk to delivery of the revenue plan, which included income of £11.9m. Plans are being developed urgently to mitigate and bridge this shortfall, with work required to progress at pace. There are a range of risks which are driving an underlying deficit and further industrial action is expected. Other risks include delivery of the activity plan, high volumes of no right to reside patients, sustained levels of high length of stay, 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 £1.6m adverse to plan at the end of month 3, which will need to be recovered before the end of the financial year. The national scrutiny on the GM ICS position will be sustained via monthly meetings with the NHSE Chief Finance Officer.

The retraction of funding support from Wigan locality creates a shortfall of £11.9m within the financial plan for 2023/24. The Trust is working on bridging the gap with various options developed for consideration. It is acknowledged that none of the options being considered to bridge the financial gap are palatable and full consideration will be given from an operational, quality and safety perspective alongside the financial impact.

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, and to identify further opportunities for CIP.

In addition, there is a risk that income is less than planned where activity does not meet the targets under the aligned payment and incentive (API) regime. As at month 3, NHSE have advised providers not to report any variance against ERF or API, with an indication further guidance will follow in month 4. The indication is that it will still be applied but with an allowance made for industrial action, and therefore the extent of the financial impact will need to be assessed once further information is known.

Scenario modelling is underway to assess the impact of all significant risks, and to create a most likely, best, and worst case forecast for the financial year end. This will be reported from month 4 onwards.

At present the Trust's cash balance is above plan and there is 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 will have 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 Board of Directors are asked to note the contents of this report.

Financial Performance

Key Messages

In month 3, The Trust has reported an actual deficit of £0.4m, which is an adverse variance of £0.6m to plan.

Year to date, the Trust has reported an actual deficit of £1.6m, which is £2.1m adverse to the planned surplus of £0.2m. The year to date position excludes any reduction in income for under performance on the activity plan, as advised by NHSE.

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

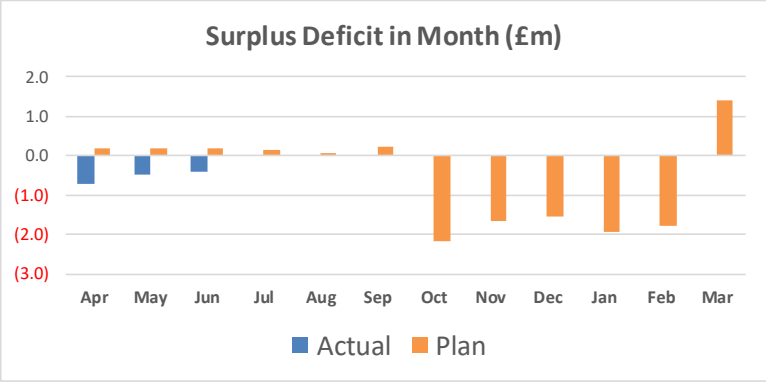
The Trust reported an actual deficit of £0.4m in month 3 (June 2023), which is an adverse variance of £0.6m to the plan. Year to date, the Trust is reporting an actual deficit of £1.6m which is £2.1m adverse to plan.

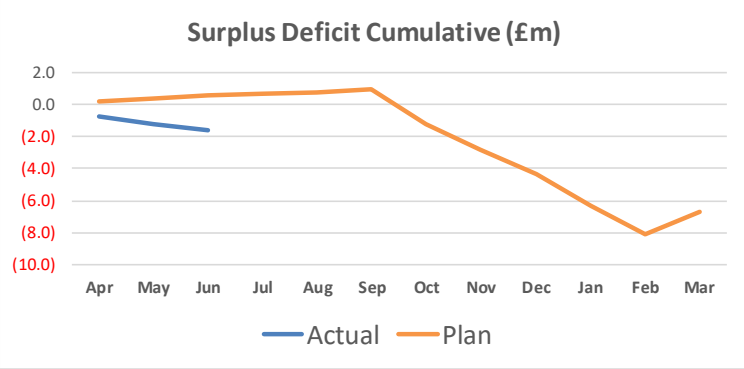
Since last month, Wigan Council have indicated that they are no longer in a position to provide financial support to the Trust. The final Trust plan for 2023/24 included £11.9m from Wigan Council, which included £7.0m to support escalation costs in the first half of the year and £4.9m to support unfunded bed capacity. Work is being undertaken urgently with the locality and GM ICB to bridge this gap. In month 3, income is £2.8m adverse to plan which includes the loss of Council income.

The draft year to date position collectively for all Greater Manchester providers at month 3 is a deficit of £87.0m, which is £36.5m adverse to the planned deficit of £50.5m.

As reported previously, the income position does not reflect the potential underperformance against the Aligned Payment and Incentive scheme (API) which is estimated at £1.7m year to date against the internal plan. NHSE have advised not to report any variance as at month 3.

Operating expenditure is £1.9m favourable to plan in month. This includes a non-recurrent benefit of £2.8m due to a review of prior year accruals.





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	39,726	42,470	(2,744)	125,901	126,890	(989)	503,343
Pay	(28,508)	(28,931)	423	(88,585)	(86,356)	(2,228)	(348,796)
Non Pay	(10,094)	(11,576)	1,483	(33,659)	(34,593)	934	(139,412)
Financing / Technical	(1,512)	(1,783)	271	(5,215)	(5,407)	192	(21,829)
Surplus / Deficit	(388)	179	(567)	(1,557)	534	(2,091)	(6,693)
Adjusted Financial Performance *	(376)	195	(571)	(1,566)	582	(2,148)	(6,500)
Memo Items							
CIP	2,407	2,152	256	5,123	6,095	(972)	24,404
Bank Expenditure	2,618	858	(1,760)	8,063	2,574	(5,490)	12,136
Agency Expenditure	862	1,055	193	2,626	855	(1,771)	3,629
Cash Balance	35,234	31,958	3,276	35,234	31,958	3,276	30,403
Capital Spend - CDEL	851	1,959	1,108	1,826	4,384	2,558	11,640
Capital Spend - PDC	597	821	224	1,120	2,464	1,344	13,150

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

Financial Performance

- Income is £2.7m adverse to plan in month and £1.0m adverse to plan year to date (see appendix 2).
- Operating expenditure is £1.9m favourble to plan in month (see appendix 4). Year to date, operating expenditure is £1.3m adverse to plan.
- Trust financing £0.3m favourable in month and is £0.2m favourable to plan year to date due to interest receivable.

Temporary Spend

- Bank spend £2.6m in month and £8.1m year to date.
- Agency Spend £0.9m in month and £2.6m year to date (see appendix 5). Currently below the agency ceiling at 2.9% of total pay bill (ceiling 3.7%).

CIP

- £2.4m transacted in month, which is £0.3m ahead of plan.
- £5.1m transacted year to date, £1.0m adverse year to date.
- Split in month: Divisional £1.3m; Centralised CIP £1.1m (see appendix 7).

Cash

- £32.2m cash balance.
- £3.3m better than plan, due to timing of pay award cash flows. (see appendix 9)

Capital

- Capital spend of £1.4m against a plan of £2.8m in month. (see appendix 10), due to CDC and Leigh Theatre 4 project.
- CDEL exependiture £0.8m which is £1.1m below plan.
- PDC expenditure £0.6m which is £0.2m below plan.

Divisional Performance

Medicine

- (£1.7m) Adverse to plan in month (a deterioration of £0.6m on last month)
- (£0.9m) Escalation (reduced by £0.1m on last month – see appendix 6)
- (£0.2m) Unachieved CIP
- (£0.3m) Temporary staffing spend in elective specialties – vacancy cover
- (£0.2m) Supernumerary staff and unfunded nurses placed in month 3

Surgery

- (£0.3m) Adverse to plan in month
- (£0.1m) Industrial action
- (£0.1m) Supernumerary staff and unfunded nurses
- (£0.1m) Drugs and medical & surgical equipment
- (£0.1m) Medical rota gap cover
- £0.1m CIP over performance

Specialist Services

- £0.2m Favourable to plan in month
- (£0.2m) Unachieved CIP
- £0.1m Theatre non pay & prosthesis
- £0.2m Private patient income
- £0.1m Vacancies

Community

- On plan in month
- £0.2m virtual hub
- (£0.2m) Temporary staffing spend – vacancy cover

Estates & Facilities

- On plan in month
- (£0.1m) Unachieved CIP
- (£0.2m) Lease costs
- £0.3m Sustainability

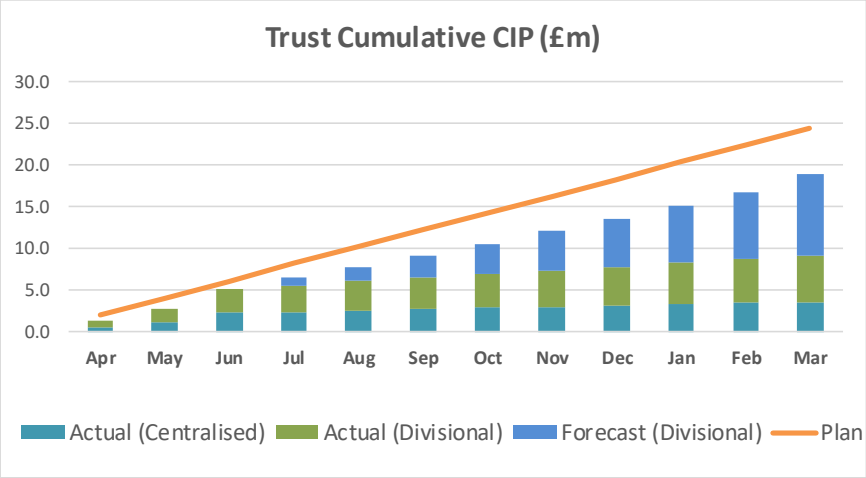
Corporate Divisions

- (£0.1m) Adverse to plan in month
- (£0.1m) Microsoft Office licences
- (£0.2m) Other small variances
- £0.2m IM&T CIP

Following a review of the flash metrics by the Executive Team, all divisions with the exception of Surgery will be escalated to RAPID for month 3.

As instructed by NHSE the Trust has not reported the adverse position relating to API in the month end position which would impact divisional performance if applied.

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 3, actual CIP of £2.4m has been transacted which is £0.2m ahead of the £2.2m plan. £1.3m has been transacted against the divisional CIP target (including the divisional stretch) and 1.1m against the centralised CIP target.

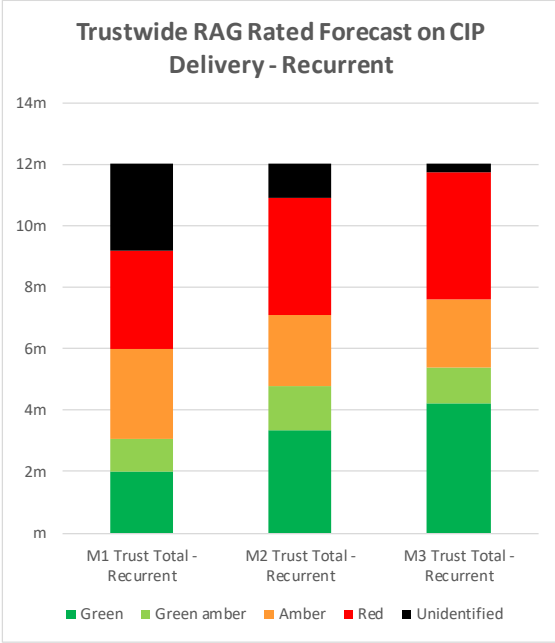
In month 3, the Divisional CIP transacted is split £0.1m for transactional schemes and £1.2m for transformational schemes.

The chart on the right shows the Trust wide RAG rated forecast for the divisional CIP of £12.0m. As at month 3, there is an unidentified gap of £1.4m (12%) in-year and £0.3m (2%) recurrently.

The CIP focused divisional "lock in" meetings held in May contributed to an improvement in the identified schemes of circa £2m. The detail is reported through the Transformation Board at divisional level for additional scrutiny.

As at month 3, £4.6m has been transacted recurrently in year for divisional CIP, an increase of £1.1m from last month. £1.0m relates to private patient income, £1.1m are non-pay savings, the remainder is a 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



Forward Look

The GM ICB have issued a standardised financial control checklist to all GM providers, to provide assurance around grip and control. This was issued to coincide with the system meeting with the NHSE Chief Finance Officer, Julian Kelly. The checklist is being reviewed by both the Finance and Workforce senior teams, and recommendations will be put forward about any additional measures required.

The BMA have announced further industrial action for junior doctors on 13th to 18th July, increasing the length of the action to 5 days compared to previous strikes. This action is anticipated to impact some elective activity and contribute further unplanned costs as consultants and other staff groups step in to support essential patient services. This will be shortly followed by industrial action by consultants on 20th – 22nd July. This is likely to have a further impact on planned elective care as activity is postponed.

Following a national panel review meeting on 11th July 2023, the Trust has received approval from NHSE for the Trust's bid for an additional theatre at Wrightington. Theatre 11 will be a modular build ultra-clean theatre with focus on lower limb high volume low complexity (HVLC) activity to support Wrightington's position as a GM elective hub. The bid secures £6.1m of capital PDC funding from the Targeted Investment Fund (TIF) split over the 2023/24 and 2024/25 financial years.

The finance team are developing high level scenario analysis to support financial planning to deliver the revenue plan for 2023/24. This calculates a forecast range, from best case, most likely and worst case, and considers the key sensitivities within the forecast as well as emerging risks and mitigations. This will be included within the finance report from month 4.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Maternity Dashboard Report
Presented to:	Trust Board
On:	2 July 2023
Presented by:	Rabina Tindale
Prepared by:	Gemma Weinberg for Cathy Stanford
Contact details:	gemma.weinberg@wwl.nhs.uk

Executive summary

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

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

The key performance targets are measured using a RAG system which reflects national, regional, and local performance indicators. 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 dashboard is reviewed at Directorate, Divisional and Corporate Clinical Governance Meetings.

Recommendation(s)

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

Maternity Dashboard June 2023

Introduction

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

June 2023 Exception report
Summary

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

- There were two midwifery red flags reported. There was one occasion where the unit was placed on divert and there was one occasion where there was a delay in care. The shift coordinator was able to remain supernumerary for all shifts in June and 1-2-1 care in labour was 100%.
- There were two Maternity complaints received in June and the service continues to receive positive feedback letters and messages from Women regarding the excellent care they have received.

Steis reportable Incidents

There was one 24+ weeks stillbirth recorded in June.

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 readmitted within 28 days of Delivery. There were 0 maternal readmissions recorded in June.

Women booked by 12+6 weeks This has remained consistently green for 10 months.

Re-admissions of babies within 30 days These figures have remained green in June. Most cases were due to jaundice or poor feeding. All cases were managed appropriately and there were no omissions in care.

Smoking at the time of Delivery (SATOD). This has seen a decrease from the May figures and remains green and at normal levels. The metric has remained green since June 2022. Work continues to promote and encourage smoking cessation throughout pregnancy.

3rd / 4th degree tear. This sees a slight rise from May figures. It should be noted that this metric was being calculated incorrectly and the dashboard has been altered for this year to reflect this.

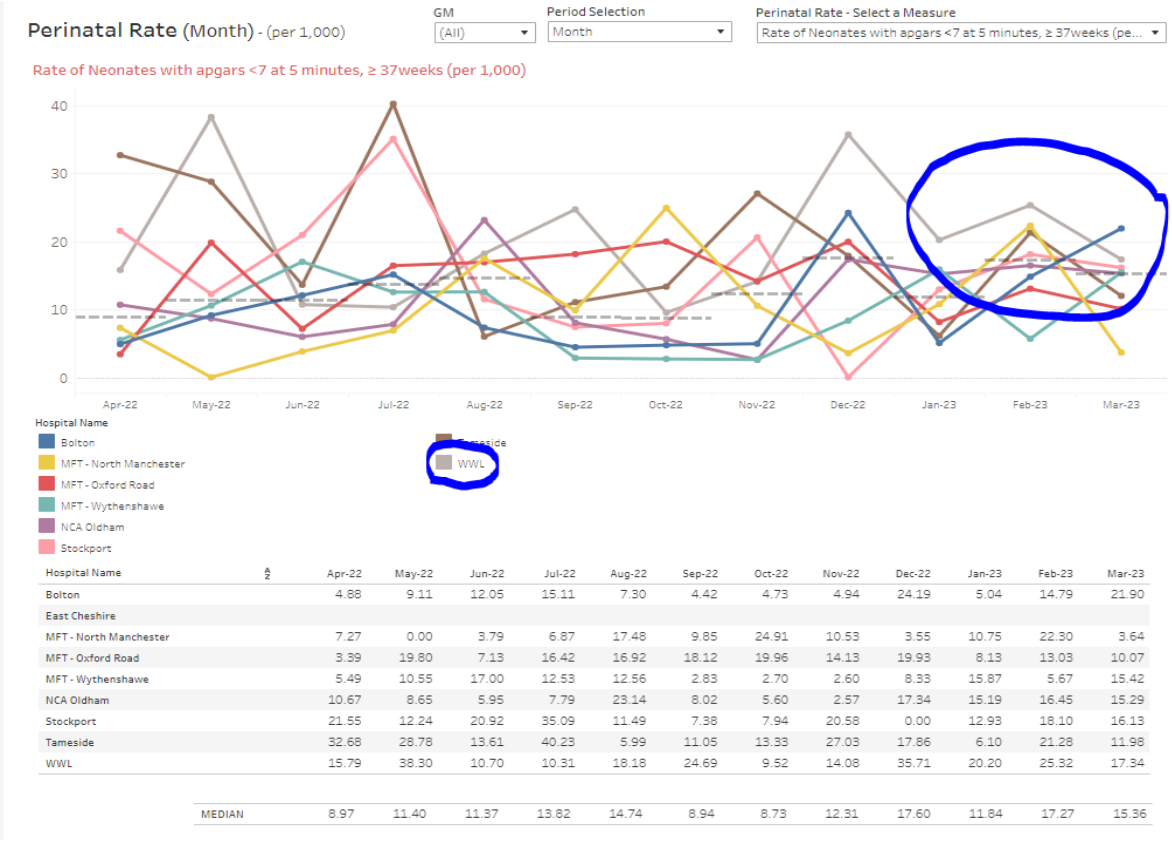
The number of mothers who have opted to breastfeed – After a drop in levels in May this has seen an increase in June.

Number of registerable births. After a drop in levels in February and March this metric has returned to green and normal levels for three consecutive months.

Induction of Labour (IOL) There have been significant spikes in IOL figures in February, March and May. April and June have seen a return to normal levels. 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.

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

All infants with Apgar's less than 7. This has remained green for 4 months after a spike in December, January and February. There were no recorded cases of infants with an Apgar less than 7 at 5 minutes of age in June. A decreasing pattern can be seen on Tableau.



Hospital Name	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Bolton	4.88	9.11	12.05	15.11	7.30	4.42	4.73	4.94	24.19	5.04	14.79	21.90
East Cheshire												
MFT - North Manchester	7.27	0.00	3.79	6.87	17.48	9.85	24.91	10.53	3.55	10.75	22.30	3.64
MFT - Oxford Road	3.39	19.80	7.13	16.42	16.92	18.12	19.96	14.13	19.93	8.13	13.03	10.07
MFT - Wythenshawe	5.49	10.55	17.00	12.53	12.56	2.83	2.70	2.60	8.33	15.87	5.67	15.42
NCA Oldham	10.67	8.65	5.95	7.79	23.14	8.02	5.60	2.57	17.34	15.19	16.45	15.29
Stockport	21.55	12.24	20.92	35.09	11.49	7.38	7.94	20.58	0.00	12.93	18.10	16.13
Tameside	32.68	28.78	13.61	40.23	5.99	11.05	13.33	27.03	17.86	6.10	21.28	11.98
WWL	15.79	38.30	10.70	10.31	18.18	24.69	9.52	14.08	35.71	20.20	25.32	17.34
MEDIAN	8.97	11.40	11.37	13.82	14.74	8.94	8.73	12.31	17.60	11.84	17.27	15.36

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

Skills drills / mandatory training. The training was cancelled in May due to room availability. June sees a return to normal levels.

Amber

Bookings. These have seen a very slight dip which takes the figure into amber levels in June.

PN length of stay. After a drop to green levels in April, this metric has shown a rise into amber levels in May and June.

Skin to skin contact – After a significant drop in April, this figure rose in May. June sees a very slight drop for this metric which takes it into amber levels. Work continues to improve this metric.

Red

Term admissions to NNU. This figure remains red and has been relatively static for the past three months. All cases continue to be reviewed within the ATAIN 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 ATAIN audit to try to improve the figures in this metric.

Conclusion

Normal variation and fluctuations are noted with the figures this month and many positive factors have been sustained. No issues are raised with care given or in the management of cases. The figures show largely green and amber indicators with just one red area. This red area will be closely observed and investigated. Persistently amber areas will 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 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.

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**						
	Number of Bookings (*one month retrospective*)	**≥ 240**	**≤ 200**	**2022 Bookings**	**254**	**258**	**215**	**260**	**247**	**249**	**201**	**241**	**237**						
	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%						
	% 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%						
	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%						
	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%						
	% Emergency Caesaean Sections				28.63%	25.44%	30.52%	24.44%	25.44%	28.35%	22.43%	26.51%	21.13%						
	% Elective Caesarean Sections				18.80%	14.47%	15.49%	14.67%	16.57%	13.92%	18.22%	18.60%	15.02%						
	% 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%						
	% 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%						
	Number of Successful VBAC Deliveries			Births/month	6	5	4	3	1	7	3	3	6						
	% 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%						
	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%**						
	% 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%						
	% of Women Induced for Suspected SGA				4.27%	4.39%	7.51%	2.67%	5.92%	9.79%	5.61%	4.19%	5.63%						
	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**						
	Number of In-Utero Transfers In from Other Units				1	1	1	2	0	0	4	5	5						
	Number of In-Utero Transfers Out to Other Units				0	0	0	1	0	0	1	3	4						
	%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%						

	% 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%**					
	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%**					
	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%**					
	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%**					
Workforce	**Prospective Consultant Hours on Delivery Suite**	**60 hours**	**< 60 hours**	**Nat Standard**	**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**					
	1:1 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%**					
	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%**					
	Diverts: Number of Occasions Unit Unable to Accept Admissions				1	1	0	0	0	0	0	0	1					
	Diverts: Number of Women During Period Affected by Unit Closure				0	0	0	0	0	0	0	0	2					
	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%**					
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%**					
	% 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%					
	Episiotomies with Episcissors				81.25%	87.50%	85.00%	83.33%	94.44%	84.00%	90.91%	86.36%	84.00%					
	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%					
	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%					
	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%					
	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					
	Number of Women Requiring Level 3 Critical Care			Births/month	0	0	0	0	0	0	0	0	0					
	Maternal Deaths			Nat rate per 1000	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**					
	Number of Women Readmitted Within 28 Days of Delivery with Infection / Query Sepsis				0	2	0	0	1	2	2	1	0					
	Stillbirths**			Nat rate 3.5 per 1000 births	0	1	1	2	0	2	2	0	1					
	Early Neonatal Deaths (*before 7 days*)			Nat rate per 1000 births	3	0	0	1	1	0	1	0	0					

Neonatal Morbidity & Mortality	Number of Babies Born Under 37 Weeks				20	13	17	23	12	18	10	18	21					
	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**					
	HIE 2 & 3 > 37 Weeks (*reported retrospectively*)			GM avg. 1.95 per 1000	1	0	2	1	0	2	0	0	0					
	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%					
	Singleton Babies Born < 30 Weeks Gestation			Births/month	1	0	0	1	1	2	1	0	2					
	% 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%					
	Singleton Babies Born < 34 Weeks Gestation			Births/month	7	2	5	2	2	4	4	4	3					
	% 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%					
	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**					
	% of Babies Who Had Defered Cord Clamping				84%	84%	81%	82%	82%	82%	85%	84%	92%					
	% of Babies Born < 37 Weeks Whose Mother Recieved IV Antibiotics				35%	31%	12%	22%	0%	44%	50%	50%	14%					
	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%**					
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**					
	Number of Incidents Reported				66	51	59	78	50	84	74	94	86					
	Number of Concise Investigations				2	1	0	0	0	0	0	0	0					
	Number of StEIS Reported Incidents				2	0	0	2	0	1	0	0	1					
	Number of Midwifery Red Flags Reported				5	1	5	5	1	4	1	0	2					
	Number of Complaints				0	1	0	1	1	2	2	4	2					
	Number of Letters of Claim Received				0	0	1	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							582	631	0	0	1213
Number of Registerable Births	225	169	194	214	215	213							588	642	0	0	1230
Number of Bookings(retrospective 1 month)	260	247	249	201	241	237							756	679	0	0	1435
Normal Births as % of births	118	86	96	98	98	108							300	304	0	0	604
% of Successful Planned Home Births	4	5	0	3	2	6							9	11	0	0	20
Instrumental Deliveries as % of births	19	12	14	26	19	27							45	72	0	0	117
Total Caesarean Sections as % of births	88	71	82	87	97	77							241	261	0	0	502
% Emergency Caesaean Sections	55	43	55	48	57	45							153	150	0	0	303
% Elective Caesarean Sections	33	28	27	39	40	32							88	111	0	0	199
% 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%							60.57%	65.40%			125.97%
% 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%							58.98%	43.80%			102.78%
Number of successful VBAC deliveries	3	1	7	3	3	6							11	12	0	0	23
%of Caesarean Sections at Full Dilatation	4	5	8	5	12	3							17	20	0	0	37
Induction of Labour as % of women delivered	70	72	93	77	97	79							235	253	0	0	488
% of women induced when RFM is the only indication <39 weeks	4	1	1	1	1	0							6	2	0	0	8
% of women induced for Suspected SGA	6	10	19	12	9	12							35	33	0	0	68
Average Postnatal Length of Stay	1.8	1.8	1.9	1.5	1.8	1.8							10.6	5.1	0	0	10.6
Number of In-utero transfers in from other units	2	0	0	4	5	5							2	14	0	0	16
Number of In-utero transfers out to other units	1	0	0	1	3	4							1	8	0	0	9
%of Women Smoking at Booking	11.15%	11.74%	10.44%	9.45%	11.60%	8.86%							33%	0.2991	0	0	0.6324
% of Women Smoking at Delivery	7.72%	11.24%	13.47%	11.68%	11%	9.38%							0.3243	0.3196	0	0	0.6439
Babies in Skin-to-Skin within 1 hour of birth	165	132	163	111	177	168							460	456	0	0	916
Percentage of Women Initiating Breastfeeding	126	103	105	158	110	127							334	395	0	0	729
Percentage of Women booked by 12+6 weeks	245	235	240	193	227	229							720	649	0	0	1369
Prospective Consultant hours on Delivery Suite	60	60	60	60	60	60							180	180	0	0	360
Midwife: Birth Ratio	01:28	01:28	01:28	01:28	01:28	1.28							0.183333333	1.4022	0	0	1.58556
1:1 Care in Labour	98.93%	99%	100%	100%	100%	100%							3.9793	3	0	0	5.9793
Percentage of shifts where shift Co-ordinator able to remain supernumerary	100%	100%	98.20%	100%	100	100							2.982	201	0	0	203.982
Diverts: Number of occasions unit unable to accept admissions	0	0	0	0	0	1							0	1	0	0	1
Diverts: Number of women during period affected by unit closure	0	0	0	0	0	0							0	0	0	0	0
Number of Midwives in Post	133	132	131	128	124	123							396	375	0	0	771
Attendance at Skills Drills/Mandatory Training	14	0	20	15	0	17							34	32	0	0	66
3rd/4th Degree Tear as % of births	2	2	5	4	1	2							9	7	0	0	16
Episiotomies in Normal Birth	6	6	9	8	6	3							21	17	0	0	38
PPH >2.5L as % of births	1	0	1	2	0	2							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							5	5	0	0	10
Number of Women Requiring Level 3 Critical Care	0		0	0	0	0							0	0	0	0	0
Maternal Deaths	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	4	0	0	8
Number of Women Redmitted Within 28 Days of Delivery with Infection / Query Sepsis	0	0	2	2	1	0							5	3			
Stillbirths **	2	0	2	2	0	1							4	3	0	0	7
Early Neonatal Deaths (before 7 days)	1	1	0	1	0	0							2	1	0	0	3
Number of Babies Born Under 37 Weeks	23	12	18	10	18	21							102				
Number of Neonates with Apgars <7 at 5 minutes (>37 weeks gestation)	4	4	3	3	3	0							11	6	0	0	17
HIE 2 &3 > 37 weeks (reported retrospectively)	1	0	2	0	0								3	0	0	0	3
Shoulder Dystocia	4	1	1	4	3	1							6	8	0	0	14
Singleton Babies born <30 weeks gestation	1	1	2	1	0	2							4	3	0	0	7
% whose mother received magnesium sulphate	0	0	1	100%	N/A	1							2	2	0	0	3
Singleton Babies born <34 weeks gestation	2	2	4	4	4	3							8	11	0	0	19
% whose mother received full course steriods (1 week prior to delivery)	1	1	4	1	4	2							6	7	0	0	13
Births >37 weeks gestation	198	158	173	189	195	192							529	576	0	0	1105
Unexpected Term Admissions to NNU as % of births > 37 weeks gestation.	16	16	15	11	11	11							47	33	0	0	80
Number of babies re-admitted with 28 days of birth	17	8	16	9	11	9							41	29	0	0	70
Number of indicents reported	78	50	84	74	94								212	168	0	0	380
Number of Concise Investigations	0	0	0	0	0								0	0	0	0	0
Number of StEIS Reported Incidents	2	0	1	0	0								3	0	0	0	3
Number of Midwifery Red Flags Reported	4	1	4	1	0								9	1	0	0	10
Number of Complaints	1	1	2	2	4								4	6	0	0	10
Number of Letters of Claim Received		0		0	0								0	0	0	0	0
													0	0	0	0	0
Live Births	222	169	192	211	215	212							1221	638	0	0	1221
REGIONAL METRICS																	
Number of Live Births born ≥16 weeks to <24 weeks	1	1	0	0	0	1							3				6
Number of Live Births born ≥24 weeks to <37 weeks	23	12	18	10	18	20							101				139
Number of Live Births born ≥24 weeks to <34 weeks	6	2	4	3	6	8											
Number of Live Births ≥38 weeks	180	136	152	169	173	167											
Number of Live Births ≥39 weeks	145	112	110	131	135	134											
Number of Episiotomies performed	24	18	25	33	22	25											
Number of babies born <3rd centile	13	9	13	8	7	9											
Number of Major Haemorrhages > 2500mls	1	0	1	2	0	2											
Intrapartum Stillbirths	0	0	0	0	0	0											
Number of Early Neonatal Deaths 20+0 to 23+6 weeks	0	1	0	1	0	0											
Number of Early Neonatal Deaths > 24 weeks	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											
Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received steroids	3	1	4	1	6	7											
Number of babies less than 3rd centile delivered >38 weeks	6	2	8	1	4	1											
Number of women smoking at the time of booking	29	29	26	19	28	21											
Number of women smoking at delivery	17	19	26	25	23	20											
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											
Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were asymptomatic	0	0	0	0	0	0											
Number of babies born at Home Midwife NOT present	0	0	0	0	0	0											
Number of babies born in Other location Midwife NOT present	2	2	2	3	1	2											
Episiotomies with Episcissors	20	17	21	30	19	21											
Mothers who did not receive full course and omissions in care notec	0	0	N/A	0	0	0							0	0	0	0	0
PPH 500-1499mls as % of births	79	60	73	82	87	74							455	0	0	0	455
PPH 1500-2499mls as % of births	8	1	6	7	8	6							36	243	0	0	36
% of babies who had differed cord clamping - ENTER NUMBER OF BABIES	.		159	181	180	196											
% of babies born <37 weeks who's mother recieved IV Antibiotics ENTER NUMBER OF BABIES	.		8	5	9	3											

			2022 Data					2023 Data												
		Indicator	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
DENOMINATOR Metrics	1	Number of Bookers	220	232	254	258	215	260	247	249	201	241	237							1435
	2	Number of Registrable Births	238	191	234	228	213	225	169	194	214	215	213							1230
	3	Number of Women Delivered	234	190	233	227	212	220	169	193	212	211	208							1213
	4	Number of Successful Planned Home Births	4	4	1	3	2	4	5		3	2	6							20
	5	Number of Midwifery Led Unit births	234	190	233	227	212	220	169	193	212	211	208							1213
	6	Number of Live Births at any gestation	238	191	234	228	213	225	169	194	214	215	213							1230
	7	Number of Live Births born ≥16 weeks to <24 weeks	0	0	0	0	0	1	1	0	0	0	1	0	0	0	0	0	0	3
	8	Number of Live Births born ≥24 weeks to <37 weeks	16	24	20	13	17	23	12	18	10	18	20							101
	9	Number of Live Births born ≥24 weeks to <34 weeks	9	4	2	2	5	6	2	4	3	6	8							29
	10	Number of Live Births ≥37 weeks	220	162	210	213	196	198	158	173	189	195	192							1105
	11	Number of Live Births ≥38 weeks	202	143	193	192	170	180	136	152	169	173	167							977
	12	Number of Live Births ≥39 weeks	160	112	146	158	138	145	112	110	131	135	134							767
	13	Number of Episiotomies performed	34	22	32	24	20	24	18	25	33	22	25							147
	14	Episiotomies with Episcissors	28	21	26	21	17	20	17	21	30	19	21							128
	15	Number of babies born <3rd centile	11	14	16	14	14	13	9	13	8	7	9							59
MATERNAL Morbidity and Mortality Metrics	16	Number of Maternal Deaths	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							10
	19	Number of Women Requiring Level 3 Critical Care	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							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							8
	22	Number of 3rd and 4th degree tears	7	4	4	3	5	2	2	5	4	1	2							16
	23	Number of Episiotomies in normal birth	4	7	4	7	5	6	6	9	8	6	3							38
	24	Number of Emergency LSCS	42	43	67	58	65	55	43	55	48	57	45							303
	25	Number of Elective LSCS	38	30	44	33	33	33	28	27	39	40	32							199
	26	Number of LSCS at Full Dilatation	1	3	4	7	6	4	5	8	5	12	3							37
	27	Number of Operative Vaginal Deliveries	34	16	29	17	15	19	12	14	26	19	27							117
	28	Number of Normal Vaginal Deliveries	123	106	93	119	99	118	86	96	98	98	108							604
	29	Number of Inductions (excluding augmentations)	98	73	88	93	87	70	72	93	77	97	79							488
	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							8
PERINATAL Morbidity and Mortality Metrics	31	Number of Stillbirths	1	1	0	1	1	2	0	2	2	0	1							7
	32	Number of Intrapartum Stillbirths	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							2
	34	Number of Early Neonatal Deaths > 24 weeks	1	0	1	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							3
	36	Number of Neonates with Apgars <7 at 5 Minutes, ≥ 37 Weeks	4	4	2	3	7	4	4	3	3	3	zero							17
	37	Number of admissions to Neonatal Unit ≥ 37 Weeks	4	15	8	18	16	16	16	15	11	11	11							80
	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							17
	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							22
	40	Number of babies less than 3rd centile delivered >38 weeks	5	5	8	9	4	6	2	8	1	4	1							22
PROCESS	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							10.6
	42	Number of In-utero Transfers In	2	2	1	1	1	2	0	0	4	5	5							16
	43	Number of In-utero Transfers Out	0	0	0	0	0	1	0	0	1	3	4							9
	44	Diverts: Number of occasions the unit has been unable to accept admissions	0	1	1	1	0	0	0	0	0	0	1							1
	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
	46	Number of women booked by 12 + 6 weeks	199	206	236	242	206	245	235	240	193	227	229							1369
	47	Number of women smoking at the time of booking	39	27	31	37	25	29	29	26	19	28	21							152
	48	Number of women smoking at delivery	30	17	22	27	23	17	19	26	25	23	20							130
	49	Number of women initiating breast feeding including attempted and expressed	136	118	125	107	121	126	103	105	158	110	127							729
	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							916

	51	Number of successful VBAC deliveries	5	3	6	5	4	3	1	7	3	3	6									23
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									707
	55	Midwife to Birth Ratio	28	28	28	28	28	28	28	28	28	28	1.28									141.3
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		zero									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		zero									0
Safety	58	Number of babies born at Home Midwife NOT present	2	1	0	0	1	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									12

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**						
	% 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**						
	Unit Closed Due to Capacity	**0**	**≥ 1**	**Datix**	**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**							
Admissions	Number of Births from Maternity			Maternity Data	234	228	213	224	170	194	214	215	213						
	Admissions Under 27 Weeks to NNU	**< 1**	**≥ 1**	**Badger**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**1**	**2**						
	Admissions 27+1 – 34 Weeks to NNU			Badger	16	28	31	35	22	34	30	32	7						
	Total Admissions to Neonatal Unit			Badger	16	28	31	36	22	34	30	33	41						
	Transitional Care Admissions: 34 – 36+6			Badger	2	3	1	4	3	2	1	5	7						
	Transitional Care Admissions: 37+			Badger	6	6	3	4	6	4	6	12	15						
	Total TC Admissions			Badger	8	9	4	8	9	6	7	17	22						
	Number of unexpected Term Admissions to NNU				6	17	18	18	16	15	11	11	11						
	Unexpected Term Admissions to NNU (*as % of Births > 37 Weeks Gestation*)	**6%**	**≥ 6%**	**Maternity/Badger**	**2.56%**	**7.46%**	**8.45%**	**8.04%**	**9.41%**	**8.67%**	**5.82%**	**5.64%**	**5.72%**						
	Unexpected Term Admissions to NNU (*as % of Total Admissions*)			Badger/ NWNODN							36.66%	33.33%	26.80%						
	Mothers Eligible for AN Steroids (*< 34 Weeks*)			NNAP/ NWNODN	2	2	5	4	2	4	4	6	5						
	% of Mothers Who Received Full Course of Antental Steroids	**≥ 93%**	**< 89%**	**NNAP/ NWNODN**	**100%**	**50%**	**100%**	**50%**	**50%**	**75%**	**25%**	**100%**	**60%**						
	Mothers Eligible for AN $MgSO_4$ (*< 30 Weeks*)			NNAP/ NWNODN	1	0	0	1	1	1	1	0	2						
	% of Mothers Receiving Antenatal $MgSO_4$	**≥ 85%**	**< 73%**	**NNAP/ NWNODN**	**100%**	**NA**	**NA**	**0**	**0**	**100%**	**100%**	**NA**	**50%**						
	Babies Eligible for Delayed Cord Clamping			NNAP/ NWNODN	2	2	6	6	2	3	4	6	8						

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%**						
	Babies Eligible for Temperature on Admission (*< 32 Weeks*)			NNAP/ NWNODN	2	1	1	1	2	2	1	6	8						
	% of Babies With Temperature Within First Hour of Admission (*< 32 Weeks*)			NNAP/ NWNODN	100%	100%	100%	0	50%	100%	100%	6	8						
	% 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						
	Babies Eligible for Senior Review			NNAP/ NWNODN	11	23	27	28	21	27	15	18	22						
	Number of Babies Receiving Senior Review Within 24 Hours			NNAP/ NWNODN	7	19	26	28	21	26	14	18	20						
	% of Babies Receiving Senior Review Within 24 Hours			NNAP/ NWNODN	63.64%	82.61%	96.30%	100%	100%	96.29%	93.30%	100%	91%						
	Total Ward Rounds Where Parents Present			NNAP/ NWNODN	20	27	28	31	22	21	22	23	27						
	% of Ward Rounds Where Parents Present			NNAP/ NWNODN	100%	92.59%	100%	100%	95.45%	100%	95.70%	100%	96.30%						
	% of Eligible Babies Reciving Retinopathy Screening (*ROP*)			NNAP/ NWNODN	100%	N/A	33%	100%	N/A	N/A	33%	50%	50%						
	% of Babies With Central Line Blood Infections			NNAP/ NWNODN	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						
	% of Babies Receiving Follow-Up At 2 Years			NNAP/ NWNODN	N/A	75%	N/A	50%	50%	100%	N/A	100%	50%						
Incidents	Number of Incidents Reported			Datix	11	12	15	17	16		23	9	23						
	Number of Network Exception Reports			NWNODN	1	0	2	2	2		1	0							
	Number of Concise Investigations	**0**	**≥ 1**	**Datix**	**0**	**0**	**0**	**0**	**0**		**0**	**0**	**0**						
	Number of StEIS Reported Incidents	**0**	**≥ 1**	**Datix**	**0**	**0**	**0**	**0**	**0**		**0**	**0**	**0**						
	Number of Complaints	**< 2**	**≥ 2**	**Datix**	**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**						
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%						
	% 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%						
	% 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						
	% 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						
	% 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						

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					
	% 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%					
	Number of Babies < 34 Weeks Eligible for Breast Milk at Day 14			NNAP/ NWNODN	5	1	6	6	3	1	4	3	7					
	% 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%					
	Number of Babies < 34 Weeks Eligible for Breast Milk at Discharge			NNAP/ NWNODN	5	4	5	7	1	1	6	4	9					
	% of Babies < 34 Weeks Receiving Breast Milk at Discharge			NNAP/ NWNODN	80%	50%	60%	85.71%	0	100%	33.30%	50%	66.70%					
Activity	Care Days ICU (*HRG1*)			Badger	15	5	9	11	5	40	16	7	44					
	Care Days HDU (*HRG2*)			Badger	52	42	41	29	19	77	61	115	39					
	Care Days SC (*HRG3, HRG4, HRG5, and code9*)			Badger	173	173	251	198	101	173	237	172	270					
	Cot Capacity ICU %			Badger	48.39%	16.67%	29.03%	35.48%	17.86%	129%	53.30%	22.58%	146%					
	Cot Capacity HDU %			Badger	55.91%	46.67%	44.09%	31.18%	22.62%	82.70%	67.77%	123.60%	43.33%					
	Cot Capacity SC %			Badger	55.81%	57.67%	80.97%	63.87%	36.07%	55.80%	79%	55.48%	90%					
	Overall Cot Capacity %			Badger	55.30%	52.38%	69.35%	54.84%	31.89%	69.04%	74.70%	68%	84%					
	Care Days TC (*HRG3*)			Badger	0	0	0	0	0	0	0	0	0					
	Care Days TC (*HRG4*)			Badger	51	56	23	35	53	21	17	40	64					
	Care Days TC (*HRG5*)			Badger	8	1	0	3	2	0	0	0	0					
	Care Days TC (*code 9*)			Badger	4	10	5	2	2	0	0	0	0					
	Total TC Care Days			Badger	63	67	28	40	57	21	17	40	64					
	Overall TC Cot Capacity %			Badger	50.81%	55.83%	22.58%	32.26%	50.89%	16.93%	14.16%	32.25%	18.30%					
Training	**NLS Accrediated**	**≥ 70%**	**< 70%**	**WWL**	**94.44%**	**91.43%**	**91.43%**	**97.22%**	**94.74%**	**91.00%**	**92.30%**	**90%**	**92.10%**					
	NLS In-House	**≥ 90%**	**< 90%**	**WWL**	**97.56%**	**97.56%**	**97.56%**	**97.56%**	**97.56%**	**100.00%**	**100%**	**100%**	**100%**					
	Qualified In Speciality of Intensive Neonates	**≥ 70%**	**< 70%**	**WWL**	**84.21%**	**81.08%**	**81.08%**	**84.21%**	**85.00%**	**85.00%**	**85%**	**85%**	**85%**					
	Foundation In Neonates	**≥ 70%**	**< 70%**	**WWL**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**98.00%**	**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%**					
	Unicef BFI	**100%**	**< 80%**	**WWL**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**98.00%**	**99%**	**99%**	**100%**					

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

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Perinatal Quality Surveillance Full Report (Q1 2023-2024, Apr- June 23)
Presented to:	Trust Board
On:	2 August 2023
Presented by:	Rabina Tindale Chief Nurse
Prepared by:	Eve Broadhurst Head of Governance Maternity and Child Health
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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

Q1 has seen a decrease in StEIS reported incidents as compared to Q4 (2).

Q1 has seen a decrease in HSIB referrals as compared to Q4 (0).

In response to outlier status in GM for assessment of HIE 1 & 2 a data review has taken place.

Themes from completed investigations include the importance of ongoing risk assessment in the perinatal period, the importance of risk assessing that the baby is 'fit for labour' before induction, local guidance not being in line with NICE, patient controlled analgesia availability on ward, and antenatal CTG categorisation.

Feedback and complaints

The MVP have undertaken a piece of work on women's experience of pain relief in the intrapartum and postnatal period. The full results will be shared with ward managers. The MVP and service leads are working together to have a rolling program of patient surveys to inform and action plan and quality improvement.

6 complaints were received in Q1 with re-current sub-themes of communication and clinical treatment.

Several e-mail compliments from service users and positive feedback from the MVP have been received and shared with the staff involved.

Risks

The Risk Register has been included for maternity and neonatal services.

In Q1, 3 new risks have been added to the risk register and are currently under review.

- Maternity Ligature Risk – 10
- Maintenance of Maternity Equipment - 6
- Transfer of Babies to NNU for Antibiotics – 6

1 significant new risk - Euroking System Error - has been reviewed at Divisional Risk group and is awaiting approval at next RMEG due to a score of 20.

4 risks have been approved and added to the live risk register,

- Potential inability to undertake more than 1 emergency delivery at a time due to number of theatres available - 8
- Junior Doctors Strike – 6
- Medical Devices Training – 8
- Entonox Risk – 8

1 moderate risk in relation to the CritCool Cooling machine has been resolved and closed.

Risks continue to be pro-actively managed within the Division. Risks scoring 15 and over are monitored through RMEG. The risk register is tabled at the relevant monthly Clinical Cabinet for over-sight.

Ockenden 2

Q1 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. 8 amber actions remain with continuous progress. (Progress against Ockenden 1 is monitored via the LMNS).

Maternity Incentive scheme Year 5

The technical guidance for the Year 5 scheme was launched on 31st May 2023. The relevant time period is 30th May 2023 to the 7th December 2023.

A monthly Assurance Meeting has been set up within our Maternity Services for leads to provide feedback and allow over-sight of compliance against the 10 Safety Actions. All leads have been identified.

ATAIN

Q4 22-23 audit found unexpected term admission rate to the neonatal unit to be **8.5%.** There is work to be done, with 5 admissions thought to be avoidable on review. The target is <6% with the NWNODN setting the target at <4.5%. Weekly MDT ATAIN meetings led by governance are now in progress to enable timely review, support, and oversight. A working party has been set up to target actions. The initial focus will be to

embed the warm bundle as respiratory distress continues to be the principal reason for admissions. Care in the first hour of life and thermoregulation is vital.

Mortality and PMRT

Q1 - 3 stillbirths, 1 late fetal loss and 1 neonatal death recorded. Some immediate incidental learning has been identified and shared. PMRT where applicable underway. 3 stillbirths were noted to have a social deprivation score of 1 (the highest score) – from July 2023 these families will be offered enhanced midwifery care.

In Q1, 4 cases of antenatal stillbirth from 2022/23 were 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 (no issues identified).

Saving Babies Lives

MIS Year 5 gap analysis has been undertaken as several new additions. New parameters and additional topic of diabetes added to the care bundle. Processes have been set up for data collection. Good to go. Element 6 (diabetes) will require some service redesign around MDT bespoke clinics and management of the care of women with diabetes.

Mandatory training

All training is scheduled for the year. A full review of all Maternity and MDT requirements has been completed and a structured programme of attendance has been developed to ensure that all elements are included and that there is a clear trajectory in place to achieve all elements of the Core competencies in line with The Maternity Incentive Scheme and Saving Babies Lives V3.

For escalation - So far there are only 12 anaesthetists booked onto PROMPT with 6 still to book a place meaning compliance for 90% may not be achieved by the end of the year if staff do not book on for the training.

Workforce/ Safe staffing

There are currently 15.17 midwifery vacancies. The Recruitment Day in May 2023 was successful and 10.56. WTE student midwives were appointed who will complete their training in September 2023 from the GM and neighbouring universities, and 2.72 WTE will commence in January 2024.

WWL has expressed an interest in recruiting 3 International Midwives from Cohort 3 of the Northwest recruitment programmes and 1 Cos, (Certificate of Sponsorship) has been submitted. Additionally, 1 WTE Band 6 Midwife will commence in July 2023.

Sickness rates across the service are currently 4.5%.

GMEC data

This report looks at WWL/GMEC data, with a focus on outlier status and opportunities for learning. In Q4 2022-2023, WWL has performed better than the GM average in rates of major haemorrhages >2500mls and early neonatal deaths. WWL has performed worse than the GM average in smoking at the time of delivery, 3rd and 4th degree tears, term admissions to NNU, pre-term births, term babies Apgar score <7 at 5 minutes, HIE grades 2 and 3 at ≥ 37 weeks, stillbirth and emergency LSCS.

Analysis of outlier status is undertaken and recommendations made where appropriate. A recommendation from the report is to undertake a focussed piece of work around 3 & 4th degree tears although it is acknowledged that the numbers of tears has reduced over the year.

It is important to note that the HIE 2 and 3 at term data will be re-submitted as WWLs current method of reporting is not in line with rest of GM as the outcome of the diagnostic MRI is not considered, and the figure will be significantly reduced.

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 Full 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	1	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.

2 incidents have been reported to StEIS in Q1.
Retrospective StEIS following review of HSIB report for cooled baby. Maternity Unit Divert due to no Registrar cover overnight due to sickness. Consultant on call to cover however had been working all day. Letter of apology sent to the family affected. Immediate learning regarding the sustainability of current on-call arrangements and medical staffing. Risk added to the risk register for review.

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.

0 cases required reporting to NHSR ENS in Q1

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 reported to StEIS may not be in the month that the incident occurred, although early StEIS reporting is a priority.

1.2 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.		

1.3 Learning from outlier data – HIE 2 & 3 as a theme

In response to data indicating that WWL are an outlier for baby's with 'suspected' Hypoxic Ischaemic Encephalopathy (HIE) 2 and 3, in GM, the following deep dive has been undertaken for the last 13 months. This information will be forwarded to the LMNS to ensure our reporting is in line with other Trusts in GM. GM dashboard keeps oversight of 'confirmed' HIE cases therefore it is important to retrospectively update data following MRI. Moving forward our data will be retrospectively reported in line with GM processes.

Date	Number of neonates assessed as HIE 2 or 3	Outcome of MRI	Comments
June 22	0	-	
July 22	0	-	
Aug 22	1	No evidence of HIE	
Sep 22	1	No evidence of HIE	
Oct 22	1	Chronic HIE	Complicated by maternal opiate use
Nov 22	0	-	
Dec 22	2	No evidence of HIE	
		NA	Early neonatal death at term following placental abruption at home – no labour. No care or service delivery issues found.
Jan 23	1	NA	Early neonatal death at term following placental abruption on the ward. HSIB investigation – no findings or safety recommendations
Feb 23	0		
Mar 23	1	No evidence of HIE	
April 23	0	-	
May 23	0	-	
June 23	0	-	

Source Badgernet – data pull 14.7.2023

Between 1.6.22 – 30.6.2023 7 neonates were clinically assessed with HIE 2 or 3 and reported via the Maternity Dashboard.
5 out of the 7 neonates were eligible for MRI.
2 of the 7 neonates died in the first week of life (therefore no MRI). Both were following placental abruption and no learning was identified. (These cases remain HIE 3).
1 out of the 5 MRIs undertaken demonstrated chronic HIE (mother's history complicated by opiate and other drug use).
4 of the 5 MRIs demonstrated no evidence of HIE.

Considering the outcome of the MRI, a total of 3 cases have diagnosed HIE. No learning identified.

1.4 Learning from completed investigations.

In Q1, 6 investigations were finalised at ESG. Actions will be uploaded to DATIX, and progress monitored through SIRI.

WEB number	Date	Incident	Learning
WEB126471 StEIS 2023/7591	May 2022	Uterine rupture/Therapeutically Cooled (HSIB)	Safety recommendations focussed on HOLISTIC RISK ASSESSMENT of antenatal and intrapartum factors to inform the timing of birth. In the context of the risk factors of grand multiparity and previous LSCS - uterine rupture should be considered if there is a fetal bradycardia.
WEB127436	June 2022	Therapeutically Cooled	The importance of antenatal RISK ASSESSMENT and 'Fit for Labour' assessment to be added to the mandatory training CTG agenda. To introduce new antenatal CTG stickers on the maternity floor WC 29th August 2022 which offer a 'fit for labour' risk assessment potentially influencing decision to /not to perform artificial rupture of membranes.
WEB130683	Aug 2022	Neonatal Death (HSIB) (cardiac arrest)	No safety recommendations.
WEB132239	Sep 2022	PPH/Hysterectomy	Trust GUIDANCE to be brought in line with national guidance and women who have pre-labour spontaneous rupture of membranes at term to be offered induction 'as soon as possible' as well as conservative management for up to 24 hrs. Liaise with anaesthetic and theatre team regarding ability to offer Patient Controlled Analgesia (PCA) on the Maternity unit in the future. There are 2 units of 0 Rh negative blood available in the Blood Fridge in the laboratory and 2 units of 0 Rh negative blood in the General Theatres Fridge which should be considered in an emergency.

WEB132660	Oct 2022	Therapeutically Cooled (HSIB)	There were no safety recommendations identified in the HSIB report. There was some learning identified around using the correct ANTENATAL CTG CLASSIFICATION There is some learning regarding transfer directly to Theatre from Triage in the event of an abnormal CTG.
WEB144268 StEIS 2023/12299	June 2023	Maternity Unit Divert (staff sickness)	Immediate learning regarding the sustainability of current on-call arrangements and medical staffing.

1.5 Investigation progress– overview

Q1 has continued momentum progressing investigations through Trust processes.

At the end of Q1, 5 investigations are open. 2 of which have now been received in Division.

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. The appointment of the governance facilitator in June 23 will support this process.

WEB number	Date	Incident	Progress	Stage	Plan
WEB131310	Sep 2022	Therapeutically Cooled	Received in Division	Reviewed in Division – not complete	To work with investigators to complete
WEB136351	Dec 2022	Neonatal stroke (HSIB)	Final Report Received	Action plan	MDT to complete action plan
WEB136650	Jan 2023	Early Neonatal Death (HSIB)	Final Report Received	No actions required	Scheduled for ESG 20.7.23
WEB139693	Mar 2023	Therapeutically Cooled (HSIB)	Draft report received	Factual accuracy returned	Await final report

2. MVP Feedback

In March 2023 the MVP undertook a Pain Relief survey and the results were shared with the Trust in April 2023. The full presentation will be shared with the service leads.

Pain relief survey - Positive Comments
All went well
I felt my needs and wishes were listened to

Pain relief survey - Negative Comments
Post C-Section care not satisfactory – did not get the pain killers requested
Was declined an epidural – had forceps birth. Only offered analgesia when asked postnatally. Affected birth experience significantly.
Lack of support after complicated C Section adding to pain
No alternative offered after failed epidural

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	1	4	1						
NNU	0	0	0	0	0	0						

In Q1, 6 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. A Birth Thoughts group is available where women can self-refer.

No complaints have been received for the NNU.

Clinical treatment and communication are themes in Q1

- Clinical treatment X 4
- Communication X 6
-

All complaints involved themes around communication including information giving and feeling pressured to decision making.

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	14	10	0

Under review	MAT	3780	Maternity Ligature Risk	10
	MAT	3782	Maintenance of Maternity Equipment	6

	MAT	3781	Transfer of Babies to NNU for Antibiotics	6
Awaiting approval	MAT	3772	Euroking System Error	20
Approved	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	3727	Euroking To PAS Error Risk	9
	MAT	3756	Medical Devices Training	8
	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
	MAT	3732	Entonox Risk	8
	NEO	2281	There are a significant number of staff who do not have current accreditation for NLS course	8
	MAT	3669	Potential inability to undertake more than 1 emergency delivery at a time due to number of theatres available.	8
	BOTH	3725	Junior Doctors Strike	6

	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
Closed	NEO	3695	CritiCool Cooling Machine (Neonatal patients) beyond repair	

In Q1, 3 new risks have been added to the risk register and are currently under review.

- Maternity Ligature Risk – 10
- Maintenance of Maternity Equipment - 6
- Transfer of Babies to NNU for Antibiotics – 6

1 significant new risk - Euroking System Error - has been reviewed at Divisional Risk group and is awaiting approval at next RMEG due to a score of 20.

4 risks have been approved and added to the live risk register,

- Potential inability to undertake more than 1 emergency delivery at a time due to number of theatres available - 8
- Junior Doctors Strike – 6
- Medical Devices Training – 8
- Entonox Risk – 8

1 moderate risk in relation to the CritCool Cooling machine has been resolved and closed.

Risks continue to be pro-actively managed within the Division. Risks scoring 15 and over are monitored through RMEG. The risk register is tabled at the relevant monthly Clinical Cabinet for over-sight.

4. Ockenden 2 progress Update

Q3 Update		Local Actions			N/A	Trust Corp Action	National/ regional Action
		Red	Amber	Green			
EA1	Workforce planning and sustainability	0	2	6			3
EA2	Safe staffing	0	0	9			1
EA3	Escalation and accountability	0	0	5			
EA4	Clinical governance-leadership	0	1	5		1	
EA5	Clinical governance – incident investigation and complaints	0	0	7			
EA6	Learning from maternal deaths	0	0	2			1
EA7	Multidisciplinary training	0	2	5			
EA8	Complex antenatal care	0	1	3			1
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	0	5			3
EA15	Supporting families	0	0	3			
	Total	0	8	71	2	1	10

There are a total of 15 immediate and essential actions and 92 sub actions from the Ockenden 2 report. Q1 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. 8 amber actions remain.

5. Maternity Incentive Scheme Year 5

The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. The technical guidance for the Year 5 scheme was launched on 31st May 2023. The relevant time period is 30th May 2023 to the 7th December 2023.

A monthly Assurance Meeting has been set up within our Maternity Services for leads to provide feedback and allow over-sight of compliance against the 10 Safety Actions. All leads have been identified.

Safety Action		Required standard	RAG
1	PMRT	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.	Data available on MBRRACE
		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.	Data available on MBRRACE
		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.	Data available on MBRRACE
		d) Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023.	
2	MSDS	a) 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 publication series for data submissions relating to activity in July 2023. Final data for July 2023 will be published during October 2023.	Embedded
		b) July 2023 data contained 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. (MSD001)	Embedded

		c) 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:	Embedded
		If the data quality for criteria 3 are not met, Trusts can still pass safety action 2 by evidencing sustained engagement with NHS England which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS England (see technical guidance for further information).	Carried out as failsafe
		d) Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023.	Complete
		e) Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust.	2 submitters in BI.
3	TC/ATAIN	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.	
		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. 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.	
		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.	
4	Clinical Workforce Planning	a) Obstetric medical workforce	Individual action plan required
		b) Anaesthetic medical workforce	
		c) Neonatal medical workforce	
		d) Neonatal nursing workforce	

5	Midwifery Workforce Planning	a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.	Birthrate+
		b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.	Business case to be submitted
		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.	
		d) All women in active labour receive one-to-one midwifery care.	
		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.	
6	SBL3	1) Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024.	On track. All SBL2 data collection embedded. SBL3 gap analysis undertaken, parameters set up, ready for data collection.
		2) Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool once available	
7	Listening to women / MNVP	1. 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.	
		2. 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.	Action plan in development
		3. 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.	In progress
8	Multi-professional Training	1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework.	
		2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB. 3. 3. The plan is developed based on the “How to” Guide developed by NHS England.	
9	Board assurance	a) All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded.	

	process		
		b) Evidence that 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.	To be discussed at Q&S and Safety Champions
		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.	
10	HSIB/NHSR	A) Reporting of all qualifying cases to HSIB/CQC//MNSI from 30 May 2023 to 7 December 2023.	Embedded
		B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 until 7 December 2023.	Embedded
		C) For all qualifying cases which have occurred during the period 30 May 2023 to 7 December 2023, the Trust Board are assured that: i. the family have received information on the role of HSIB/CQC/MNSI and NHS Resolution's EN scheme; and 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.	Embedded

6. Avoiding Term Admissions into Neonatal Units (ATAIN) Q4

Q4	Total Term Live Births	Total Term Admissions to NNU	Unexpected Term Admissions to NNU	'Avoidable' admissions to NNU
Jan-March 2023	588	52 (8.8%)	50 (8.5%)	**5**

In Q4, the unexpected term admission to NNU rate was 8.5% of total term live births. There is work to be done. Weekly MDT ATAIN meetings led by the Deputy Governance Lead are now scheduled to enable timely review, support, and oversight. An ATAIN working party to drive QI.

<u>Avoidable admissions</u>

1 admission to the NNU due respiratory reasons was determined to be avoidable. After a short stay on the NNU (<24 hours) the baby was transferred back to the postnatal ward therefore separation of mother and baby was kept to a minimum.

1 admission to the NNU due to respiratory reason requiring observation only was determined to be avoidable Baby could have been admitted to TC to avoid mother and baby separation.

2 admissions to the NNU due to feeding issues and low blood glucose levels were determined to be potentially avoidable. Babies required no nasogastric tube feeding or TPN. Normoglycaemia after admission, remaining on NNU before discharge to Mother.

1 admission to the NNU at day 3 for poor feeding. Due to a lack of staffing on TC the baby was transferred to the NNU for nasogastric tube feeding support. Maternity staff are not currently trained to support NG feeding.

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.

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
1	1	1

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

7.1 Mortality overview

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23
	Q2 22-23			Q3 22-23			Q4 22-23			Q1 23-24		
Total births	220	238	191	234	228	213	224	170	194	214	215	213
Total Stillbirths ≥ 24 weeks	0	1	1	0	1	1	2	0	2	2	0	1
MTOP & Lethal Anomalies ≥ 24 weeks							1	0	1	0	0	1
Late fetal loss 22 – 23+6 weeks										1	0	0
Total Neonatal Deaths (0 days – 28 days)	0	1	0	3	1	1	1	1	0	1	0	0
Early neonatal deaths (0-7 days)	0	1	0	3	1	1	1	1	0	1	0	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 3 stillbirths in Q1, 1 of which was a medical termination of pregnancy due to lethal anomalies.

All 3 stillbirths are subject to 72hr review, only 1 will be subject to PMRT (1 MTOP, 1 no care accessed in pregnancy).

- 28+5 weeks gestation (calculated from GROW), query antenatal stillbirth at home. Reported to MBRRACE for information only. Not for full PMRT review, due to not being booked for antenatal care, query concealed / query unknown pregnancy and born at home with no health care professional present. Under Home Office investigation.

- 32+4 weeks gestation antenatal stillbirth. Known pre-term rupture of membranes, cord prolapse at home. Transferred to hospital, emergency caesarean section, stillborn. No learning identified which would affect the outcome. Placenta for histology only. Parents declined post-mortem and cytogenetics. For PMRT.

- 24+ 4 weeks gestation medical termination/feticide for fetal anomaly left hypoplastic heart, reported to MBRRACE for information only. Stillborn. Not eligible for PMRT. No learning identified.

There was 1 late fetal loss between 22 and 23+6 (Twin 2) in Q1 which is subject to 72 hr review and PMRT.

7.2.1 Multiple Pregnancy

1 twin pregnancy at 22 weeks gestation – Twin 1 was a neonatal death and Twin 2 was a late fetal loss (as described above).

7.2.2 Social deprivation

Of the 3 stillbirths in Q1, all 3 had a social deprivation score of 1 (highest level of deprivation). Care was provided in line with guidance at the time. A proposed change in practice from July 2023, will mean the women with a deprivation score of 1 will be cared for by an enhanced midwifery team.

7.2.3 Ethnicity

All stillbirths were from women of white ethnic backgrounds.

7.3 Neonatal Deaths

There was 1 early neonatal death at 22 weeks (Twin1) in Q1 which is subject to 72 hr review and PMRT.

7.4 PMRT

Grade	Care in Antenatal Period	Percentage (%)	Care in Postnatal Period	Percentage (%)
A	4	100%	4	100%
B	0	0	0	0
C	0	0	0	0
D	0	0	0	0
In Q1, 4 cases of antenatal stillbirth from 2022/23 were 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

7.5 MBRRACE Perinatal Mortality Report: 2021 births (latest report)

The MBRRACE perinatal mortality report concerns stillbirths and neonatal deaths among the 2,480 babies born within the Trust in 2021, excluding births before 24 weeks gestational age and all terminations of pregnancy. It includes details of the stillbirths and neonatal deaths for births that occurred in the Trust in 2021, as well as background information on all births. Neonatal deaths are reported by place of birth, irrespective of where the death occurred.

- The stabilised & adjusted stillbirth rate for WWL was 3.14 per 1,000 total births. This is around the average for similar Trusts & Health Boards.

- The stabilised & adjusted neonatal mortality rate was 0.91 per 1,000 live births. This is lower than the average for similar Trusts & Health Boards.

- The stabilised & adjusted extended perinatal mortality rate was 4.03 per 1,000 total births. This is lower than the average for similar Trusts & Health Boards.

Trusts are asked to review all cases if their aspiration is to seek comparable rates with the best performing countries such as Scandinavia, therefore a further full review of all stillbirths and neonatal deaths in 2021 will be undertaken to identify if there is any additional learning that wasn't identified in the PMRT review. A summary of the findings will be presented at the next Quality and Safety Committee. This will include 6 stillbirths and 1 Early Neonatal Death.

8. Saving Babies Lives (SBL)

Element 1 Reducing Smoking in Pregnancy	Compliance	Improvement Plan
CO at booking	99%	Smoking cessation midwife and Saving Babies Lives Lead addressing data input and collation from antenatal staff and delivery suite staff,
CO at 36 weeks	96%	

		some ongoing issues due to Euroking system. Correct input of data and regular teaching sessions of CO monitors are undertaken. Audit regularly undertaken.
Smokers referred at booking to in house stop smoking service	95%	
Smokers referred who set a quit date	60%	New members of the team commence duties July 23 to support improvements
Element 2 Risk Assessment and surveillance for FGR	Compliance	Improvement Plan
Risk at booking	100%	Most babies at risk of FGR and SGA are detected within antenatal period. WWL is in the top 10 in the country for detection rates.
Detection of <3rd centile at >37+6	100%	
Perinatal mortality cases linked to identification and management of FGR (PMRT)	0%	
Element 3 Reduced Fetal Movements	Compliance	Improvement Plan
Women attending for RFM receiving computerised CTG	100%	
Women who attend with recurrent RFM* who had an ultrasound scan to assess fetal growth.		**New metric – all set up prepared to collate data**
Element 4 Effective fetal monitoring in labour	Compliance	Improvement Plan
Staff received fetal monitoring training		
Staff successfully completed annual competency assessment		
Fetal monitoring leads appointed	100%	
Element 5 Reducing preterm births	Compliance	Improvement Plan
Correct birthplace		
Steroids		
MgSO4		
Intrapartum IVAs GBS		New metrics all set up and prepared to collate data
<34 delayed cord clamping		
<34 temp 36-53.5C within 1 hr of birth		
<34 own mother's breastmilk within 24 hrs		
Element 6 Diabetes	Compliance	Improvement Plan
New element		New metric – all set up prepared to collate data
SBL Training		
SBL Training (Elements 1,2,3,5)	94%	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 Midwifery

	Number attended in Q1	Percentage of staff	Rolling percent
BLS	41	27%	87.5%
NLS	41	27%	87.5%
PROMPT	28	18%	84%

From September 23 the structure of mandatory training will be changing. All Midwives will be allocated 4 maternity training sessions per year, consisting of PROMPT, full day fetal physiology, maternity safety day and specialist services update. This will ensure all elements of CNST and core competencies are covered. PROMPT compliance has dipped this quarter due to the cancellation of May's session.

8.1 Mandatory Training Compliance Other Specialities

	PROMPT	
	Number attended in Q1	Rolling percentage
Consultant Obstetrician	1	91%
Obstetric registrar	2	84%
Anaesthetist	0	88%
MSW	6	81%

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.

8.2 Mandatory Fetal Physiology Training

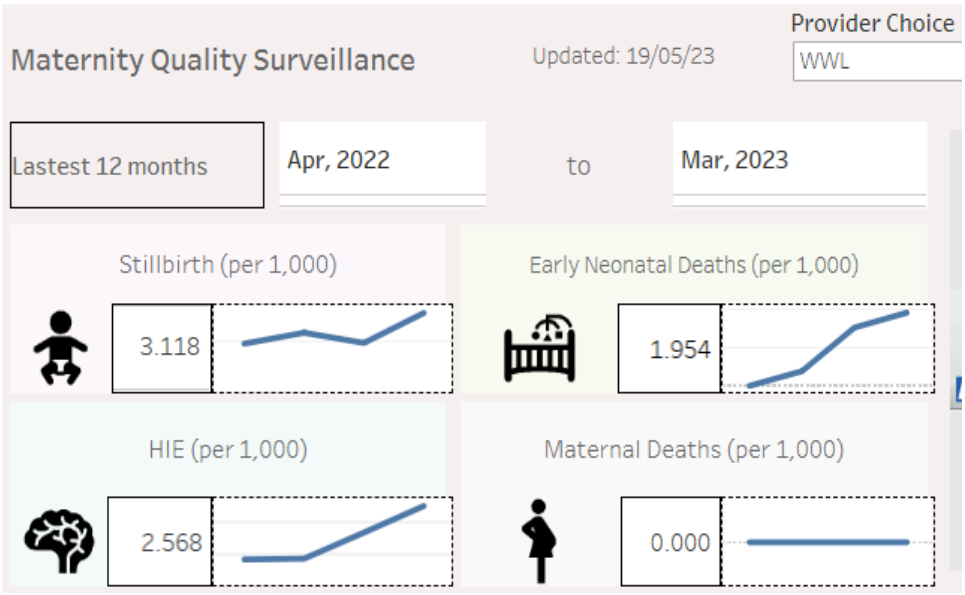
	Apr 2023	Rolling %	May 2023	Rolling %	June 2023	Rolling %
Midwives	21	98%	16	97.7%	13	98%
Obstetric Consultants	2	91%	4	91%	0	91%
Obstetric Registrars	1	100%	0	100%	1	100%

No exceptions.

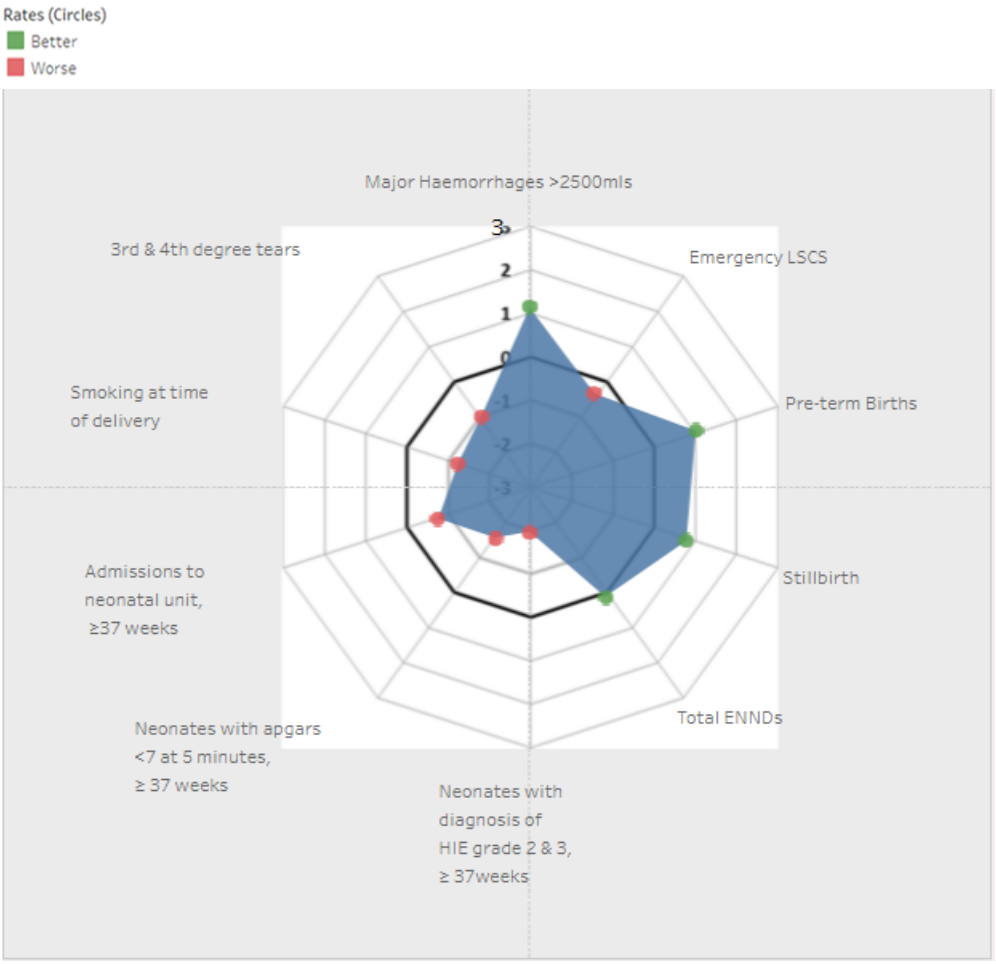
9. Maternity Quality Surveillance Dashboard, WWL Data – <u>April 22- March 23</u>

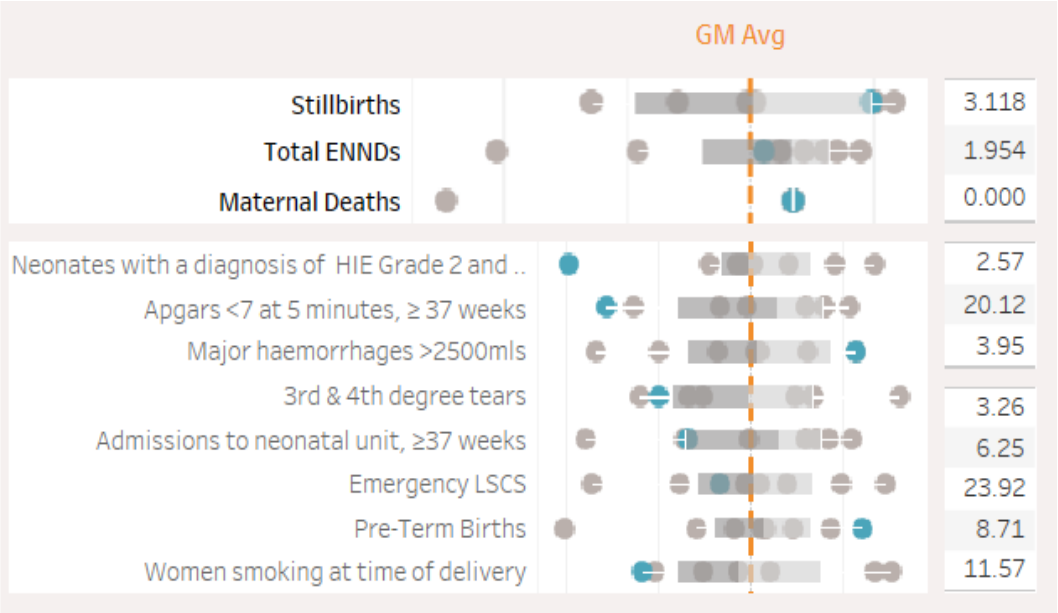
Source Tableaux

9.1 WWL rates of stillbirths, early neonatal deaths, maternal deaths and Hypoxic Ischaemic Encephalopathy (HIE).



9.2 WWL data as compared to GM April 2022 - May 23

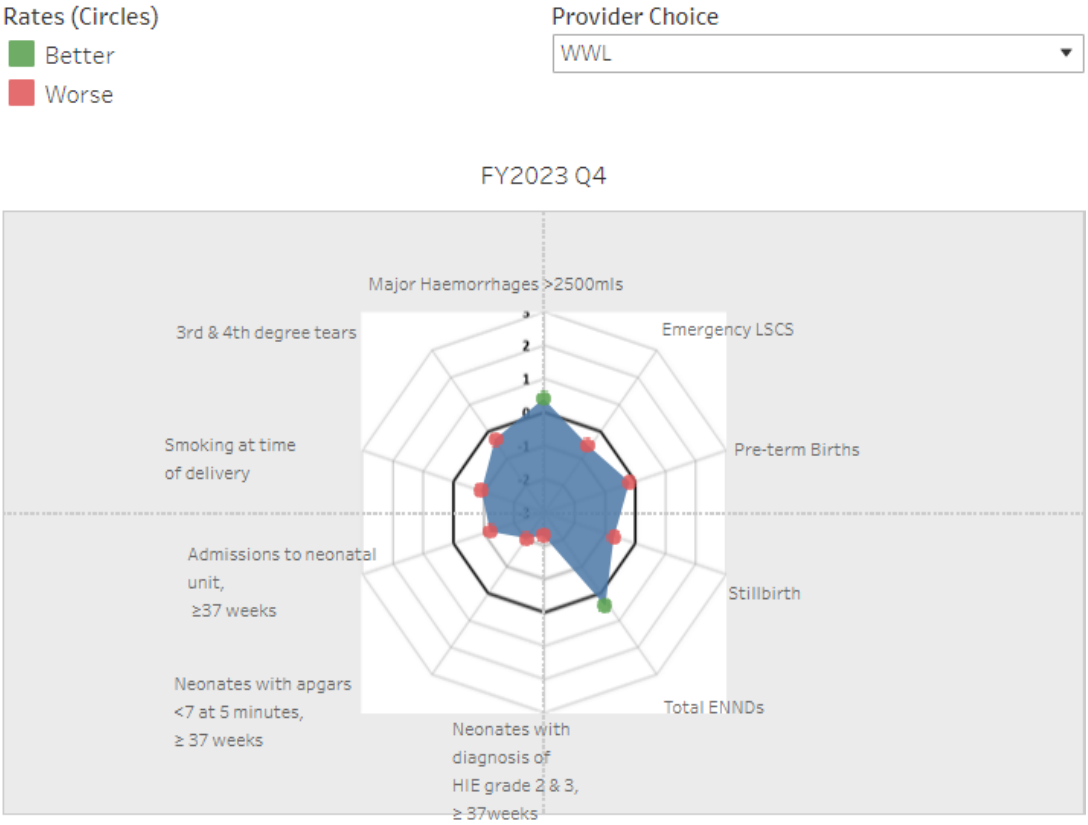




Between April 2022 and March 2023, WWL (blue dot) performed better than the GM average for number of stillbirths, early neonatal deaths, maternal deaths, major haemorrhage >2500mls and pre-term births.

WWL was outside the GM average for the number of Apgar's<7 @5 at term, HIE 2 or 3 at term, 3rd and 4th degree tears, term admissions to the NNU, emergency LSCS and women smoking at time of delivery.

9.4 WWL Data compared to GMEC average – Q4 2023 (latest data available) Source Tableaux



In Q4 2023, WWL has performed better than the GM average in rates of major haemorrhages >2500mls and early neonatal deaths.

WWL has performed worse than the GM average in smoking at the time of delivery, 3rd and 4th degree tears, term admissions to NNU, pre-term births, term babies Apgar score <7 at 5 minutes, HIE grades 2 and 3 at ≥ 37 weeks, stillbirth and emergency LSCS.

Analysis

It is important to note that the HIE 2 and 3 at term data will be re-submitted as WWLs current method of reporting is not in line with rest of GM as the outcome of the diagnostic MRI is not considered, and the figure will be significantly reduced.

The number of women smoking at time of delivery has seen a month on month decrease over Q1 2023 from 11.68% in April, to 10.9% in May and 9.38% in June. It is also noted that in April and June the number of women smoking at booking was <10% which is a reduction compared to previous months.

The number of term admissions to the NNU has remained below 6% in Q1 2023 which is an improvement on Q4 2023. Work continues with focussed efforts on respiratory distress and hypoglycaemia via the ATAIN team. Improving care in the first hour of life with a focus on embedding the warm bundle continues.

The number of 3rd and 4th degree tears has reduced each quarter over 2022-2023. It is important to continue the progress and a review of practice against the recommendations of the OASI 2 care bundle with the aim of identifying any quality improvements in care is indicated.

Summary

Q1 has seen improving metrics across several clinical outcomes. There have been significant risks identified in regard to the Maternity Information system Euroking and the integrity of the data contained within it, which has been appropriately escalated to the highest levels. Progress continues against National recommendations and quality improvement measures.

Wrightington, Wigan And Leigh NHS Foundation Trust

Perinatal Monthly Surveillance Dashboard

2022 - 2023

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

	Jul-22	Aug-22	Sep-22	Oct 22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Training compliance for all staff groups in maternity as per CNST requirments (need 90% compliance rate for all staff groups)												
Cardiotocograph (CTG) training and competency assessment	Midwives = 16 (99% rolling compliance) Consultant= 1 (100% rolling compliance) Registrar = 0 (100% rolling compliance)	No training in August	Midwives = 14 (96% rolling compliance) Consultant = 1 (100% rolling compliance) Registrars = 4 (90% rolling compliance)	Midwives = (96% rolling compliance) Consultant = (100% rolling compliance) Registrars = (90% rolling compliance)	Midwives = 13 (96% rolling compliance) Consultant = (100% rolling compliance) Registrars = 1 (90% rolling compliance)	Midwives = 57 (91% rolling compliance) Consultant = (100% rolling compliance) Registrars = 3 (90% rolling compliance)	Midwives = 13 (94% rolling compliance) Consultant = 1 (100% rolling compliance) Registrars = 1 (90% rolling compliance)	Midwives = 22 (96% rolling compliance) Consultant = 1 (100% rolling compliance) Registrars = 1 (90% rolling compliance)	Midwives = 11 (98% rolling compliance) Consultant = 0 (91.6% rolling compliance) Registrars = 2 (100% rolling compliance)	Midwives = 21 (98% rolling compliance) Consultant = 2 (91% rolling compliance) Registrars = 1 (100% rolling compliance)	Midwives = 13 (98% rolling compliance) Consultant = 0 (91% rolling compliance) Registrars = 1 (100% rolling compliance)	Midwives = 16 (97.7% rolling compliance) Consultant = 4 (91% rolling compliance) Registrars = 0 (100% rolling compliance)
Practical Obstetric Multi-Professional Training (PROMPT) (emergency Skills Drills Training)	Midwives 15 attended (10.4%) rolling % 87.5% Obstetric consultants 1 attended (9%), rolling % 82% Obstetric registrars 0 attended, rolling% 82% Anaesthetists 0 attended, rolling% 58% MSW 4 attended, rolling% 64%	no Training in August	Midwives rolling % 87.4% Obstetric consultants rolling % 91% Obstetric registrars rolling% 67% Anaesthetists rolling% 63% MSW rolling% 78%	Midwives 11 attended (7%) rolling% 82% Obstetric consultants 1 attended (9%) rolling% 91% Obstetric registrars 1 attended (9%) rolling% 82% Anaesthetists 3 attended (16%) rolling% 74% MSW's 5 attended (14%) rolling% 81%	Midwives 12 attended (8%) rolling % 88% Obstetric consultants 0 attended (0%), rolling % 91% Obstetric registrars 2 attended (18%), rolling% 82% Anaesthetists 1 attended (5%) rolling% 79% MSW's 4 attended (11%) rolling % 86%	Midwives 12 attended (8%) rolling % 91% Obstetric consultants 0 attended (0%), rolling % 91% Obstetric registrars 2 attended (18%), rolling% 91% Anaesthetists 6 attended rolling% 100% MSW's 4 attended (11%) rolling % 94%	Midwives 11 attended (7%) rolling % 91% Obstetric consultants 1 attended (8%), rolling % 92% Obstetric registrars 0 attended (0%), rolling% 82% Anaesthetists 0 attended (0%) rolling% 100% MSW's 3 attended (8%) rolling % 92%	No PROMPT in February	Midwives 11 attended rolling % 88% MSW 6% attended rolling% 88% Consultants 9% attended rolling 82% Registrars 8 attended rolling % 75% Anaesthetist 0 attended rolling % 100%	Midwives 15 attended (10%) rolling % 87% MSW 1 attended (3%) rolling % 86% Obs consultants 1 attended (8%) rolling% 91% Obs reg 0 attended rolling % 91% Anaesthetists 0 attended rolling % 84%	**PROMPT cancelled May**	Midwives 17 attended (11%) Rolling % 84% MSW's 6 attended (17%) Rolling % 81% Obs Consultants 0 attended Rolling % 91% Obs Registrars 2 attended (18%) 100% Anaesthetists 0 attended Rolling% 88%
Prospective Consultant Delivery Suite Cover (60 as standard for WWL)	60	60	60	60	60	60	60	60	60	60	60	60
1:1 care in labour	99%	99%	99%	98%	98%	100%	99%	99%	100%	100%	100%	100%
Maternity Red Flags reported (>3)	0	0	2	1	2	5	4	1	4	1	0	2
Diverts: Number of occasions unit unable to accept admissions(>1)	0		1	1	1	0	0	0	0	0	0	1
Supernumeray Shift Co-ordinator	100%	100%	100%	100%	100%	98%	100%	100%	98%	100%	100%	100%
The number of incidents logged graded as moderate or above (>5)	0	4	1	5	1	4	2	2	2	1	2	0
All cases eligible for referral to HSIB.	0	1	1	1	0	3	1	0	1	0	0	0
Number of Datix submitted when shift co-ordinator not supernumerary	0	0	0	0	0	0	0	0	0	0	0	0
Service User Voice feedback	**Maternity Voice Partnership Feedback** Really positive comments from service user who is a WWL employee. She found continuity with her Antenatal Care as she saw the same midwife throughout, and the postnatal staff were amazing. Parentcraft was highlighted as an area which she felt could be developed and we were able to share the improvements we have made to our antenatal education	**Feedback from Patient** Concerned about lack of movement during my pregnancy the student I spoke to at RAEI was calm and reassuring and avoided making me feel any kind of anxiety or worry with how she handled the call. Without her I would have become even more distressed	**Maternity Voice Partnership Feedback** *Woman shared her journey with her struggles with mental health during her pregnancy and reflected on how she has had a positive experience this pregancy with support from Perinatal Mental Health *New mum shared her experience around birth and postnatal care and felt that we should have talked about colostrum harvesting We were able to reassure her we would learn from her expereince and offered her Birth Afterthoughts service	**Feedback from Patient** "We received excellent, personalised care from the team at the Maternity Ward. We were admitted with our newborn son to treat his jaundice; this is a common but worrying complaint in newborn children depending on the cause. The maternity team were excellent in their reassurance, support and advice. "	**Feedback from Patient** Thank you to all staff at the Maternity Ward; you are an excellent team and we would not hesitate to return should it ever be required.	**Feedback from Patient** Woman shared her experience with her community midwife ..... came to see as a friend and you did and said so much to put my anxiety at ease. Having continuity with you was the best gift and you were amazing at your job and felt blessed to have had you as her midwife.	**Feedback from Patient** 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. 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** 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 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** The family were so complimentary about the care they received. In their words, they said that they will 'NEVER forget the NHS staff [who were there for them] when they needed them the most'.	**Feedback from Patient** "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" His words initially were "the care Annie and

Staff feedback from frontline champions and walk-abouts	**Ockenden Insight visit 18/07/2022** The team heard positive feedback around Quality Champions and the Midwifery Preceptorship programme. The visit also highlighted challenges with the reporting structure for the Director of Midwifery, process for compensatory rest and review of PA's allocated. There was concern to the lack of midwifery led care rooms which was addressed immediately.	**No Formal walkabout took place**	**CQC Sharing Success** Maternity Birthing Pool Evacuation Skills Drill performed from which learning points were identified and shared with the maternity and obsteteric staff	**Formal walkabout** Non Executive Director Steven Elliott undertook a walkabout across Maternity and No safety issues identified. Staff reported no concerns and positive feedback to the staff being really friendly	**Formal walkabout** Non Executive Director Steven Elliott undertook a walkabout across Maternity. Maternity staff were able to discuss any issues that concerned them and were provided with information about the Freedom to Speak Up guardian	**No Formal walkabout took place**	**Formal walkabout** 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** Chief Nurse Rabina Tindale and an Non Executive Director have arranged a walkabout across Maternity in April.	**Formal walkabout** 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** Chief Nurse Rabina Tindale provided positive feedback to the team on their hard workfollowing the CQC visit on the 16th May 2023	**Formal walkabout** Depty Chief Nurse Allison Luxon and an Non Executive Director undertook a walkabout across Maternity in June.
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	0	0	0	0
Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0	0	0	0	0	0
Progress in achievement of CNST 10	Work ongoing with Year 4 All standards remain on Track	Work ongoing with Year 4 All standards remain on Track	Work ongoing with Year 4 All standards remain on Track	Work ongoing with Year 4 All standards remain on Track	Work ongoing with Year 4 All standards remain on Track	Work ongoing with Year 4 All standards remain on Track	Work ongoing with Year 4 All standards remain on Track	Evidence submitted for Year 4	Awaiting the publication of CNST Year 5	Awaiting the publication of CNST Year 5	Awaiting the publication of CNST Year 5	Publication of CNST Year 5 Progress with all standards underway
Number of StEIS Reportable Incidents	1	0	1	2	0	0	2	0	1	0	0	1
Number of Stillbirths	0	1	1	0	1	1	2	0	2	1	0	1
Number of Neonatal Deaths	0	1	0	3	0	0	1	1	0	0	0	0
Number of Maternal Deaths	0	0	0	0	0	0	0	0	0	0	0	0

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Neonatal staffing Review **July 2023**
Presented to:	Trust Board
On:	2 August 2023
Presented by:	Rabina Tindale Chief Nurse
Prepared by:	Cathy Stanford Divisional Director of Midwifery and Child Health
Contact details:	Cathy.stanford@wwl.nhs.uk 01942 773107

Executive summary

All trusts are required to undertake an annual Neonatal Unit staffing review against the Neonatal Nurses Association and British Association of Perinatal Medicine (BAPM) staffing recommendations. The findings of the review must be submitted to the Maternity Incentive Scheme, a key requirement of this submission is oversight by Trust Board.

This 2023 report details the nursing staffing tool methodology and subsequent gap analysis of the staffing within WWL Neonatal Unit, to provide assurance of safe staffing. The vision for neonatal services across England as outline in The Neonatal Critical Care review (NCCR) is for a seamless, responsive, and multidisciplinary service built around the needs of new-born babies and the involvement of families in their care. It has been identified that their inclusion not only benefits the neurodevelopment of the baby during critical periods of early life it also results in long term quality of life and family cohesion. High quality neonatal care will be networked together across England, to improve outcomes for all families, provide safe expert care as close to their home as possible, and keep mother and baby together while they need care. The evidence shows that outcomes are better for babies whose parents are able to play an active role in their neonatal care. The review, published in 2019, highlighted 7 key actions for neonatal care across the UK:

1. Review and invest in neonatal capacity.
2. Develop Transport Pathways
3. Develop the neonatal nursing workforce.

4. Optimise medical staffing.
5. Develop strategies for the allied health professions.
6. Develop and invest in support for parents.
7. Develop local implementation plans.

Background

One in thirteen babies are born prematurely and require care within a neonatal unit, this equates to approximately 60,000 babies born before 37 weeks gestation each year. Babies that are born 28-32 weeks are classified as extremely premature.
Neonatal services are inextricably interdependent with maternity services and are a key part of the Maternity Transformation Programme, established to implement Better Births. Together, they form a programme to improve outcomes for women and babies using maternity and neonatal services, ensuring that implementation of both neonatal and maternity transformation plans remain coordinated and proceed together is an important part of national, regional, and local planning. (Implementing the Recommendations of the Neonatal Critical Care Transformation Review NHSE&I 2021).

The Neonatal unit (NNU) at WWL is a level 2 unit with 10 x Special care cots, 3 x HDU cots and 1 x ICU cot. The Neonatal Nurses Association and British Association of Perinatal Medicine (BAPM) developed recommendations for the safe staffing of all neonatal units which are:

- Babies requiring special care: 1:4 staff-to-baby ratio.
- Babies requiring high dependency care 1:2 staff-to-baby ratio.
- Babies requiring intensive care 1:1 staff-to-baby ratio.
- One supernumerary Shift Coordinator per shift

Methodology

This paper outlines the annual staffing and skill mix review and the further requirements for Neonatal services to work towards the integration of Allied Health Professionals into the Multi-disciplinary team, to enhance care and provide a holistic approach to neonatal care that is fully supportive of Family Integrated Care (FiCare).
The Neonatal Nursing Workforce Tool (2020) has been adapted from the CRG Workforce Calculator (Dinning) Tool (2013) and has been developed with the National Lead Nurses Group. **(See Table 1)**
It is intended to support neonatal nurse managers by providing a consistent method for the calculation of nursing establishment requirements which meet national standards i.e.,

NHSI (2018); NHSE Neonatal Service Specification e08 (2015); DH (2009); BAPM (2010); NICE (2010). All recommend an adequate and appropriate workforce, with the leadership and skill mix competencies to provide excellent care at the point of delivery for babies receiving medical and surgical interventions. DH (2009) stipulates that:

> 70% of the nursing establishment must be 'qualified in specialty' (QIS) and that there should be a supernumerary team leader additional to the staff caring for the babies on each shift.

Staffing shortfalls (Table 2)

Budgeted Nurse staffing shortfalls of 1.32 wte are currently in the process of being recruited to and there are no anticipated issues that will affect this recruitment. The increased number of training days that Neonatal Nurses require in order to be compliant with the training and development requirements, and maintaining competency and skills, is no longer supported by the 20% uplift, and it is requested that the uplift is increased to 25% this would then require an additional 1.69wte for Nurse staffing to cover the shortfalls due to training needs which is not covered within the current budgeted establishment.

To be able to facilitate Family Integrated care (FiCare) parents require support from a service that provides appropriately trained nursing and/or AHP staff, working alongside medical and nursing teams. Parental support involves education for parents in the specialised needs of their baby and training of all staff in the provision of developmentally sensitive care from a multidisciplinary team. (NCCR 2019). Currently there are shortfalls in all Allied Health Professional Posts and funding is required for 0.96 wte to support these roles within the unit.

There is an agreed plan within the Division to recruit to Advanced Neonatal Nurse Practitioners which will cover the Tier 1 shortfalls going forward and provide additional skilled senior support to the Neonatal unit.

This is not an immediate solution as staff will need to be trained through an accredited Training Programme which will take 2 years until completion.

In February 2023 the Trust submitted its action plan against the maternity Incentive Scheme Year 4 (Standard 4 Neonatal Workforce) in order to declare compliance against this action.

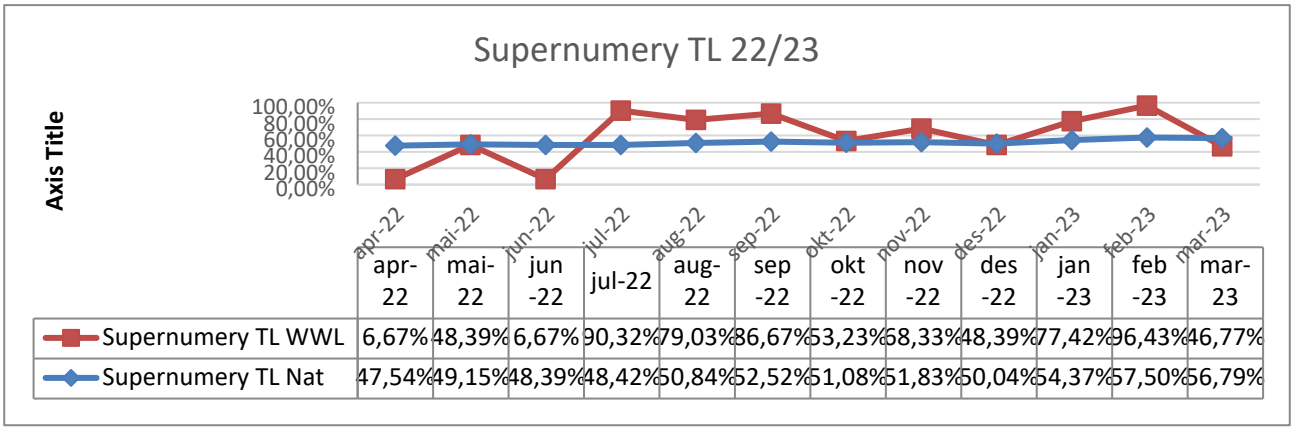
The action plan remains in place; however, funding has been received through the Critical Care Fund which will part fund one ANNP post with additional funding secured from within the Division, and recruitment plans are in place to facilitate this, however, to date there have been no candidates and the recruitment remains ongoing.

The recruitment of this component of the workforce is an ongoing national issue and therefore WWL are currently looking at all suitable options to increase compliance with the Tier 1 medical rota. A further Business case will be submitted when funding may be available for 2 posts either to train existing Neonatal Nurses or to recruit qualified practitioners or Medical Trainees.

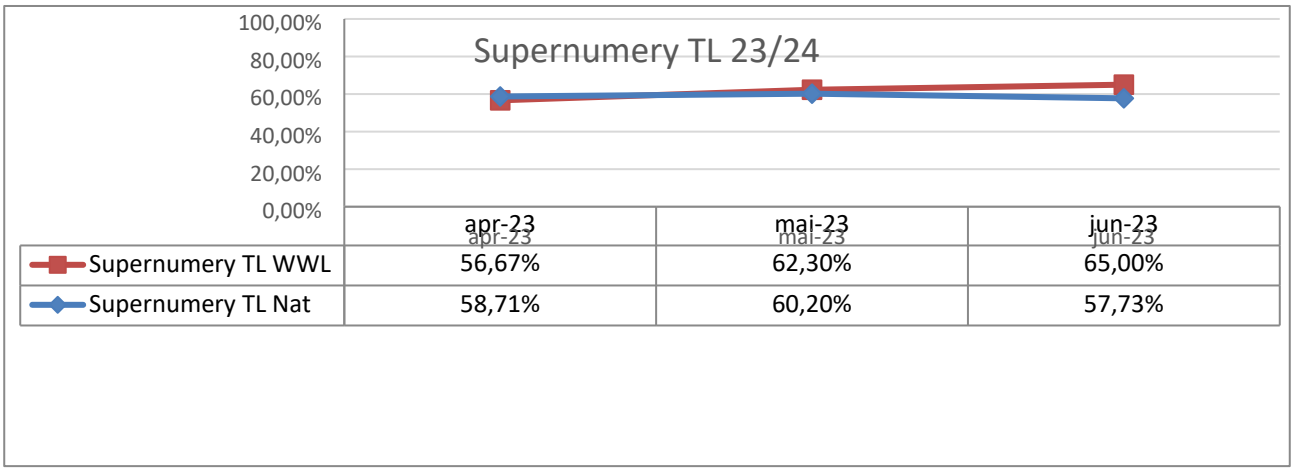
Current sickness and Bank Usage.

Short term sickness is currently affecting rotas on a daily basis and BAPM compliance is affected as the Shift Coordinator is not able to remain supernumerary. The rolling 12-month average for NNU is 8.13% with some weeks within the last months at 11-12%. HR assistance to review the sickness levels and assurance that sickness reviews are being affectively actioned is to be requested.

Compliance with Supernumerary Shift Leader



	apr-22	mai-22	jun-22	jul-22	aug-22	sep-22	okt-22	nov-22	des-22	jan-23	feb-23	mar-23
Supernumery TL WWL	6,67%	48,39%	6,67%	90,32%	79,03%	86,67%	53,23%	58,33%	48,39%	77,42%	96,43%	46,77%
Supernumery TL Nat	47,54%	49,15%	48,39%	48,42%	50,84%	52,52%	51,08%	51,83%	50,04%	54,37%	57,50%	56,79%



	apr-23	mai-23	jun-23
Supernumery TL WWL	56,67%	62,30%	65,00%
Supernumery TL Nat	58,71%	60,20%	57,73%

Neonatal Critical Care Review (NCCR)

Funding was received in 2022 to increase Neonatal Nurse staffing and to support the Advance Neonatal Nurse recruitment. An additional 0.20wte was recently received to

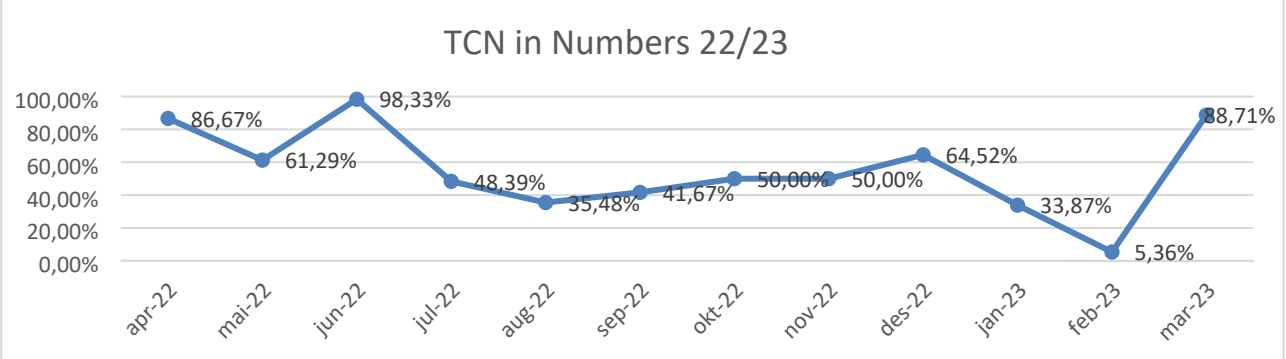
support Governance and a current Band 7 who leads on this now has 12 hrs protected time to support the Governance role within NNU and to attend the Regional Clinical Effectiveness Group (CEG). No additional funding has been received to support the recommended quality or Allied Health Professionals roles.

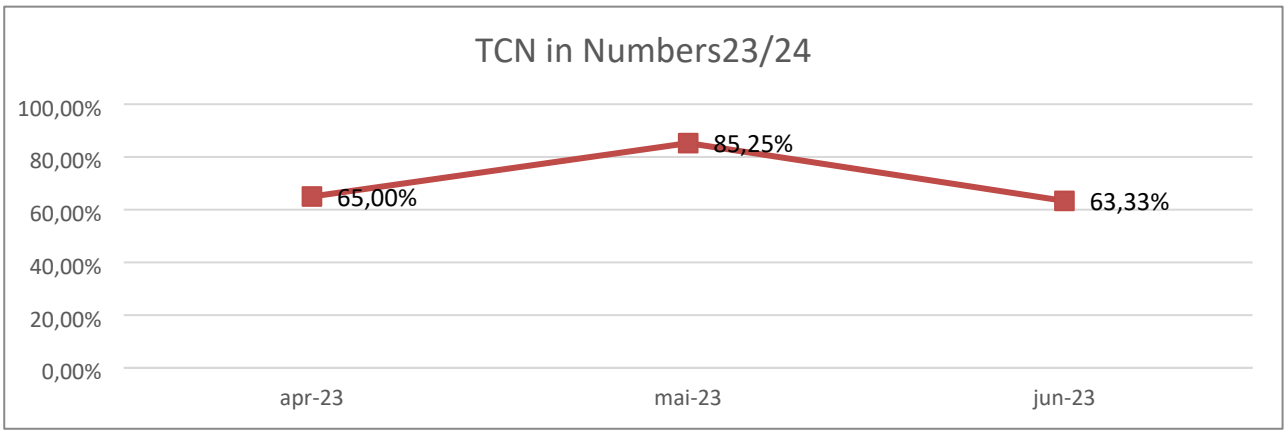
Neonatal Transitional Care (NTC)

Neonatal Transitional Care supports resident mothers as primary care providers for their babies with care requirements in excess of normal newborn care, but who do not require to be in a neonatal unit.

Implementation of NTC has the potential to prevent admissions to neonatal units, and also to provide additional support for small and/or late preterm babies and their families. The current model of TC at WWL is facilitated by staff from the Neonatal Unit but hosted on the Maternity ward. Staffing was funded for this service from Year 1 of the Maternity Incentive Scheme, however at times of staffing shortfalls this service is the first to be stepped down as Nurses cannot be released to the Maternity ward to support.

Therefore, it is proposed that WWL review the staffing model and consider upskilling Maternity Support workers to Band 4 with a comprehensive package of competencies, to provide the transitional care needs of the baby supported by the Midwife who is caring for the mother and a Neonatal Nurse facilitating the daily plan of care, who would attend at each shift and for the ward round. This would release 5.38 wte nurse staffing back into the Neonatal unit staffing and cover the current shortfall. Additional funding would be required for the Band 3 to 4 uplift with some possible recruitment to posts at Band 2 (care makers to bridge the gap that the enhanced roles will leave). This would additionally provide an excellent development opportunity for the current Band 3 workforce across the Maternity and Neonatal service.





Summary

The outcome of the review is that the neonatal unit at WWL has the right level of leadership in place with substantive Ward Manger and Supernumerary shift coordinators, however, **there are some nurse staffing shortfalls, although these are minimal at 1.32 wte.**

In addition, **there is a deficit of 1.0 wte Advanced Neonatal Nurse Practitioner**, as recruitment to these posts has not been possible.

The Shortfall in the recommended quality roles is highlighted in Yellow on Table 2, this is approximately 2.53wte.

By releasing the 5.38wte Transitional Care nurses back into the Neonatal budget and uplifting 5.38 wte Band 3 to 4 this will cover the staffing shortfall and provide the opportunity to implement some of the quality roles and provide career development for Band 3 Support workers.

Additional funding will be required to upskill band 3 to 4 posts within the Maternity Budget and some recruitment at Band 2 to provide the care maker role left vacant by the upskilled Maternity Support workers.

Whilst it is recognised that funding is currently limited it is nevertheless requested that a 25% uplift is considered when the Trust is in a position to improve the uplift that is applied to cover all study and training requirements in order to achieve BAPM compliance.

Recommendations

The Quality and Safety Committee are requested to consider the recommendations within the staffing report and the requirements for the additional funding to upskill Band 3 support workers for Neonatal Transitional Care.

Table 1

Neonatal Nursing Workforce Tool (2020): Wigan

Input unit details			
Trust	WWL		
Unit	Wigan		
Designation	LNU		
Completed by			
Date completed			
Activity period	ave 3 years 2018/19; 19/20; 20/21	Days in period	365

Input activity (HRG 2016)		
	Activity	Declared cots
HRG 1 (IC)	137	1
HRG 2 (HD)	631	3
HRG 3 (SC)	2,319	10
Total	**3,087**	**14**

Input staffing numbers (WTE) DIRECT PATIENT CARE ONLY		
	Budget	In post
Total QIS	20.68	20.04
Total Non QIS	3.34	3.34
Total Non Reg	0.00	0.00
Total	**24.02**	**23.38**

Activity (HRG 2016)							
	Activity	*For calculations*		Declared cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
		80% of daily activity	*WTE (6.07 / BAPM)*				
HRG 1	137	*0.5*	*6.07*	1	37.53%	1	0
HRG 2	631	*2.2*	*3.04*	3	57.63%	2	1
HRG 3	2,319	*7.9*	*1.52*	10	63.53%	8	2
Total	**3,087**			**14**	**60.41%**	**11**	**3**

Activity (HRG 2016)							
	Activity	*For calculations*		Declared cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
		80% of daily activity	*WTE (6.07 / BAPM)*				
HRG 1	137	*0.5*	*6.07*	1	37.53%	1	0
HRG 2	631	*2.2*	*3.04*	3	57.63%	2	1
HRG 3	2,319	*7.9*	*1.52*	10	63.53%	8	2
Total	**3,087**			**14**	**60.41%**	**11**	**3**

Nursing workforce (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 36.42, of which 25.49 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	24.02	23.38	27.53	-3.51	-4.15
Total reg nurses	24.02	23.38	23.91	0.11	-0.53
Total QIS	20.68	20.04	16.74	3.94	3.30
Total non-QIS	3.34	3.34	7.17	-3.83	-3.83
Total non-reg	0.00	0.00	3.62	-3.62	-3.62
Reg nurses as % nursing staff	100.0%	100.0%	86.9%		
QIS as % reg nurses	86.1%	85.7%	70.0%		

Table 2

2023 Staffing in post & required	Band	Current Budget WTE	Required WTE	Variance
Cot Side Funded Posts				
Supernumerary Shift Coordinator	7	5.38	5.32	0.06
Nursing Sister	6	5.38	4.40	0.98
Nurse	5	21.52	21.31	0.20
Nurse	3	2.69	2.92	0.23
Non cot side Nursing posts				
Ward Manager	7	1.00	1.00	0.00
Advanced/ Enhanced Neonatal Nurse Practitioner (ANNP)	8a	2.00	4.00	1.00
Governance Link Nurse	7	0.20	0.32	0.12
Training and Development Lead	7	0.80	1.00	0.20
Transitional Care Nurse	5	5.38	5.38	0.00
Neonatal Outreach Team	6	2.60	2.39	0.21
Speech & Language Therapist	7	1.00	0.50	1.00
HCA	3	2.69	2.92	0.23
Support staff				
Housekeeper	2	1.00	0.80	0.20
Ward Clerk	2	0.85	0.75	0.10
Unfunded Allied Health Professional Posts				
Dietician	7	0.14	0.00	0.14
Physiotherapist	7	0.42	0.00	0.42
Psychologist	8a	0.28	0.00	0.28
Pharmacist	7/8	0.25	0.13	0.12
Unfunded Recommended Nursing Quality and Administrative Roles				
Neonatal Risk Lead/Governance	6/7	0.32	0.32	0.52
Breastfeeding/Infant Support	5/6	0.84	0.00	0.84
Developmental Care	5/6	0.28	0.00	0.28
Family Support and Education (Ficare)	5/6	0.42	0.00	0.42
Palliative and Bereavement support	5/6	0.05	0.00	0.05
Discharge Coordinator	5/6	0.42	0.00	0.42
Infection prevention and control	5/6			
Data Entry / System Administrator	4	1.00	0.00	1.00

Table 3

Data 22/23	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
BAPM Avg Shift	5.02	4.39	5.04	4.08	3.92	4.07	4.11	3.79	3.96	3.35	2.61	5.01
Staff Avg Shift	4.73	4.89	4.78	5.17	5.05	5.15	4.91	4.57	4.77	4.73	4.93	4.90
Difference Avg WTE	-0.29	0.50	-0.26	1.09	1.13	1.08	0.80	0.78	0.81	1.38	2.32	-0.01
Supernumery TL WWL	6.67%	48.39%	6.67%	90.32%	79.03%	86.67%	53.23%	68.33%	48.39%	77.42%	96.43%	46.77%
Supernumery TL Nat	47.54%	49.15%	48.39%	48.42%	50.84%	52.52%	51.08%	51.83%	50.04%	54.37%	57.50%	56.79%
TCN in Numbers	86.67%	61.29%	98.33%	48.39%	35.48%	41.67%	50.00%	50.00%	64.52%	33.87%	5.36%	88.71%
Bank Usage	21.67%	17.74%	30.00%	30.65%	46.77%	41.67%	20.97%	28.33%	20.97%	29.03%	32.14%	27.42%

Data 23/24	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
BAPM Avg Shift	4.70	4.72	5.03									
Staff Avg Shift	5.18	4.96	5.33									
Difference Avg WTE	0.49	0.24	0.31									
Supernumery TL WWL	56.67%	62.30%	65.00%									
Supernumery TL Nat	58.71%	60.20%	57.73%									
TCN in Numbers	65.00%	85.25%	63.33%									
Bank Usage	46.67%	45.90%	28.33%									

Quarterly Data 22/23	Q1	Q2	Q3	Q4	Total
BAPM Avg Shift	4.82	4.03	3.95	3.66	4.11
Staff Avg Shift	4.80	5.04	4.75	4.85	4.88
Difference Avg WTE	-0.02	1.00	0.80	1.23	0.78
Supernumerary Team Leader WWL	20.57%	72.97%	56.65%	73.54%	59.03%
Supernumerary Team Leader Nat	48.36%	51.48%	50.98%	56.22%	51.54%
Transitional Care Nurse in Numbers	82.10%	42.38%	54.84%	42.65%	55.36%
Bank Usage	23.14%	36.47%	23.42%	29.53%	28.95%
Quarterly Data 23/24	Q1	Q2	Q3	Q4	Total
BAPM Avg Shift	4.81	#DIV/0!	#DIV/0!	#DIV/0!	4.81
Staff Avg Shift	5.16	#DIV/0!	#DIV/0!	#DIV/0!	5.16
Difference Avg WTE	0.34	#DIV/0!	#DIV/0!	#DIV/0!	0.34
Supernumerary Team Leader WWL	61.32%	#DIV/0!	#DIV/0!	#DIV/0!	61.32%
Supernumerary Team Leader Nat	58.88%	#DIV/0!	#DIV/0!	#DIV/0!	58.88%
Transitional Care Nurse in Numbers	71.19%	#DIV/0!	#DIV/0!	#DIV/0!	71.19%
Bank Usage	40.30%	#DIV/0!	#DIV/0!	#DIV/0!	40.30%

CS July 2023

References

A workforce strategy for Northwest Neonatal Units 2021-2026. Working together to provide the highest standard of care for babies and families. Mainwaring & Waters August 2021

Implementing the Recommendations of the Neonatal Critical Care Review. NHS England and NHS Improvement Dec 2019

National Institute for Health and Care Excellence (NICE) (2010) Quality standard. Specialist neonatal care. https://www.nice.org.uk/Guidance/QS4

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Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Maternity Bimonthly safety Update Report. May -June 2023
Presented to:	Trust Board
On:	2 August 2023
Presented by:	Rabina Tindale Chief Nurse
Prepared by:	Cathy Stanford Divisional Director of Midwifery and Child Health
Contact details:	01942 773107 cathy.stanford@wwl.nhs.uk

Report Outline

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 the 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.

This Bi-Monthly report (to correspond with Q&S and Trust Board time frames) provides oversight for assurance committees and Board of any issues, concerns or additional items for escalation and communication.

Quarter 1 Perinatal Quality Surveillance Report provides the detail for the majority of metrics included below.

Report

Incidents and investigations

A themed analysis of StEIS incidents reported incidents has been undertaken with a focus on CTG monitoring. All learning has been identified and shared with staff. Assurance that robust actions are in place is being monitored through governance forums and via the SIRI panel. Report to be tabled at August Q&S Committee.

Q1 has seen a decrease in StEIS reported incidents as compared to Q4.

Q1 has seen a decrease in HSIB referrals as compared to Q4.

In response to outlier status in GM for assessment of HIE 1 & 2 a data review has taken place. 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 pain relief in the intrapartum and postnatal period. The full results will be shared with ward managers.

6 complaints were received in Q1 with re-current sub-themes of communication and clinical treatment. Several email compliments from service users and positive feedback from the MVP has been received and shared with the staff involved.

Staff engagement

The culture programme undertaken within Maternity services facilitated by the OD team is due to be reported in July and findings will be fed back to staff at the planned away day.

Additionally, a survey around staff wellbeing will be facilitated for Neonatal staff supported by the OD Team as part of the Neonatal Senior leadership programme.

Maternity Information System (Euroking)

There has been a critical flaw identified in the maternity Information system where several questions are configured to overwrite previous answers. The system back copies data captured (populating retrospectively) and doesn't offer a time stamped, copy forward functionality. This is causing inaccurate records and data. We have raised the issue with the provider (Magentus) and sought support from the Trust Chief Information Officer and the Associate Director or IM&T Data Quality but have had little success with a suitable resolution from the system provider.

Mitigations are currently in place and several workflows have been discontinued, and only Booking, Birth and discharge are currently in use as some fixes have been applied to these workflows. This has halted the digital plans in place to become paper free.

The concerns have been shared with other Euroking users, and they too have discovered the same problem. As all Trusts have a system that is specific to them locally, there will be differing levels of concern. At WWL we have discovered that there around 140 questions that are configured to copy backwards.

The National Digital Midwife has been informed and issued a National alert to all Digital Midwives to raise awareness of the issue.

Currently there are serious concerns, not only about the accuracy of any data, but also potential safety concerns. This has been logged with the National Service Desk and will await further input from them and the relevant National teams at NHS Digital. There is also a risk that the issues cannot be fixed on the scale that it has now escalated to and WWL will be without a Maternity information system and no means of data capture for National Regional and local reporting measures.

Risks

The Risk Register has been included for maternity and neonatal services. 3 new risks have been added to the risk register and are currently under review. 1 significant new risk - Euroking System Error - has been reviewed at Divisional Risk group and is awaiting approval at next RMEG due to a score of 20 and has been discussed at SIRO.

4 risks have been approved and added to the live risk register. 1 moderate risk in relation to the CritiCool Cooling machine has been resolved and closed.

Risks continue to be pro-actively managed within the Division. Risks scoring 15 and over are monitored through RMEG. The risk register is tabled at the relevant monthly Clinical Cabinet for over-sight.

Ockenden 2

There has been significant 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 against Ockenden 1 is monitored via the LMNS. The progress towards compliance in reaching the Ockenden essential actions (IEAs) from both reports (Ockenden 1&2) are continuing to be considered and implemented within the Division.

Maternity Incentive scheme Year 5

Year 5 of the Maternity Incentive Scheme has been released with a deadline for submission of 1 February 2024. There has been some significant changes in regard to reporting elements and Training requirements. Updates will be provided within the quarterly Perinatal Quality Surveillance report at present there are no immediate concerns for compliance that need to be escalated. **(See Q1 Report)**

CQC Safe and Well Led Inspection

A draft report has been received from the CQC which has rated the service Good for Well Led and Requires Improvement for Safe with an overall rating of Good. The service are looking to challenge the rating as it is felt to be disproportionate to the findings and recommendations to the 2 Must Do and 4 Should Do actions.

In particular we are challenging the mandatory training compliance and the interpretation of this in regard to what is mandatory and the time lines for completion in line with the Maternity Incentive Scheme and Saving Babies Lives requirements.

Mortality and PMRT (Perinatal Mortality Review Tool)

There has been 1 stillbirth in June and 0 NND’s in the reporting period.

All PMRT cases will be reported within the quarterly Perinatal Quality Surveillance report in accordance with the Maternity Incentive Scheme requirements.

MBRRACE perinatal mortality report: 2021 births (latest report)

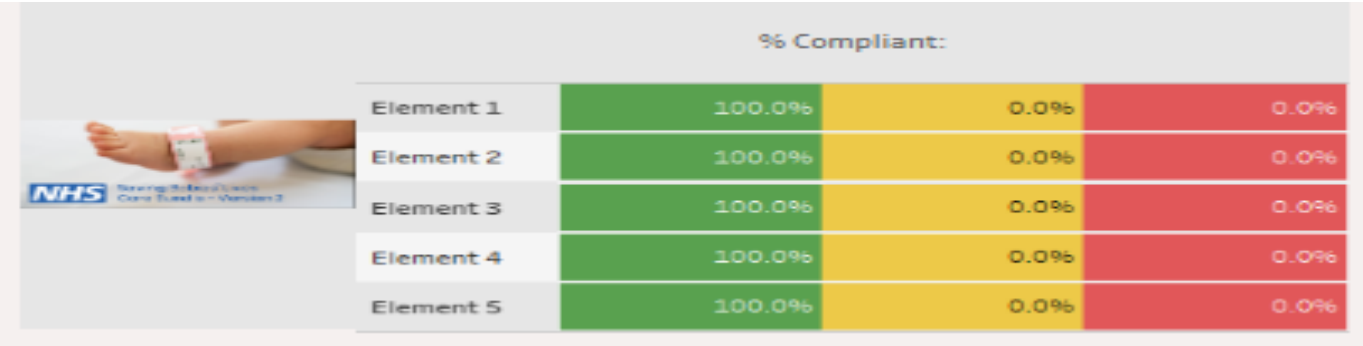
The MBRRACE perinatal mortality report concerns stillbirths and neonatal deaths among the 2,480 babies born within the Trust in 2021, excluding births before 24 weeks gestational age and all terminations of pregnancy. It includes details of the stillbirths and neonatal deaths for births that occurred in the Trust in 2021, as well as background information on all births. Neonatal deaths are reported by place of birth, irrespective of where the death occurred.

- The stabilised & adjusted stillbirth rate for WWL was 3.14 per 1,000 total births. **This is around the average** for similar Trusts & Health Boards.
- The stabilised & adjusted neonatal mortality rate was 0.91 per 1,000 live births. **This is lower than the average** for similar Trusts & Health Boards.
- The stabilised & adjusted extended perinatal mortality rate was 4.03 per 1,000 total births. **This is lower than the average** for similar Trusts & Health Boards.

Trusts are asked to review all cases if their aspiration is to seek comparable rates with the best performing countries such as Scandinavia, therefore a further full review of all stillbirths and neonatal deaths in 2021 will be undertaken to identify if there is any additional learning that wasn't identified in the PMRT review. A summary of the findings will be presented at the Next Quality and Safety Committee. This will include 6 stillbirths and 1 Early Neonatal Death.

Saving Babies Lives Care Bundle V3 (SBL v3)

SBL v3 has been published and a 6th Element introduced around management of Diabetes in pregnancy. Current compliance in the 5 existing elements remains on track and no concerns have been identified. However, Element 6 will require some service redesign around MDT bespoke clinics and management of Diabetic women.



Mandatory training

All training is scheduled for the year. A full review of all Maternity and MDT requirements has been completed and a structed programme of attendance has been developed to ensure that all elements are included and that there is a clear trajectory in place to achieve all elements of the Core competencies in line with The Maternity Incentive Scheme and Saving Babies Lives V3. Monthly compliance will be reported

on the Maternity Dashboards and Quarterly Perinatal Quality Surveillance report. So far there are only 12 anaesthetists booked onto PROMPT with 6 still to book a place meaning compliance for 90% may not be achieved by the end of the year if staff do not book on for the training. This will be escalated to the Clinical Director for Anaesthetics.

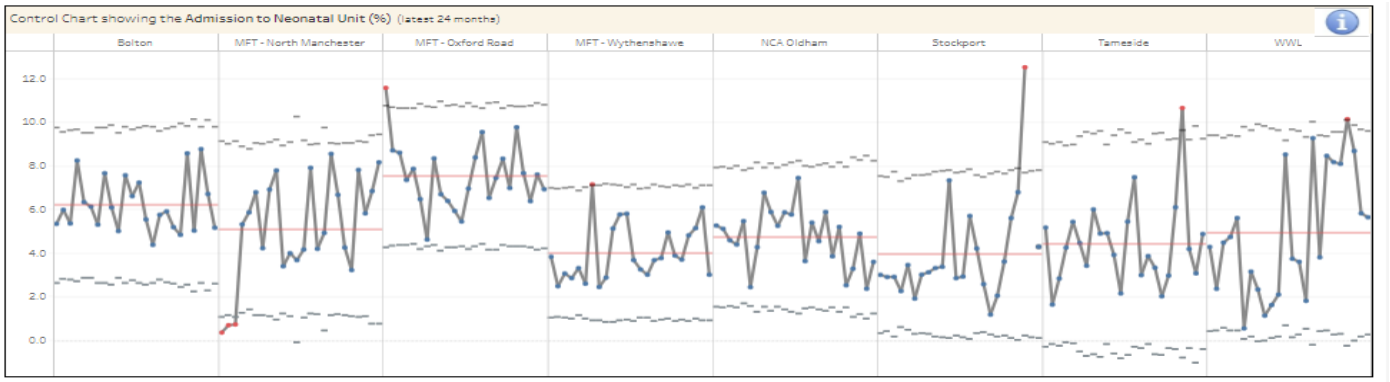
Maternity dashboard

Term admissions to NNU

There has been a continued upwards trend in term admissions to NNU since September of Q2 22-23. This figure remains red in May and June, but a downward trend is now being seen following the significant spike in February. Weekly MDT ATAIN meetings led by the Governance Team are now scheduled to enable timely review, support, and oversight. The initial focus will be to embed the warm care bundle as respiratory distress continues to be the principal reason for admissions. It has been noted that the temperature in main theatres are set lower than the Maternity Theatre and this has now been rectified with staff ensuring this is turned up prior to elective Caesarean section lists.

Key themes from the ATAIN Q3 audit have been identified as:

- Increase in the number of babies becoming Hypoglycaemic on the Maternity Ward
- Babies being admitted straight from theatre following and Elective Caesarean Section
- Increase in the number of babies with respiratory problems.



Maternal Steroids

In the 2-month period there were 7 singleton babies under 34 gestation whose mothers were eligible for Steroids with 6 having received a full course. No omissions in care were noted.

Magnesium Sulphate

In the 2-month period there were 4 babies born under 30 weeks gestation whose mothers were eligible for Magnesium sulphate and 3 received. No omissions in care were noted.

Infants with Apgar's <7.

In the 2 months period this has remained green after a spike in Q4. There were 3 babies in May and none in June with a Apgar less than 7. All cases continue to be fully investigated for patterns or concerns.

Induction of Labour (IOL)

The early months of the year saw significant increase in IOL cases. The numbers continue to fluctuate but remain predominantly high. An ongoing audit is in place to identify reason and appropriateness for IOL and whether the change in NICE guidance reducing the gestation to Term+7 for post-dates inductions is contributing to the upwards trend.

All cases continue to be reviewed for appropriate medical reasons, gestations, and outcomes.

HIE (Hypoxic Ischemic Encephalopathy)

WWL had been identified as an outlier on the GM Regional dashboard for HIE. On review of all cases that have occurred within the last 12 months

- **7** neonates were diagnosed with HIE2/3.
- 5 out of the 7 neonates were eligible for MRI.
- 2 of the 7 neonates died in the first week of life. Both were following placental abruption and no learning was identified.
- 1 out of the 5 MRIs undertaken demonstrated chronic HIE (mother's history complicated by opiate and other drug use).
- 4 of the 5 MRIs demonstrated no evidence of HIE.

Following this review, the regional dashboard will now be updated, and it is expected that WWL will no loner show as an outlier for this outcome.

Workforce/ Safe staffing

There are currently 15.17 midwifery vacancies. The Recruitment Day in May 2023 was successful and 10.56. wte Student midwives were appointed who will complete their training in September 2023 from the GM and neighbouring universities, and 2.72 wte will commence in January 2024.

WWL has expressed an interest in recruiting 3 International Midwives from Cohort 3 of the Northwest recruitment programmes and 1 CoS, (Certificate of Sponsorship) has been submitted. Additionally, 1wte Band 6 Midwife will commence in July 2023.

Sickness rates across the service is currently 4.5%.

A workforce review for Maternity Services 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 was submitted to Quality and Safety Committee and Board in June 2023 which included 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. An additional uplift to 25% was also requested and agreed in principle however a business case now needs to be developed to support the additional uplift to base line staffing and the shortfall as identified by BirthRate+.which is 6.52wte overall.

The Neonatal Staffing review has been completed which will incorporate staffing requirements for the Transitional care beds within the Maternity ward as well as ensuring compliance with BAPM recommendations for safe Staffing.

Maternity Red Flags and 1-2-1 Care in Labour

There were 0 Midwifery Red Flags reported in May however 2 were reported in June as there was one occasion where the unit was placed on divert and a delay in care. The shift coordinator was able to remain supernumerary for all shifts in May and June and 1-2-1 care in labour was 100%.

BirtRate+ Acuity Tool

This is now in place at the testing and training stage within the delivery suite with plans to roll out across to the maternity Ward following a successful go live period. The tool provides 4 hourly updates of acuity and activity, identifying if appropriate staffing numbers are in place. Graphs and reports are available to demonstrate any Red Flag issues and staffing V workload reports.

LMNS updates.

Collaborative work across the LMNS continues. The LMNS has developed an SOP for the Maternity Incentive Scheme (CNST) reporting with timelines and the draft process for quarterly submissions to the LMNS and the additional evidence requirements.

An initial 6 monthly check-in point in August is planned to report to the LMNS on progress to include evidence.

NWNODN Updates

The Neonatal Critical Care review (NCCR) is ongoing. The case for Change for the NCCR went to the Gateway 1 process on 28th April and stakeholder events will follow to outline next steps. Public consultation will take place by October 23. Several stakeholder events are planned. It is important that all DoM's/ HoM's are included in the process as there is a huge drive for change as it has been identified that there are too many Neonatal cots across the Northwest, and any changes to Neonatal services will have a major impact on Maternity Services.

Summary

May – June has seen improving metrics across several clinical outcomes. There have been significant risks identified in regard to the Maternity Information system and the integrity of the data contained within it, which has been appropriately escalated to the highest levels. Progress continues against National recommendations and quality improvement measures. Whilst the service has retained its overall Good CQC Rating, it is very disappointing that the Safe Domain was rated as Requires Improvement, however the service do feel that there is a case for appeal.

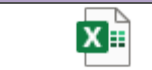
Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	ATAIN (Avoiding Term Admissions into Neonatal) Action Plan 2023/24
Presented to:	Trust Board
On:	2 August 2023
Presented by:	Rabina Tindale Chief Nurse.
Prepared by:	Cathy Stanford Divisional Director of Midwifery and Child Health
Contact details:	T: 01942 773107 E: cathy.stanford@wwl.nhs.uk

Actions Following Audit of Term Admission to the Neonatal Unit in supporting ATAIN – Maternity Incentive Scheme Year 5 (2023/24)

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Actions Following Audit of Term Admission to the Neonatal Unit in supporting ATAIN – Maternity Incentive Scheme Year 5 (2023/24)

Issue Identified/ Recommendation	Actions to be taken (Clear and specific identify resources where appropriate)	Lead Responsibility (Job Title)	Time Frame (Date to be completed)	Risk to Completion (Any risks that would prevent delivery of the action)	Progress towards Completion (Include date the narrative relates to)	Date completed (RAG rate the column)	Evidence of completion
Standardisation of Audits across the GMEC network Standardised quarterly Transitional Care (TC) and ATAIN audit template has been received from the LMNS	Trial the standardised template for Q1 audits onwards and submit quarterly to LMNS as requested.	Diane Cowley NNU Band 7 Rosie Robinson Governance Midwife	31st August 2023	None	**June 2023 Update -** Transitional Care/ATAIN Audit Group meeting in place Biweekly new tool in use. Feedback to be given in July meeting		 DRAFT TC and ATAIN tool and au
There has been an increase in the number of Term Admissions with hypoglycaemia admitted to the NNU	To review the Clinical Guidelines for hypoglycaemia Ensure there is consistency between Neonatal and Maternity guidelines	Kathryn Ashton Infant Feeding Lead Midwife Rosie Robinson Governance Midwife Cheryl Phillips	31st October 2023	None	**June 2023 Update** – awaiting BAPM updated guidance. **June 2023 Update –**		

Actions Following Audit of Term Admission to the Neonatal Unit in supporting ATAIN – Maternity Incentive Scheme Year 5 (2023/24)

	Undertake a detailed deep dive audit into the increased admission to NNU for hypoglycaemia to identify any trends/themes	Audit Midwife	31st July 2023		Review underway and findings to be shared at next Audit Meeting		
There has been an increase in the number of Term Babies admitted to the Neonatal Unit after an Elective Caesarean for Respiratory Distress	To undertake a further review of the babies admitted to the NNU for 2022/23 to identify any themes/trends that may not have been identified in the audit	Rosie Robinson Governance Midwife Cheryl Phillips Audit Midwife	31st August 2023	None	**June 2023 Update –** Current steroid guideline is up to date • It is not routine to offer steroids over 37 weeks, but this will be discussed with obstetric team. • Risks and benefits of steroids after 37 weeks to be discussed with women • Audit to include details of reason for EL/LSCS and if steroids administrated and or discussed. • Warm care Bundle introduced into General theatres • Ambient Temperature increased on EL/LSCS days reduce risk of infants getting cold. (as not at the recommended		

Actions Following Audit of Term Admission to the Neonatal Unit in supporting ATAIN – Maternity Incentive Scheme Year 5 (2023/24)

					temperature for newborns)		
Implementation of the Warm Care Bundle/MatNeoSIP/Attain – Working Group	Share the findings of the ATAIN with staff and ensure appropriate actions are put in place	Cheryl Phillips Audit Midwife	31st July 2023		**June 2023 Update** To share the findings of Quarter 4 at the next Warm Care Bundle/MatNeoSIP/Attain – Working Group meeting		
Introduce Midwife as second checker for infants receiving IV antibiotics.	Training plan to be implemented. Competency assessment to be developed by Training and development leads SOP to be developed	Suzi Faulkner NNU Training and Development Lead Keeley Jones Practice Development Lead Midwife	December 2023	None	**Update June 2023** – Training planned Timeframe date amended to reflect the training needs. Evidenced by: • SOP available on intranet, • Staff training and competency logs. • Completed competency booklets		2nd checker IVAB for midwives workb

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Actions Following Audit of Term Admission to the Neonatal Unit in supporting ATAIN – Maternity Incentive Scheme Year 5 (2023/24)

The pathway of care into transitional care has been fully implemented and is audited monthly. Audit findings are shared with the neonatal safety champion.	Update Audit proforma Monthly audit of transitional care admission Develop Action Plan from Findings	Simon Needham NNU Transitional Care Lead, Diane Cowley Shift Coordinator	Ongoing		Ongoing audits undertaken monthly with Quarterly presentation of Findings, to be tabled at Clinical Cabinet and Safety Champions	Ongoing Monthly.	TC Audit MAY 23.docx TC Audit April 23.docx TC AUDIT June 23.xlsm
Audit results to be cascaded to staff	Audit presented at Clinical Issues and Audit Meeting Summary to be shared in Safety Dashboard	Governance Leads	Quarterly	None	**June 2023 Update** Evidenced by Minutes of Clinical cabinet and audit meetings. Audits to be displayed in unit for staff.		Q4 ATAIN Jan 23-March 23 Presentat

Actions Following Audit of Term Admission to the Neonatal Unit in supporting ATAIN – Maternity Incentive Scheme Year 5 (2023/24)

							ATAIN Q3.pptx Term Admissions to NNU 2022 Q2.pptx
To consider the introduction of NG tube feeding for babies in TC	• To develop a pathway within TC for babies who require supplemental NG tube feeding • To develop a competency assessment for maternity staff for NG tube feeding	Suzi Faulkner NNU Training and Development Lead Keeley Jones Practice Development Lead Midwife	30th July 2023		**Update June 2023** Amended target date to December 2023. Neonatal Network have share competencies. • Template for training received from Clinical Educator via NWNODN Education Team		Educational workbook for CSWs Tube feeding competency.docx Competency document.pdf
	Review of current guidelines and pathways	Shift Coordinator	October 2022	None	July 2022	July 2022	Guideline awaiting

RR June 2023

Actions Following Audit of Term Admission to the Neonatal Unit in supporting ATAIN – Maternity Incentive Scheme Year 5 (2023/24)

Clear pathways and guidelines for all staff for Transitional Care	used within the Maternity/ Neonatal Service to assess if they require any changes; and to identify if any additional guidelines/flowcharts/ pathways require development. Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care.	NNU Transitional Care Lead Delivery Suite/ Maternity Ward manager			Guideline updated and criteria agreed.	October 2022	ratification at Clinical Cabinets  STANDARD OPERATING PROCE  Transitional care SOP V1.1.doc
The Transitional Care Service within the Maternity ward to be re-implemented.	Strategy for re-implementation to be developed. Including: • Ensuring there is a reserved bay for transitional care available. • Ensuring Neonatal Nurse	Maternity Ward manager	December 2022	Reduced staffing levels and High Acuity.	Staffing review undertaken, to ensure 5.38 WTE staff available to support TC on a daily basis. TC lead now in place to drive service forward and ensure that TC is considered as an option for term infants or those who meet the criteria		Remains ongoing. Rota's available as evidence of allocation.

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Actions Following Audit of Term Admission to the Neonatal Unit in supporting ATAIN – Maternity Incentive Scheme Year 5 (2023/24)

	Allocation on a Day-to-day basis to care for babies require transitional care. Communicating of the Pathways and guidance supporting transitional care across the Maternity Floor	NNU Manager	Ongoing				
A data recording process for capturing transitional care activity, (regardless of place - which could be • Transitional Care (TC), • Postnatal ward, • Virtual outreach pathway etc has been embedded.	• capturing the data for transitional care via Badger Data capture of infants to include infants admitted 34-36+6 weeks who are admitted to NNU and did not require any support or interventions.	NNU manager	December 2022	None	Functionality available on Badger Data to be requested from NWODN		

Title of report:	IPC Board Assurance Framework update. Version 1.0
Presented to:	WWL Board of Directors
On:	2 August 2023
Presented by:	[Rabina Tindale, Chief Nurse, Director Infection Prevention and Control]
Prepared by:	[Julie O'Malley, Deputy Director Infection Prevention and Control]
Contact details:	01942 77 3115 julie.omalley@wwl.nhs.uk

Executive summary

The IPC Board Assurance Framework (BAF) as issued by NHS England has been subject to review and updated to align with the National IPC Manual and criterion of the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections to support improvement and patient safety. The focus on COVID-19 is now transitioning back to pre-pandemic IPC arrangements.

This report provides an update by exception of the NHSE IPC BAF (version 1.0, April 2023), with any noted changes in compliance measures/ evidence, any gaps in assurance and any mitigating actions in place at 30.6.2023.

Gaps in Assurance and Mitigating Actions

- **Lack of an Infection Control Doctor/ Microbiologist:** Limited Microbiology provision continues within the Trust. This is noted within the Organisational Risk register and reviewed by the Risk Management Group.

- **The demand on the IPC workforce** has increased due to vacant posts; recruitment process; retirement; long term sickness; reduction in working hours and annual leave. Risk assessments continue to be reviewed.
- **The IPC Audit Programme** continues to be impacted by the demands on the IPC workforce. The IPC Team is working aligned to a quarterly work programme towards the delivery of a full IPC audit programme.
- **Mandatory Surveillance and Review of Healthcare associated infections** continues with a focus on improving outcomes for patients. CDT cases are currently ten (10) cases for Q1 against a threshold of 52 for the year 2023/24. This is a decrease compared to the Q1 position in 2022/23 at 12 cases. The review of 2022/23 CDT cases continues, in addition nine of the ten (10) cases for 2023/24 have been reviewed and the learning and improvement opportunities will be shared across the Divisions. The review of Gram-negative bloodstream infections is in operation from Q1.
- **Within the Trust there is limited side room capacity** to consistently enable isolation as required for patients with confirmed or suspected infections. The IPC Team attend daily bed meetings and support bed managers with decision making, including during IPC On-call provision. A Datix is completed if unable to isolate a patient who should be – this includes those who have infections, those who are suspected to have an infection and patients who require protective isolation.
- **Respiratory Testing capacity within Emergency Department (ED).** Point of care (POC) testing equipment for Respiratory infections is available within the Emergency Department (ED) and was installed to support the placement of patients with seasonal respiratory viruses. Training for new POC testing equipment has not commenced due to operational pressures within the ED, delaying the introduction of the new equipment. Options are being considered to enable the implementation of the new testing process, in preparation for the Winter Season planning arrangements.
- **Currently, the Trust are only cleaning prioritised areas within the non-clinical areas**. The 2nd wave of recruitment to undertake the cleaning and monitoring of non-clinical areas in 2022/23 has not been implemented due to the current financial position.
- **Inconsistent cleaning scores of patient equipment.** The scores are reported to the Ward Manager the Matron, Heads of Nursing and Deputy Chief Nurse posts. The actions required to address the standards will be discussed and actioned at the Trust Cleaning Standards Forum and monitored through the IPC Group for improvement.
- **Hand hygiene compliance** continues to have potential for improvement. Trust compliance was 85%: April 2023, 85%: May 2023, 81%: June 2023. Compared to 83%: March 2023, 82% for February 2023 and 79% in January 2023. The focus on improvement continues.
- **Increased demand on capacity within Emergency care: The** increased demands on the emergency floor and operational flow pressures have continued to require areas within the existing footprint to be utilised in a different way and areas escalated to create capacity to meet patient safety. Whilst we acknowledge that non segregation is a risk, patient safety and the timely treatment of life-threatening conditions outweighs the risk of transmission of infection.
- **Low compliance with the Staff Annual Vaccination Programme for 2022/23 season.** This will be raised at the IPC Group in collaboration with Occupational Health Services, for review and analysis of themes, trends and learning for future vaccination programme campaign, ahead of the Winter Season 2023/24.
- **Next Steps on IPC: Face Mask wearing and COVID-19 Testing.** WWL Services are now transitioning back to pre-pandemic IPC arrangements, with Face mask wearing in defined areas and settings and targeted COVID-19 testing only. Revised Flowcharts are in operation for Staff and Patients.

- **Central Trust Register for Clinical Skills and Device insertion Training and Competency records:** To review the availability of an Organisation recording system and process and to establish aligned with the current educational and training workstreams and programmes.

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

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

Financial implications: Some actions will require significant financial resource to implement fully e.g., Investment in IPC workforce, Pharmacist resource to support Antimicrobial resistance and stewardship, new cleaning standards, isolation capacity and Winter planning: Testing and Immunisation.

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

People implications: Additional resource will be required in some areas e.g., to address the current challenges associated with the reduction of HCAI/ Clostridium *difficile* infection, GNBSI Agenda, and seasonal respiratory viruses on a background of a depleted team, the increasing IPC workload that continues to create additional ongoing pressure on the IPC team.

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

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

Appendix 1: Infection Prevention and Control (IPC) Board Assurance Framework (BAF). Last update completed at: 30.06.2023

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them.				
Organisational or board systems and process should be in place to ensure that:	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**RAG Rating**
1.1 There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	WWL Governance structure includes: IPC Group (formerly Committee) Director of IPC and Deputy Director IPC in post with direct line Management to IPC Team. Assurance and oversight by Trust Board, Quality and Safety and Senior Leadership Team Structure. Governance structures in place across the Organisation and four Divisions: Medical, Surgical Specialist Services and Community.	None	Not applicable (N/A)	
1.2 There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	Reporting and Monitoring within the Organisation structure though groups and direct to Trust Board, including Executive Scrutiny Committee, Quality and Safety, IPC Group, Organisational and Divisional Governance and Assurance Structures and Groups. Infection data reporting and surveillance to UKHSA National Data Capture System and within internal reporting systems. Review process in place for Mandatory HCAI Organism reporting.	None	N/A	
1.3 That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	Evidence of active reporting within Trust incident reporting system and Ward/ Divisional level/ Governance structures. IPC requirements included in PPE needs analysis. General Reporting arrangements for incidents and near misses exist via DATIX. Trust Risk Assessment Process encourages identification and use of	None	N/A	

	control measures which protect the collective as well as the individual.			
1.4 They implement, monitor, and report adherence to the NIPCM.	Systems and processes are in place to ensure IPC practice aligns with the National IPC Manual (NIPCM), Trust Policies and Standard operating procedures (SOPs). Published NIPCM version updates are shared across the Organisation, with the DIPC, Medical Director, Clinical Leads, and all Divisions. The IPC Audit Programme monitors practice with the audit standard defined as compliance with the ten Standard Infection Control Precautions and Transmission based precautions of the NIPCM. Compliance feedback, any identified learning and good practice is shared with staff, with educational opportunities provided as indicated and requested. Monthly compliance reporting is shared with Divisions and Services, Quarterly and Annual reporting to Quality and Safety, IPC Group. Compliance against NIPCM is included within mandatory HCAI Review Process, i.e., C.*difficile* infection and Gram-negative bloodstream infections (GNBSI) case reviews. The ASPIRE Programme also aligns with the NIPCM as a standard during ward accreditation.	Health and Safety Executive (HSE) Inspection with a focus on Medical Sharps on 04.05.2023, included interviews with colleagues from across the Organisation, including Estates Services, Health and Safety, IPC, Occupational Health, Waste Management. Findings identified learning, from an Educational perspective.	IPC Team have contributed to the Organisational: Sharps Safety Education. This followed the HSE Inspection Visit and feedback in May 2023. An audit of sharps practice planned for 26.06.2023, to include clinical areas across the Divisions, including Hospital and Community services settings. Feedback and Learning will be shared.	
1.5 They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	Infection reporting and surveillance to UKHSA National Data Capture System and within internal system reporting. Review process in place for Mandatory HCAI Organism reporting.	None	N/A	

	Datix reporting system in place for reporting patient safety incidents, including confirmed mandatory reportable organisms, and outbreaks of infections with investigation via StEIS for outbreaks, and via PSIRF for mandatory organisms. Patient safety incidents are reviewed and monitored by Divisional and Organisational Governance structures/ Executive Scrutiny Group and IPC Group. Quarterly and Annual reporting via Quality and Safety Group. External reporting of Outbreaks via NHSE App. Notification of infections are reported to UKHSA as required. Evidence of Organisational communications and updates to reinforce the required Notification process to UKHSA. This was evident in response to the National Alerts of increased incidence of Measles infections Nationally. Trust colleagues are collaborating with Local Authority and ICS colleagues to support local Measles planning workstream.			
1.6 Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	Ward and Service area visits, Walk Abouts and ASPIRE accreditation visits completed by the Senior Leadership Team, including DIPC and DDIPC, Senior Nurses and Governance to provide challenge and learning opportunities to support staff, compliance, and patient safety. The visits extend to include multiple areas of care, leadership, management, learning, staff wellbeing and development.	Audit Programme in place with increase in activity by the IPC team during Quarter 1, now working towards the delivery of a robust audit programme and visibility within clinical areas. Changes to IPC Nursing	Increasing resources and capacity within the IPCT. IPC business case not progressed. Recruitment of Band 8a IPC Lead following retirement of the previous post holder. Now in active recruitment process, expected start date: 1.9.2023.	

	IPC Team provides supportive visits to clinical/ practice areas in both hospital and community settings. Audit of IPC practice includes all staff members, including external contractors and staff who may be working from an agency or Bank. Feedback is given to individuals as required. The IPC Audit Programme and ward-based assessment and audits contribute to compliance of practice. Educational and learning opportunities are adopted to support compliance with good practice. It is planned to support Hand hygiene technique, PPE compliance, CAUTI and hydration agendas during Q2. A Trust wide Urinary Catheter Point Prevalence Audit is in plan for Q2, in collaboration with the Trust Clinical Audit Lead and CAUTI Lead. The Audit will be extended to Care Homes and Hospice Services within the Borough for inclusion. Resources are in preparation for cleanliness of equipment and environment initiatives during Q2.	establishment due to vacant roles, recruitment process, retirement, long term sickness and annual leave.	Additional funding agreed for an IPC Nurse secondment post, Band 6, successful and active recruitment/ pre-employment checks. Expected start date: 1.8.2023. Phased return and reduction in hours going forward for Band 7 post holder following Long-term sickness. Hours reduced to 25.5hrs from 1.7.2023. Resignation of Band 7 IPC Nurse for Promotion. Leave date: 28.7.2023 Active recruitment process in place for two Band 7 IPC Nurses (To replace vacant post, reduction in hours and retirement)	

1.7 All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	Mandatory Training compliance rates have increased during Q1 2023/24 from the Q4 2022/23 position: ▪ IPC Level 1: June 2023: 97%, May 2023: 96%, April 2023: 96% ▪ IPC Level 2: June 2023: 90%, May 2023: 90%, April 2023: 88%. ▪ Bowel Management: June 2023: 90%, May 2023: 92%, April 2023: 91%. ▪ Cavendish Induction Education and Link Practitioner Education has been delivered during May and June 2023. ▪ IPC Team target support and educational opportunities within ward areas in response to audit feedback and requests from colleagues. ▪ IPC Team have contributed to the Organisational: Medical Sharps Safety Education. This followed the HSE Inspection Visit and feedback on 04.05.2023.	None	N/A	
1.8 There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (Community care and Outpatient settings, Acute in-patient areas)	Trust Risk Assessment Process encourages use of hierarchy of controls (eliminate, substitute, engineering controls, administrative controls, PPE) within Trust Division and Services, including Community care, Outpatient settings, and Acute in-patient areas.	None	N/A	

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				
System and process are in place to ensure that:	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**RAG Rating**
2.1 There is evidence of compliance with National cleanliness standards including monitoring and mitigations (excludes some settings e.g., ambulance, primary care/dental unless part of the NHS standard contract these setting will have locally agreed processes in place).	Compliant with standards and monitored in line with National Cleanliness Standards (NCS). All results identified and presented to IPC and shared with Wards and Departments.	None	N/A	
2.2 There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	Fully Compliant, in 2022 WWL place assessments where completed and we were placed 5th Nationally and 3rd within region. Awarded 100% cleanliness.	None	N/A	
2.3 There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	▪ WWL meets compliance in all clinical areas and meet the NCS. ▪ Audits are undertaken following guidelines from NHSE and displayed accordingly across the trust in public areas.			
2.4 There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	2.4.1 - Critical ventilation systems are subject to independent (IOM) annual inspection and verification as per HTM 03-01. Likewise, all new ventilation systems are independently validated. A Trust Policy and SOPs document this process. Trust reporting and overview is via a Trust Ventilation Working Group (VWG) and the Trust IPC Group. 2.4.2 - A Trust Policy and SOPs document the process for achieving L8/ HTM 04-01 compliance. The Trust also employs an independent water safety specialist (AEC) that provides advice, guidance, and oversight. Trust reporting and overview is via a Trust Water Management Working Group (WMWG) and the Trust IPC Group.	2.4.1 - Some critical ventilation systems pre-date the HTM 2025 and HTM 03-01 documents - however these facilities are still verified on an annual basis. Any performance below HTM 03-01 standards is documented and Risk Assessed. However, all Theatre (and similar invasive	2.4.1 - Inspection and verification reports create action plans that are resolved or escalated for funding etc, as appropriate. Oversight and reporting via VWG and IPC Group. 2.4.2 - Routine Legionella and Pseudomonas sampling is undertaken. If required action plans are developed and actioned with	

		facilities) UCV or air changes performance is confirmed as being to HTM 03-01 standard. 2.4.2 - Some older areas do not always achieve the L8 / HTM 03-01 Thermal Regime temperatures - in such instances compliance is achieved via routine Legionella sampling. However, this sampling (recognised method of compliance) proves that Legionella is not an issue across those areas.	oversight and reporting via WMWG and IPCG. Under this process WWL is proven not to have persistent Legionella or Pseudomonas colonisation.	
2.5 There is evidence of a programme of planned preventative maintenance (PPM) for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	2.5 - Operational Estates PPM Programme is documented via a Trust Policy and are visible via BORIS/ MICAD systems etc. IPC audit areas with action plans developed and actioned with Estates. Estates and IPC liaise closely and via VWG, WMWG and IPC Group reporting. Estates new build and refurbishment designs are reviewed by IPC/ Estates in line with HTM 00-009 etc. Sterile Services and Decontamination Unit (SSDU) at Bolton and Endoscopy	2.5 - Estates and IPC liaise closely and via VWG, WMW Group and IPC Group reporting. Estates new build and refurbishment designs are reviewed by IPC/ Estates in line with HTM 00-009.		

	Reprocessing Unit (ERU) are audited annually by external persons to provide assurance that the units are compliant to relevant regulations. 2.5 - Estates and IPC liaise closely and via VWG, WMW Group and IPC Group reporting. Estates new build and refurbishment designs are reviewed by IPC/ Estates in line with HTM 00-009. 2.5 - Any derogations (if applicable) are Risk Assessed and suitably agreed / documented.			
2.6 The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Trust operates a daily top up service to ensure adequate linen meets all areas and patient needs.	None	N/A	
2.7 The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Waste Management Policy and associated SOPs in place including SOP 2: Category A Waste and Segregation, SOP 3: Waste Management Procedures and SOP 5: Community Nursing – Dangerous Goods and Waste Procedure. Organisational systems in place for reporting, identification, mitigating and monitoring of incidents. The Organisational Datix reporting system is operational with evidence of incident reporting by staff. Waste incidents are raised on Datix are investigated by staff through the Governance process. Risk Assessments are in place and monitored at Corporate and Division level. Trust Waste Management Audit Programme is operational and includes,	None	N/A	

	Internal Waste Audits Programme completed by the Waste Management Team. External Audits: Annual Pre-Acceptance Clinical Waste Audits and Dangerous Goods Audits carried out annually by External Auditor. Any identified learning is provided to the staff and Organisation, audit plans completed by Divisional staff and monitored by the Waste Management Team with Quarterly reporting as above with escalation as indicated to Executive Lead, via Health and Safety Groups, Divisional Groups, and Governance Leads. Plan to receive the Quarterly Waste Report at the IPC Group. Action noted: New Waste management posters and pedal bin labels implemented across the Trust. Waste Management Training included in: Mandatory Clinical Waste Management training e-module for all clinical staff, porters, housekeepers and domestic supervisors every three years and new starters. Face to face Waste 'toolbox' as part of Trust Induction for new starters. Community Services Link Nurse training. Bespoke training and learning opportunities are enabled as requested and indicated.			
2.8 There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	SSDU at Bolton and both ERU are audited annually by external persons to provide assurance that the units are compliant to relevant regulations. External audit to ISO 13485 2016 and UKCA part II medical device regulations.	None	N/A	

	AE(D) audit to Joint Advisory Group: on GI Endoscopy (JAG) Accreditation.			
2.9 Food hygiene training is commensurate with the duties of staff as per food hygiene regulations. If food is brought into the care setting by a patient/service user, family/carer, or staff this must be stored in line with food hygiene regulations.	**Food Safety Policy** in place. The Trust is committed to ensuring the production and service of food and drink on its premises, to the highest quality standard and the Policy aligns with The Food Safety Act 1990 as amended and The Food Safety and Hygiene (England) Regulations 2013 as amended, and additional associated regulations to cover the full scope of food and drink production from, construction of premises, registration of food businesses, to temperature controls, risk assessment and training. The Food Safety Policy links to SOP 1: Ward kitchen Food Safety SOP 2: Charity Bake Sales SOP 3: Allergen Aware procedure **Food Hygiene Training:** The Trust Catering Service staff are compliant with qualification requirements: Facilities/ Catering Service Manager: Level 4 Operational Managers: Level 3 Catering staff: Level 2 **Food Storage:** Ward /kitchen -food safety (SOP) associated with TW14-006 Food Safety policy. The standard operating procedure (SOP) covers all ward kitchens and any in patient or outpatient area that serves food or drink to patients	**Educational** need: For Matrons and Ward Leaders. For all ward staff, volunteers preparing or serving food and drink to patients **Food Storage:** Visitors should be discouraged from bringing in food for patients. If this does happen it must be labelled clearly with the patients name and date and be consumed on that day. Any food stored will be discarded at the end of the evening meal staff by the catering staff	Proposed learning package for Matrons and Ward Leaders. Proposed Food Safety Awareness training for all other trust wide staff who prepare or serve food and drink to patients. Completed awaiting implementation to E-Learning **Food Storage:** Propose minimum of ambient food to minimise the risk . Trust wide food safety awareness training	

3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance				
Systems and process are in place to ensure that:	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**RAG Rating**
3.1 If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated. Recruitment of new/ Microbiologist discussed at Senior Meeting (Risk Management Group). Microbiology provision remains on Organisational Risk Register Assessment: reviewed by Risk Management Group	AMS Formal Lead identified: Medical Director. The Trust has a nominated Microbiologist and Antimicrobial Pharmacist with the following provision: Substantive Consultant Microbiologist available 09:00hrs to 13:00hrs, Monday to Friday. Within a typical work week, two AMS ward reviews are performed. Data collected by Antimicrobial Pharmacist and discussed with the Consultant Microbiologist.	Inability to deliver AMS activity if there are competing clinical commitments, due to the lack of availability of the nominated staff: Microbiologist from 13:00hrs.	Availability of Antimicrobial Pharmacist 09:30hrs to 17:30hrs, Monday-Friday. Additional resource required to deliver AMS: Microbiology and Antimicrobial Pharmacist. Microbiology recruitment discussed at Senior Meetings: Risk Management Group/ Corporate Risk Group. Microbiology provision remains on Organisational Risk Register Assessment: reviewed by Risk Management Group	
3.2 The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	Minutes of Medicines Management Safety Group and IPC Group when reports are added to the agenda. Reporting of AMS activities presented within annual and quarterly reporting to the Trust IPC Group and Quality and Safety Committee.	Limited AMS activity due to the lack of availability and capacity of the nominated staff: Microbiologist and Antimicrobial Pharmacist	Additional resource required to deliver AMS: Microbiology and Antimicrobial Pharmacist.	
3.3 There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	Executives on the Board: DIPC and Medical Director	None	N/A	

3.4 NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored: • To optimise patient outcomes. • To minimise inappropriate prescribing. • To ensure the principles of Start Smart, then Focus are followed.	Hospital perspective: Activity listed against *Smart Start then Focus*. 1. Daily review of Therapeutic Drug Monitoring antimicrobials by the Antimicrobial Pharmacist 2. Two weekly reviews of ward prescribing (see 3.2) 3. Three weekly MDT between a Locum Consultant Microbiologist, Antimicrobial Pharmacist, and Anaesthetist team on Intensive Care Unit 4. One weekly review of "Reserve" list antimicrobials to improve compliance with the NHSE Standard Contract.	No resilience in the system to cover for absences through illness or planned annual leave. Substantive post: Microbiologist resource required	Additional resource required to deliver AMS: Microbiology and Antimicrobial Pharmacist.	
3.5 Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • total antimicrobial prescribing. • broad-spectrum prescribing. • intravenous route prescribing. • treatment course length.	Chief Pharmacist: Update from CQUIN against NICE: Intravenous Oral Switch (IVOS) Gathering and reporting to monitor against improvement schemes Quarterly and annual reporting within the Organisation. Included as part of evidence: 2, 3, 4 in (3.4). Also, forms the basis of point prevalence reports completed during a financial year: 1. Two Trust wide Point Prevalence Audits, completed twice a year (typically March and October). 2. One Divisional Point Prevalence Audit completed once a year (typically between June-September).	Requires post/ role whole time equivalent (WTE) of 15 hours to complete data collection, can take WTE of a further 15 to 30hrs to analyse, verify and report on the collected data.	Additional resource required to deliver AMS: Microbiology and Antimicrobial Pharmacist.	
3.6 Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	One part-time substantive Consultant Microbiologist providing Six sessions per week, supported by Two Locum Microbiologist's, providing 20 sessions per week. Antimicrobial Specialist Pharmacist	Limited Microbiology and Antimicrobial Pharmacist provision to support AMR and	Current virtual microbiology provision with one part-time substantive and two locum roles in place. Dedicating	

	provision: 09:30hrs to 17:30hrs, Monday-Friday, supported by a Pharmacy Technician. Activity as above: including, in addition Antimicrobial policy reviews.	Antibiotic Stewardship agenda/ activities and educational activities. Recruitment difficulties in securing permanent posts. No in-built resilience within the Microbiology provision.	approximately one and half sessions per week dedicated to AMR/ AMS. Risk Assessment in place at risk rating of 25. Additional resource required to deliver AMS: Microbiology and Antimicrobial Pharmacist.	
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care, or treatment nursing/medical in a timely fashion				
Systems and processes are in place to ensure that:	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**RAG Rating**
4.1 Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	Patient information leaflets are developed within the Trust recognising the needs of the local population in collaboration with the process as above. Collaboration with local authority, ICS colleagues supports development of Borough wide activities, and the development of leaflet/ information resources. National resources are also available, aligned with current agendas, initiatives, i.e., Measles for example with UKHSA resources, Immunisation/ Vaccination, in line with recent National and Regional communications. Leaflets are available to everyone, including patients, public and staff, are uploaded and available via the trust website, via digital and paper formats. IPC Leaflets are developed in collaboration with Divisions, Department	None	N/A	

	and Trust staff, including lay readers and are reviewed and approved by the IPC Group. Programme of review in place.			
4.2 Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (e.g., digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	Patient information leaflets are developed within the Trust in collaboration with the IPC Team and the Patient Experience and Engagement Department with the process co-ordinated by the Patient Information Facilitator. Review and approval, aligns with Trust Patient Information Policy. Leaflets are available for staff only, in-patients, out-patients within departments and areas, in both digital and paper formats, via staff intranet. Leaflets available to everyone, including patients, public and staff, are uploaded and available via the trust website. IPC Leaflets are developed in collaboration with Divisions, Department and Trust staff, including lay readers and are reviewed and approved by the IPC Group.	None	N/A	
4.3 The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	IPC information is available to support IPC measures and initiatives and workstreams with current activity focus including, hydration, hand hygiene for in-patients and staff, CAUTI, reduction of GNBSI and CDI.	Limited Microbiology provision to support AMR and Antibiotic Stewardship agenda/ activities. Recruitment difficulties in securing permanent posts.	Current virtual microbiology provision with one part time substantive and two locum roles in place.	
4.4 Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are	Aligned with IPC Work programme, National IPC Manual (2023), Trust Policies, guidance, and SOPs:	None	N/A	

clearly outlined to support good standards of IPC and AMR and include: • Hand hygiene, respiratory hygiene, PPE (mask use if applicable) • Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (e.g., cleanliness) • Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. • Provide published materials from national/local public health campaigns (e.g., AMR awareness/ vaccination programmes/ seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/ service users, care givers, visitors, and advocates to minimise the risk of transmission of infections.	IPC Audit and Educational programme. Cleaning aligned with National Cleanliness Standards. IPC collaboration with Estates and Facilities AMR/ Antimicrobial Stewardship: Antimicrobial Pharmacist, Technician and Microbiology. ASPIRE Programme and quality improvement initiatives/ projects. Patient information leaflets. Annual Vaccination Programme: Influenza/ COVID-19. Current focus on Measles, with communication of information within Divisions, specific information to Emergency Village, Walk-in-Centre, Urgent Care Areas, Occupational Health including: UKHSA information and resources, early identification of cases, prevention of transmission, testing and notification of infection requirements, vaccination/ immunisation of patients and staff.			
4.5 Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	Electronic systems support flagging and recording infectious status within HIS. Documentation within patient records/ care plans of care and treatment. Transfer documentation processes and documentation for transfer and discharge of patients to home, other organisations/ services/ social care/ care home/independent care settings/ inter healthcare transfers. Catheter passport in operation within all Divisions, including community, hospital and home/ out of hospital settings.	None	N/A	

5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.				
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**RAG Rating**
5.1 All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have or are at risk of developing an infection, receive timely and appropriate treatment to reduce the risk of infection transmission.	Medical/ Nursing review and admission processes in operation, include screening for specific organisms, on admission/ transfer. Scheduled screening is operational within augmented care areas (ITU/Neonatal areas). Microbiology, Antimicrobial Pharmacist support Senior Medical/ Consultant reviews. Sepsis screening, NEWS/ PEWS, and deteriorating patient procedures. Early identification and isolation in line with Trust Policies/ SOPs.	None	N/A	
5.2 Patients' infectious status should be continuously reviewed throughout their stay/period of care. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	IPC and Microbiology provide seven day and On-call Service support (in collaboration with Salford Pathology Services). Continued surveillance and review of laboratory result via electronic notification system. Result reporting systems accessible by Medical/ Nursing and IPC/ Microbiology Teams. IPC manage and support patient placement/ isolation/ cohorting in collaboration with Ward, Operations and Bed Management Teams. Electronic HIS patient management system for recording/ documentation.	Limited capacity to segregate within ED. IPCT, Estates, Operations and ED Teams continue to collaborate to identify options to enable safe patient placement where isolation is required. Lack of isolation facilities at RAEI.	Risk assessment for further reassessment due to continued lack of isolation capacity and facilities.	
5.3 The infection status of the patient is communicated prior to transfer to the receiving	Planning for transfer and communication of infection status is operational for all patients being discharged to place of	None	N/A	

organisation, department, or transferring services ensuring correct management/placement. ▪ This is adopted whenever possible and practicable in conjunction with IPC, Bed Management and Operations Teams. ▪ Microbiology results are obtained and documented in HIS before patients are moved to designated COVID negative or positive wards. ▪ The process to limit movement of the patient contacts of a positive case, during the isolation period continues to operate. An IPC Team member attends the daily bed meetings to support appropriate patient placement.	residence or transfer to another care organisation. COVID-19 testing continues 48 hours prior to all planned discharges to Care home settings in line with UKHSA guidance, discharge paused, isolation period commenced and negotiation with Care home for discharge planning.			
5.4 Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Signage available within Emergency Care Centre/ Walk-in-Centre/ Urgent Care areas to alert respiratory symptoms to enable IPC measures. Communications Alerts in response to Measles to key areas re the measures required for early identification and prevention of transmission, with identified isolation area, avoiding waiting room area.	None	N/A	
5.5 Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	All outbreaks are reported and investigated by IPC Team. Datix reporting and StEIS investigation in line with patient safety incidents/ PSIRF. External and internal reporting processes in place. Close IPC links/ collaboration with Organisational and Divisional Governance structures.	None	N/A	

6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				
Systems and processes are in place to ensure:	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**RAG Rating**
6.1 Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	▪ Mandatory Training rates have increased against the Trust target of 95% for IPC Level 1 but not achieved target for IPC 2 and Bowel Management: ▪ IPC Level 1: June 2023: 97%, May 2023: 96%, April 2023: 96% ▪ IPC Level 2: June 2023: 90%, May 2023: 90%, April 2023: 88%. ▪ Bowel Management: June 2023: 90%, May 2023: 92%, April 2023: 91%. ▪ Cavendish Induction Education and Link Practitioner Education has now recommenced. ▪ IPC Team target support and educational opportunities within ward areas in response to audit feedback and requests from colleagues. IPC Team have contributed to the Organisational: Sharps Safety Education. This followed the HSE Inspection Visit and feedback in May 2023.	None	N/A	
6.2 The workforce is competent in IPC commensurate with roles and responsibilities.	See above section: 6.1	None	N/A	
6.3 Monitoring compliance and update IPC training programs as required.	See above section: 6.1	None	N/A	
6.4 All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their	Trust offers a selection of five (5) types of disposable respirators which wearers may be tested to. Wearers are provided with a test to each specific model as part of fit testing process staff are instructed	None	N/A	

place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	in correct methods to select, don, and doff FFP3 respirators, repeated every two years or sooner if there is a change related to the wearer which may affect fit. Where a fit test is failed or refused (e.g., due to facial hair for religious reasons) an alternative Powered Air Respiratory Hood is offered. Wearers are trained by the mask fit team in the assembly, checking, donning, wearing, doffing, decontamination, disassembly, storage of the powered respirators. Hood wearers are issued with a maintenance guide, pre use checklist and inspection record (in line with manufacturer instructions) which is periodically audited.			
6.5 That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	Testing carried out by Central Mask Fitting Service and a small number of local testers who are trained by RPA Ltd to relevant HSE standards. Record of fit test result held on central database. Work ongoing to record evidence onto ESR. Reusable respirators are used by a small cohort of non-clinical staff. Testing by same central service with records maintained on central database/ for upload to ESR. Staff who carry out fit test training are trained and competent to do so. A register of trained mask fit testers is maintained, and all staff have completed the half-day Mask Fitting Train the Trainer Course. This course is repeated every two years.	None	N/A	

6.6 If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Practice Educators have led on clinical skills training i.e., Aseptic Non-touch Technique (ANTT) Training from April 2023 for Clinical staff. A review of ANTT education has been undertaken and a validated ANTT Education programme is to be delivered by an external provider. This will enable cascade trainers to be upskilled and educated to deliver an internal "Train the Trainer" ANTT Programme. Competency assessments will be included. The Programme will be supported by IPC. **Medical Device insertion:** Medical educators take responsibility for Registered Medical Practitioners for insertion of complex invasive/ Central access medical devices. Education/ Training: Local Surgical Induction for Device insertion training for Post graduate Medical staff. Within registration requirements for Senior Medical staff. **Vascular Access Devices (VAD)**: The VAD Team provide training for the management of vascular access devices in Acute/ Complex areas i.e., ITU and defined ward areas. **Venepuncture and Canulation:** Education delivered by Clinical Education Team for all Registered Nursing/ Midwifery and un-registered B3/ B4 roles if required for a specific service. **Blood culture sampling:** The education/ training programme is currently under review and consideration being given to a Pilot within ED to align with the ANTT	Central Trust Register for Clinical Skills and Device insertion Training and Competency records.	To review the availability of an Organisation recording system and process and to establish aligned with current educational and training workstreams and programmes.	

	principles/ programme, by the Sepsis Lead, Professional Practice Team and Medical Clinical Skills and Simulation Lead. **System for recording training and competency records** for Foundation Year (FY) trainees (Medical staff). Education and training for FY1 and FY2: Trust Co-ordinators, Medical Educators/ Medical Clinical Skills Simulation Lead via Induction, e-learning venepuncture and canulation in collaboration with Trust and University Sign-off. Medical students education / training under supervision/ Simulation.			

7. Provide or secure adequate isolation precautions and facilities				
Systems and processes are in place in line with the NIPCM to ensure that:	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**RAG Rating**
7.1 Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Medical/ Nursing review and admission processes in operation, include testing and screening for specific organisms, on arrival/ admission to hospital settings. Scheduled screening is operational within augmented care areas (ITU/Neonatal areas). Microbiology, Antimicrobial Pharmacist support Senior Medical/ Consultant reviews. Sepsis screening, NEWS/ PEWS, and deteriorating patient procedures. Early identification and isolation in line with Trust Policies/ SOPs. Results and presenting clinical status determines patient placement decisions and the required IPC precautions in line with the NIPCM.	None	N/A	

	Alerts are added to the HIS banner to alert staff to patient infectious status.			
7.2 Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: • Single rooms are in short supply and if there are two or more patients with the same confirmed infection. • There are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	IPCT, Bed Managers, Operations and Emergency Department (ED) Teams continue to collaborate to identify options to enable safe patient placement where isolation is required and during the management of outbreaks. IPC attend bed meetings daily to support patient placement decisions. The IPC Team maintains surveillance and review of suspected and confirmed cases of infection. Outbreaks are reported and managed by the IPC Team/ Microbiologists as identified with consideration to single and cohort isolation. Trust Policies and SOPs support solation and outbreak management and decision making, aligned with the NIPCM/ Transition based precautions. Winter Planning is being considered including testing arrangements. New testing equipment is available but the staff group to perform the testing and recording of results testing requires identification and once identified staff will require education and training to undertake the procedure. DDIPC engagement with capacity planning for current and winter pressures.	Lack of side room capacity to consistently isolate patients as required.	There is a risk assessment in place due to the lack of side room capacity. IPC attend bed meetings daily to support patient placement decisions. A DATIX is completed by staff when patients are unable to be isolated. And mitigating measures put in place to maintain safety. DDIPC, Operations and ED Teams engagement with capacity planning for current and winter pressures.	
7.3 Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	Trust Policies and SOPs support solation and outbreak management and decision making, aligned with the NIPCM/ Transition based precautions.	None	N/A	

	IPC Audit Programme in place and active to monitor practice in line with NIPCM.			
7.4 Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.,) must be made aware of the required precautions.	This is managed in collaboration with Bed Managers, Operations Team, and IPC Team. Discharge planning and communication of infection status is operational for all patients being discharged to place of residence or transfer to another care organisation. COVID-19 testing continues 48 hours prior to all planned discharges to Care home settings in line with UKHSA guidance, discharge paused, isolation period commenced and negotiation with Care home for discharge planning.	None	N/A	

8. Secure adequate access to laboratory support as appropriate: ***No changes within this Criterion*** ***Compliance with Criterion 8 demonstrated***				
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**RAG Rating**
8.1 Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	Pathology Services provided by Salford. Collaborative working and meeting attendance with Wigan and Salford Pathology Service providing testing.	None	N/A	
8.2 Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	Pathology service and reporting process in place and delivered via contractual arrangements: Pathology at Wigan and Salford providing testing. Microbiology service available 24 hours through working hours and On-call services (IPC and Microbiology).	None	N/A	
8.3 Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as	Collaborative working and meetings aligned with contractual arrangements for Pathology at Wigan and Salford providing testing.	None	N/A	

part of contract monitoring and laboratory accreditation systems.	Monitoring of turn-around times observed by Microbiology and IPC. Business arrangements managed by Medical Directorate/ Division.			
8.4 Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	Compliant: Systems and processes in place, aligned with National Guidance: NHSE and UKHSA. Trust Policies, SOPs, and Flowcharts available for staff. Organisational updates to communicate guidance updates/ changes.	None	N/A	
8.5 Patients/service users who develops symptom of infection are tested/ retested at the point symptoms arise and in line with national guidance and local protocols.	Compliant in line with Trust Policies and SOPs in line with National guidance as applicable. Microbiology and Pathology Services in place.	None	N/A	
8.6 There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	Microbiology Services are available in-house/ local during working hours with On-call Microbiology Service to support outside of working hours providing 24 hours service and support.	None	N/A	
8.7 There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	Compliance with Service agreement provided by Salford Pathology Laboratories Service in collaboration with Wigan: Pathology at Wigan and Salford.	None	N/A	
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections. ***Compliance with Criterion 9 demonstrated***				
Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, A to Z pathogen resource, and the NIPCM).	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**RAG Rating**
9.1 Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes	Compliant with a process of policy review/ update in plan.	None	N/A	

monitoring, recording, escalation, and reporting of an outbreak/incident by the registered provider.	Trust policies, procedures, and SOPs in place. Process for review and approval of Policies and SOPs through IPC Group. Outbreaks managed by IPC/ Microbiology, with collaboration with Bed Managers, Operations Team. External and internal reporting procedures/ arrangements in place, and communication of outbreak both internal and within local ICS and Local Authority colleagues.			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.
Compliance with Criterion 10 demonstrated

Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**RAG Rating**
10.1 Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	Compliant: Process and arrangements in place. Initially completed by Manager and then referred to OH for specialist advice as appropriate.	None	N/A	
10.2 Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	Process and arrangements in place. Audit of practice and staff knowledge of process and actions to take following an exposure. Reporting process via Occupational Health and Datix. Incident reporting by Occupational health received via IPC Group meetings. Medical Sharps Awareness even in planning phase, will be extend to Trust staff.	None	N/A	
10.3 Staff have had the required health checks, immunisations and clearance undertaken by a	Compliant: Process and arrangements in place.	None	N/A	

competent advisor (including those undertaking exposure prone procedures (EPPs).				

Reference: NHS England. Infection Prevention Board Assurance Framework. Version 1. Published April 2023

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Guardian of Safe working Hours Quarterly Report QTR 3 2022 -2023
Presented to:	Board of Directors
On:	02 August 2023
Item purpose:	Information
Presented by:	Dr Shams Khan Guardian of Safe Working Hours
Prepared by:	Shams Khan, Leanne Preston 09 Feb 2023
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Executive summary

Hours and rest Exceptions:
Medical 34
- Cardiology 1
- Gastroenterology 4
- Elderly Care 1
- General Medicine 28

Surgical 10
Urology 4
Obstetrics 21
Paeds 2
Orthopaedics 1

Link to strategy and corporate objectives

Safe staffing and staff wellbeing – many exceptions comment on poor staffing levels. This and an inability to take breaks and leave on time are negative influences on staff well-being.

Risks associated with this report and proposed mitigations

Risks with Obstetrics are that other potential fines are possible if the rota is identified as starting at 9 am but trainees are being asked to start at 8am. Burnout and trainees going off with stress have occurred due to high workload. Mitigation is through the exception reporting process where the

interaction between trainee and educational supervisor should highlight issues to local teams and rota co-ordinators.

Financial implications

Junior doctors are paid for their Exceptions if they are unable to be given time back and this is frequently the case. One fine has been identified from Obstetrics last year

Legal implications

Exceptions do represent a breach of the working contract

People implications

The more detailed exceptions show the stress of multiple tasks on a junior doctor. The organisation has experienced junior doctors suffering burn out and having time off work through sickness because of this

Wider implications

Junior doctor burnout and clinical incidents are the most significant risks. I notice also the stress on rota co-ordinators trying to ensure adequate cover to clinical areas

Recommendation(s)

Present findings to LNC, JDF and People's Committee
Stressing the importance of junior doctor and educational supervisor interaction for each exception produced

Report

Reviewing the above, the surprise this quarter is Obstetrics. The reports were put in by core trainees and foundation year 2 trainees. Many had to do with theatres over running but it is also clear that the rota has them down to start at 9 am whilst in practice they have to start at 8 am. This is something that should be dealt with by the Obstetrics rota co-ordinator. There was a fine last year from obstetrics due to theatres over running and that trainee having to come in the following day without the required amount of rest. It is errors such as the ones described in the exceptions (rota being timetabled for 9 am start but duties starting at 8am) that could lead to fines.

Medical and surgical exceptions are at a number I would expect. Reports highlight higher workloads due to staff shortages and again, patients deteriorating suddenly. I have noticed that the completion of bereavement paperwork after a night shift has appeared in one report and jobs from the medical examiners office has appeared in a further 2. The majority relate to the complexity of medical cases and the high workload that comes with unwell medical patients.

Surgical Exceptions are similar – there are many patients to see on a take leading to ward rounds over running and also complex cases. I note that clinics are being missed by trainees because of excessive ward work and doctors are missing breaks.

The paediatric reports were put in by a senior trainee who had to stay back to deal with unwell children, assisted by a resident on call consultant.

The one trauma and orthopaedic case stemmed from a high number of cases and the reporting doctor having to support a newly starting doctor who is unfamiliar with the system.

I noticed that one exception was due to October's clock change. There has been agreement at national level that the extra hour worked is exception reportable. The recommendation, nationally, is that individual departments should account for this hour change locally within their rotas. This is less important for a one hour of TOIL or payment but more to avoid an inadvertent fine.

Appendices

Gen Surg

1 hour
Stayed back till 930pm because there were too many patients to see and registrar and I had to create a new list before the handover hence handover was delayed. Ward rounds with consultant ended at 2pm because there were too many patients to see.
Had to stay an extra 45 mins. Matt was in for a half day and I had a very unwell patient so was behind on my jobs for the day. So I had to stay to finish the jobs as well as continually checking the unwell patient
I worked for an extra hour on this date due to it being hot week and being the only junior doctor on urology that day
Unable to attend clinic as minimum staffing
Unable to attend clinic due to poor staffing combined with poor scheduling
Unable to attend clinic due to poor ward staffing and poor timetabling
Unable to attend clinic due to poor scheduling and lack of staff on the ward
Unable to attend clinic due to combination of poor clinical staffing and lack of available clinics that fit with FY1 teaching. Alongside not formally bring explained how to find available clinics
Stayed late due to clinical demand as multiple unwell patients - ICU involvement
I was 10 minutes late for grand rounds due to speaking to an unwell patients family and updating them with the registrar.
Had to stay an extra 45 mins. Matt was in for a half day and I had a very unwell patient so was behind on my jobs for the day. So I had to stay to finish the jobs as well as continually checking the unwell patient
Clocks went back so worked an extra hour for shift, was told to exception report to get paid for this.
One hour extra worked as a result of DST change
I had to stay back for another hour to do discharge letters as there was only one EPR doctor during this shift and I was asked to do about 7-8 discharge letters on top of my urology work. I understand that EPR doctors are supposed to do discharge letters but it was really hectic today as ward rounds finished about 130-2pm and I had an hour and half to chase other jobs. There weren't any doctors available to handover as on call doctors were still doing ward rounds.
I was meant to be at teaching for 12:30 but didn't arrive till 12:31. This was due to the nurses asking me to go and explain to a patient what was happening with her treatment. I thought this would be a 10 minute conversation but she became quite upset so needed to spend

more time than I anticipated with her. I therefore had to sign the late register for teaching and was asked to exception report it,
I worked for an extra hour on this date due to it being hot week and being the only junior doctor on urology that day
I had to stay past my scheduled time to resolve non-urgent task that would otherwise burden the second on call FY1. This was due to persistently poor staffing levels leading to delayed discharges, inability to access seniors for discussion and review. I believe my colleagues are going to file a Date report regarding this. Support has been very lacking during that day as it was understaffed. I was not doing on call but the consultant had dragged me along to his additional post-take ward round which made it more difficult to finish all the task in time.
Was one minute late for grand rounds because I was reviewing a patient before going for grand rounds.
unable to take 1 hour of 1.5 hour breaks for long oncall shifts. on call covering ent gen surg and urology. i was doing on call jobs, called to see/assess patients and doing jobs from the post take ward round. same situation as sunday. i was on call and had to assist the epr doctor with discharging patients. she left later than the end of her shift on both days.
not able to take 1 hour of weekend shift 1.5 hour breaks due to unmanageable workload. i am fy1 covering urology, ent and gen surg patients. i managed to have 20 minutes for lunch. it was wigan hot week and urology workload was massive. despite being on call i had to also assist the epr shift doctor with discharging patients

Gen Med

20 minutes
Missed my allocated SDT time as we were short on doctors for the afternoon
Had to stay back late due to poor staffing and staff illness
started early due to MDT, was due to finish early in recompense. Ended up finishing late due to clinical requirements that could not be handled in time by my other F1 alone
worked later due to the post-take ward round only starting at 12.30pm instead of 8am
stayed 2 hours late with the registrar because there was an unwell patient and the on-call team were not answering/available to hand over to
Stayed 1hr late
Suppose to get 3 half hour breaks on a night shift. I didn't get to take any breaks because it was too busy.
I worked a night shift with no SHO from the 8th December till 9th December
Was dealing with a sick patient at 11pm and the other doctors on call were also dealing with very sick patients. This delayed me handing over jobs to the night F1.
I was due to finish at 11pm, but there was an arrest call just before 11. This resulted in my handover being later than excepted.
I was on the twilight shift and wasn't due to start work until 4pm. I had my case presentation to be done at 1.30pm resulting in me coming in earlier. I tried unsuccessfully to swap the date of the presentation.
There were supposed to 4 doctors on the wards according to the rota. However, only two doctors remained in the afternoon including myself, as one planned to attend clinic for the whole day and one left at mid-day. This meant that service pressures increased and the workload was difficult to manage within standard working hours. Even after one doctor was

called back from clinic later, it was very difficult to manage workload so I finished later than expected.
Staff shortages due to some doctors being at teaching and on annual leave. This meant that I had to stay overtime to manage workload
Had to stay overtime due to staffing shortages which increased work load
Had to stay overtime due to staffing shortages which increased work load
Worked 1 hour and 15 minutes over my leave time due to an acutely unwell patient I was looking after and the inability to handover safely to the night team as they were also dealing with acutely unwell patients.
Asked to fill in death certificate/paperwork post night shifts
Due to heavy workload on night shift, unable to achieve full break time. Cumulatively, only approximately 30 minutes taken from the shift. (Reporting it now as only obtained account today)
Due to heavy workload on night shift and being short of a clerking SHO, unable to achieve full break time. Cumulatively, only approximately 30 minutes taken from the shift. (Reporting it now as only obtained account today)
Due to heavy workload on night shift and being short of a clerking SHO, unable to achieve full break time. Cumulatively, only approximately 30 minutes taken from the shift. (Reporting it now as only obtained account today)
Due to heavy workload on night shift and being short of a clerking SHO, unable to achieve full break time. Cumulatively, only approximately 30 minutes taken from the shift. (Reporting it now as only obtained account today)
15 minutes late to grand round due to long and complex ward round with some unwell patients that required seeing. I was the only junior doctor on my side of patients so I was not able to leave for teaching on time.
1 minute late to grand round as ward round went on for longer than expected so was slightly late to teaching. I have been told that this must be exception reported.
There was no SHO ward cover. I carried the SHO bleep and the FY1 bleep. There was also no JDA.
handover was 45 minutes so ran 15 minutes late
Unable to attend clinic which is a mandatory requirement for my track due to staff shortages. One of the SHOs on the ward was unable to come in due to sickness which meant we were at minimum staffing levels.
Unable to attend clinic which is mandatory for my track due to minimum staffing levels. Only three doctors were on the rota for the ward for the whole day.
Similarly to the day prior, on-call FY1 general medicine twilight shift. Normal hours 16:00-23:00, however due to volume of handovers and additional ward pressures, I worked 1hr overtime.
Normal twilight shift hours 16:00-23:00 for general medicine on call Fy1. Due to volume of work and demands from the shift, I did not finish until 23:45.
I worked until 16:45 as the post-take ward round only started at 12:30pm due to short staffing so was unable to start the jobs until the afternoon.
Had to stay an extra 90 mins due to unwell patient on ward
Short staffed on Lowton due to sickness with just two doctors for 28 patients. Worked as efficiently as possible but service pressure was high due to high patient turnover meaning lots of new and sick patients with urgent jobs.
2 hours overtime

Unable to attend clinic due to ward pressures and staffing levels- only myself and 1 other Dr present for the afternoon to cover the ward
Unable to attend clinic due to ward pressures and staff levels
Unable to attend clinic session due to ward pressures and staffing levels
Unable to attend clinic due to ward pressures and staffing pressures
Unable to attend clinic due to limited number of staff on the ward and needing to stay to complete jobs
Unable to attend weekly clinic due to staffing issues on the ward and needing to be present to complete jobs
Worked an additional 1 hour. Limited staff numbers on the ward with 14 new patients. There was a Registrar led ward round in the AM till 12:30. At 12:30 we then were required to attend gastro Monday lunchtime teaching, getting back to the ward at 1:20. Consultant arrived in the afternoon at 3pm to do a whole ward board round this was very helpful but delayed and added many tasks that needed to be completed by the day team leading to myself staying an hour late to all important tasks were completed before leaving.
Had to stay behind 45 minutes extra to help out on understaffed ward
Hi I was covering CCU on Monday on my own . We had some sick patients, one of them was very unwell, after we finished WR around 1200 , she became very hypoxic . Went to see the patient , escalated to Prof Davis who advised need to speak to our ITU team ,and renal team in Salford urgently. I managed to speak to both and they gave me plan to do then had ongoing discussion with ITU regarding her escalatio , they decided not for ITU and should be for comfort . I did IPOC review and stopped her active meds We had another patient Who had AKI stage 3 , was very difficult to bleed , nurses advised to take bloods from him myself , I managed but it was hard , his kidney function was worse , advised by Prof Davis to discuss with renal team in Salford and to have ITU review . We had unexpected discharge , she had angio late afternoon, I had to do her letter I finished my work at 18 15 , had a break for 20 minutes at 1600 I would be grateful if I could take this time as TOIL, many thanks
Hi I was covering CCU on Friday on my own . We had new patients on the wards with couple sick patients and one patient for discharge I finished WR at 12 30 , I got a call from the medical examiner office asked me to come to their office to finish 2 death certificates , should be done before the weekend . I made a job list and tried to do the urgent jobs then went to the medical examiner office when I came back I chased bloods and scans results One of the patient was listed for angiogram but after his echo discussed with the consultant he advised to do CTPA , the patient had ? Reaction to iodine 2 years ago

I had to discuss with the consultant again he advised to give some medication before the scan and discuss with radiologist

I discussed with on call radiologist who agreed to do the scan but when I called CT unit they declined as they discussed with another radiologist .

I had to speak to CT team multiple times to convince them to do the scan , and get a specific time as we need to give certain meds at specific time before the scan .

I discussed with the patient expalined the risks , pt agreed .

Ct team called the ward asked for the doctor to come with pt as there is a risk of anaphylaxis, I spoke to CCU nurses no one agreed to go with the patient , discussed with Dr Sultan as I am on my own and I spent alot of time sorting out the scan for the patient but he advised to go with pt

I went down to CT , witnessed the contrast and stayed with him until he returned to CCU

By that time it was after 1700 and I still got jobs to do some of them referrals to Salford when I finished we got the scan report which showed extensive PE , NIC asked to sort this out before I leave as I know the patient rather than on call team , I discussed with on call heam consultant who gave me advice regarding anti coagulation

I finished at 18 40 and I did not take a proper break .

I would be grateful if I could take this time as TOIL, many thanks

Obs & Gyn

csection list, normal working hours contracted are 9-5, i worked from 8am till 5;20pm.
elective CS list, normal working day was 9-5 but I worked from 8am-6.15pm, delays with getting spinal in and last patient had to be converted to GA.
had to come in at 8am for elective c-section list
started 1 hour early
Assisting in elective Csection list. Started earlier and finished later than the normal working day. Delay at the start with a staff member arriving half an hour late, and the day finished 1hr 15 mins late due to delays with the last patient in getting the spinal in/converting to GA.
Theatre overran and went to review patients with the consultant post op
I was Labour ward on-call on Friday, but as we had new F2s on Gynae side, I was asked by Registrar to cover Gynae side. So after the ward round, I started seeing patients in Gynae emergency clinic from 15:00 till 21:10, then rushed to handover room, as we have handover at 21:00, and after handover finishing at 21:30, had to stay in hospital till 22:00 to finish all documentation remained from seeing patients in Gynae clinic.
I covered the Swinley ward on Friday, and the work-load was massive, as we have to do the ward round with the consultant, then doing all the action plans, including prescriptions and discharge letter, and then rush to Gynae clinic, as many patient were queuing there since the morning, I had one SHO with me for morning session, but it was very busy on Friday, and referring never stopped, so, when I handed over the shift to my on-call colleague at 17:00, I had to finish all remained jobs from the ward round and updating Gynae handover shift on my own, as my colleague also was so busy on her side, so I stayed on the ward to clear all remained jobs till 18:30.

We have to start the job 1 hour earlier comparing to normal days on theatre days (so we start at 8:00 and finish at 17:00 instead of 9:00 to 17:00)
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NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Guardian of Safe working Hours Quarterly Report QTR 4 2022 -2023
Presented to:	Board of Directors
On:	02 August 2023
Item purpose:	Information
Presented by:	Dr Shams Khan Guardian of Safe Working Hours
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Executive summary

There have been 49 hours and rest, pattern and service breaches. They are broken down as follows:

Accident and Emergency	4
General Medicine	4
General Surgery	6
Obstetrics and Gynae	7
Trauma and Ortho	11
Paeds	7

Two fines have been levied; one in Obstetrics and 1 in Gastroenterology

Link to strategy and corporate objectives

This links to safe staffing, safe working for trainees, addressing issues of burnout and fulfilling the conditions of the 2016 contract.

Risks associated with this report and proposed mitigations

Risks are junior doctor burnout, clinical error due to over work and missed breaks, clinical errors due to understaffing, financial risks due to fines, extra payment and loss of doctor hours due to TOIL. Mitigation is Educational Supervisor review after exceptions, and reporting to LNC and People's Committee

Financial implications

Fines and missed payments due to breaches of hours worked

Legal implications

Exception Reports do represent a contractual breach of hours and educational commitment.

People implications

Burnout of trainees leading to increased sickness, loss of staffing which in turn contributes to a more unsafe working environment

Wider implications

We have already seen that working conditions have in part contributed to the strikes held by junior doctors and there are risks that trainees will either leave training or seek work overseas.

Recommendation(s)

Reports to be presented to LNC and People's Committee. As Guardian of Safe Working Hours, I am very happy for reports to be shared with clinical leads who can consider implications for their own rotas.

Report

In the last quarter there were a total of 49 Exceptions covering hours and rest, service and work pattern. They are broken down as follows:

Accident and Emergency	4
General Medicine	4
General Surgery	6
Obstetrics and Gynae	7
Trauma and Ortho	11
Paeds	7

I note an increase in reports from Trauma and Orthopaedics (T&O), obstetrics and paediatrics

The accident and emergency exceptions for hours and rest all had to do with the clinical need of the patient at that time. I do not see a pattern here that is leading to a concern with the rota or handover.

In general medicine, the themes are patient volume, inadequate staff, new staff unfamiliar with the system, missed breaks and also clinical need. I note in one exception, a core trainee felt unsafe to cover a ward round given the large number of patients and very junior staff supporting. Such concerns should lead to the trainee marking this as an immediate safety concern and should trigger a DATIX by the trainee so that the issue can be dealt with by the relevant speciality.

Many exceptions report missed breaks. Given that missed breaks has already led to a fine in a medical speciality I believe clinical leads and training programme directors should take this seriously and work together to see how their trainees can take breaks in a very complex and difficult work environment.

In general surgery there are fewer exceptions than previous quarters. The themes relate to unwell patients and understaffing. I note one exception states that the doctor had to become the "corridor" doctor for medical patients. This particular exception should lead to great upset in us all at the need for patients to be bedded in the corridor. Not only is this an unsafe working environment, this is a terrible indignity to a vulnerable patient whose care and dignity is compromised by the corridor area being used as a bedded area.

This is the second quarter where Obstetrics has featured more heavily than usual. I note the majority appear to indicate that Theatre Lists commence one hour earlier than is on the doctor's work schedule. If this is correct, this must be changed as it is wholly inappropriate to not have on record the correct number of hours that a trainee is expected to be present. This could even lead to fines not being administered if the correct hours are not on a workschedule. This is being looked at closely by Leanne Preston and Elaine Middleton and if correct, must change as a matter of priority. There is one exception recording extended hours due to multiple gynaecological emergencies. This highlights the diligence of trainees when faced with emergencies.

Trauma and orthopaedic exceptions are higher and the cause appears to be similar to the obstetric rota. All hours need to be open and transparent and I have asked Leanne to provide me feedback on this from the rota co-ordinators.

I was disappointed in the Paediatric Exceptions in that the free text does not give any indication of what happened. This has been discussed in Junior Doctors' Forum and it is agreed that there must be some reasoning given for the Exception. I have asked the relevant educational supervisor to provide feedback.

Two fines have been levied – Obstetrics for a breach of 11 hours rest between shifts and General Medicine, Gastroenterology for a breach in breaks. The Educational Supervisors have been involved in each and this is why I feel Division of Medicine should look at breaks in more detail.

Finally, Junior Doctors' Forum is the meeting where the Director of Medical Education, the Medical Director, myself and a range of trainees can sit in a structured meeting to go through many of these issues and consider action for not just Hours and Rest, but Education too. The last two meetings, by necessity (strike action and staff shortages) have been very poorly attended and we have been unable to decision make. I look forward to the resumption of Junior Doctors' Forum in full in future

Appendices

Medicine Exceptions

Medical Exceptions Q4 2023
Stayed late one hour due to patient sick on the ward
There were 2 FY1s and 1 FY3s on the ward yesterday as one of our colleagues was off sick. We escalated to rota coordinator but there was no one who wanted to fill the gap. At 5pm, We had an unwell patient who deteriorated and had low GCS so we had to review her, escalate to medical registrar on call and do the necessary investigations including ABGs CXR, cannulation and bloods.
Overtime
Due to RC strike action on 18/1/23, IMT teaching (13:00H to 17:00H) on Wed afternoon was cancelled and we were asked to work on our base ward.
No medical registrar on call
Missed 1.5h of breaks
missed 1.5H of entitled break
Reg down for the night so the ward SHO went clerking, meaning I had to do all the work on the wards - missed my three half hours breaks
On 8th Feb, one of SHOs felt unwell and emailed the rota coordinator in the morning before 0900 , unfortunately due to sickness in other wards as per the rota coordinator, there was no available support or cover . Standish team yesterday was only me and 2 FY1s one of the them is new to NHS and still needs much support . On Wednesdays there is no cons WR and also I have regular IMT teaching afternoon I emailed the rota coordinator , she asked to cancel the teaching I had to review all patients from Dr O'Connell's side and the sick patients from the other side (some of them are sick from the day before with no senior input) . I reviewed at least 18 patients yesterday on my own . I do not feel safe doing that as I am still IMT1 . I came to work early yesterday at 08 30 and left 1800 I had no breaks , I had my launch while reviewing patients' notes, I missed my teaching as well. I felt very exhausted.

Medical Exceptions Q4 2023
Had to stay an additional 45 minutes after standard day because a patient with known MSCC complained of sensation loss in his thighs at 4.45pm and hence an urgent neurological examination was warranted in the event that the patient needed swift intervention. The patient was unfortunately in the toilet trying to pass bowels for a long while and hence I had to wait for the patient to return to the bed before I could perform the examination
Cancelled SDT opportunity (1pm to 5pm) due to nursing strikes. Was asked by Director of Medical Education to not take SDT on this day
Unfortunately no clerking sho available. The take meant some delays for patients to be reviewed. Similar issues with regards to staffing for the medical take. Again noted that the rota co ordinator had tried hard to fill in gaps. Increased workload for the team.
Unfortunately night clerking sho role not covered for the 6 out of the 12 hours of the shift. One sho from a&e did help cover. Extremely busy shift clinically, reduced breaks taken, noted that the rota co ordinator had tried extremely hard to cover shifts with locums pulling out last minute. Still long delays for patients seen.
Unfortunately no ward cover SHO booked. Had to carry both bleeps of med regon call for resus and the ward sho bleep. All breaks not taken. Busy shift.
Suppose to get 3 half hour breaks on a night shift. I didn't get to take any breaks - SHO down for most of the night
Suppose to get 3 half hour breaks on a night shift. I didn't get to take any breaks, short staffed and too busy
Suppose to get 3 half hour breaks on a night shift. I didn't get to take any breaks due to clinical demand
I supposed to have an IMT teaching on Wednesday afternoon but because the nurses strike and IMT teaching was cancelled and I had to stay in ward to support my colleagues. We were not able to take STD . I would be grateful if I could take this time as TOIL, many thanks
Due to RC strike action on 18/2/23, IMT teaching (13:00H to 17:00H) on Wed afternoon was cancelled and we were asked to work on our base ward.
I was due to cover Lowton as per my GP on call rota, however the locum Cons was unwell and the MAU F2 was also off sick. I therefore had to do the ward rounds for both MAU and Lowton with Dr Suleiman, which finished at 19:45. I had support on Lowton for a couple of hours but the SHOs both left at 4pm and had only seen 5 patients between them. An on call F1 helped mop up jobs in the evening. This was highly unsafe and the only reason this was manageable was because the patients were generally stable, if there were more unwell patients then this would have been a huge safety concern as the ward cover team were busy enough. I did my best but I may have missed jobs and this concerns me - I do not want this situation to happen again in the future.
I was one minute late to grand rounds on friday because I was finishing a discharge for a patient. We have been told to exception report it.
stayed an extra hour and 15 mins to finish work
IMT teaching was cancelled due to Nursing Strike at RAEI
Due to multiple staff absences (ward cover FY1 off sick and clerking FY1 family emergency) we were stretched for staff covering the wards. I had to cover both the wards and clerking shifts and had to stay back late to ensure that urgent jobs were completed from post-take and ward reviews to ensure a safe handover.
I was on my own covering both cardiology and care of the elderly in the afternoon. Due to minimal staffing (one doctor on CCU and one doctor on Ince) I had to manage multiple complex patients by myself with minimal access to senior support. This placed significant stress on myself and meant I had no opportunity for a break on my on-call shift. It is often that cardiology is left understaffed / at bare minimum staffing on Thursdays due to many of the team having teaching commitments on the same day.
Due to the lack of SHO support for ward cover during the night shift, I did not manage to get a break nor was I able to leave on time. It was difficult to escalate matters appropriately or seek help for patients I

Medical Exceptions Q4 2023
had concerns about due to the lack of SHO. This lasted for Monday, Tuesday, and Thursday. I was leaving at least 30 minutes late each day because the work load was not proportionately distributed. This also left the night F1 under a lot of stress and left her unsupported without an SHO.
Due to the lack of SHO support for ward cover during the night shift, I did not manage to get a break nor was I able to leave on time. It was difficult to escalate matters appropriately or seek help for patients I had concerns about due to the lack of SHO. This lasted for Monday, Tuesday, and Thursday. I was leaving at least 30 minutes late each day because the work load was not proportionately distributed. This also left the night F1 under a lot of stress and left her unsupported without an SHO.
Due to the lack of SHO support for ward cover during the night shift, I did not manage to get a break nor was I able to leave on time. It was difficult to escalate matters appropriately or seek help for patients I had concerns about due to the lack of SHO. This lasted for Monday, Tuesday, and Thursday. I was leaving at least 30 minutes late each day because the work load was not proportionately distributed. This also left the night F1 under a lot of stress and left her unsupported without an SHO.

T & O Exceptions

T&O
Change in work schedule from 8:00-16:00 to 8:00 to 17:00 due to change in mandatory teaching time.
Schedule changes 8:00 to 17:00 , ie extra hour due to change in teaching times
handover ran over 30mins
handover ran over 30mins
handover ran over 30mins
Usual work pattern is 08:00-16:00. Due to change in teaching times, this is now 08:00-17:00 on Tuesdays
I am contracted to finish at 4pm however FY1 teaching Tuesday has now changed to finish at 5pm
I am contracted to finish at 4pm however FY1 teaching has now changed to finish at 5pm
My usual work hours are 8:00am to 16:00pm. However teaching times have changed to finish 17:00pm.
I usually work 08:00 to 16:00 hours. I had to stay back 40 minutes due to ward pressures and being the only doctor on the ortho geriatric team.
My standard day is 08:00 to 16:00. However mandatory teaching has been changed to finish at 17:00. Hence i am expected to stay back 1 hour later than usual.

Surgical Exceptions

Surgical Exceptions
Change in regular work time. Normal work time 08:00-16:00 however due to change in teaching time on Tuesday. On Tuesday finish at 17:00 , one hour extra.
Had to stay late to handover sick patient
Had to stay late to handover sick patient
50 minutes
Asked to step onto being a corridor doctor for the medics from general surgery 9am-12:30pm. Missed educational opportunities in surgery due to understaffing of corridors.
30 mins over scheduled time
30mins over contracted hours due to understaffing

Paediatric Exceptions

Paediatric Exceptions
Hour overtime
1 hour 30 minutes

Paediatric Exceptions
1 hour 30 minutes
1 hour 15 minutes
1 hour 50 minutes
Could not take teaching / SDT 2-5pm. Worked these 3 hours
2 hours overtime

O & G Exceptions

Obstetric Exceptions
Theatre day. - extra 1 hour
Only 2 SHOs rota'd to work, 1 on a long day on labour ward, and myself. I was supposed to work on a gynae half day till 1pm, however there were multiple obstetric emergencies which meant that the gynae ward round did not happen till 12pm, and the gynae assessment unit was full of patients waiting to be seen. I could not leave at 1pm and handover this immense workload as it would mean that potentially emergency gynae patients would not be seen for hours until the obstetric SHO was out of theatre. Unsafe staffing, and I had to ask another SHO who was scheduled for teaching to come in and help that afternoon. I stayed behind >2 hours to safely manage GAU patients and complete ward jobs until cover was found. This was at the end of a week of oncalls, and in total over the past 7 days I had worked 68.5 hours.
Scheduled theatre to start earlier than 9 am
Scheduled in morning CS list
Started at 8am as was scheduled to be in theatre
Surgery ran over and finished one hour late
early start for surgery

Title of report:	Guardian of Safe working Hours Annual Report 2023
Presented to:	Board of Directors
On:	02 August 2023
Item purpose:	Information
Presented by:	Dr Shams Khan Guardian of Safe Working Hours
Prepared by:	Shams Khan, Leanne Preston 20 June 2023
Contact details:	E: leanne.preston@wwl.nhs.uk shams.khan@wwl.nhs.uk

Executive summary

General Medical 73
General Surgical 50
Accident and Emergency 4
Trauma and Orthopaedics 16
Obstetrics and Gynaecology 30
Paediatrics 9
Urology 4
Total 186

Fines :

Obstetrics breach of 11 hours rest between shifts due to theatres overrunning
Gastroenterology breach of breaks (winter pressures and short staffing cited by educational supervisor)

Issues discussed at JDF, LNC and Peoples Committee:

Double bleep holding
Shortage of equipment (computers) for documentation
Patient complexity leading to exceptions
Fines administered
Barriers to Exception Reporting
Work schedule not including hours resulting in ERs for T&O and Obstetrics
Junior Doctor Strikes

Vacancies

Medicine 4 vacancies and and 3 LTFT
Surgery 2 vacancies
Paediatrics 3 vacancies and 3 LTFT
A&E 1 vacancy and 4 LTFT
T&O 1 vacancy CT1/2

Link to strategy and corporate objectives

Corporate strategy and objectives centre very heavily around the safety of patients in hospital and good medical practice of clinicians. The exceptions highlight the holes that appear when sickness occurs last minute and also how multiple jobs placed upon a single clinician can link to incidents. The exceptions fit with the experiences of junior doctors who highlight some of their issues in Junior Doctors Forum

Risks associated with this report and proposed mitigations

Mitigation to these risks come from interaction between junior doctor and educational supervisor. This allows feedback and debriefing to the junior but also involvement of the clinical supervisor in that speciality. The double bleep holding reported twice in these exceptions, whilst in itself not necessarily allowing for TOIL or payment should be addressed by Division of Medicine in their own governance processes

Financial implications

TOIL or Time of in Lieu will remove a doctor from the rota and impact on day to day working and payment to the doctor is a financial cost to the Trust

Legal implications

Exceptions do represent a breach of the working contract

People implications

The more detailed exceptions show the stress of multiple tasks on a junior doctor. The organisation has experienced junior doctors suffering burn out and having time off work through sickness because of this

Wider implications

Junior doctor burnout and clinical incidents are the most significant risks. I notice also the stress on rota co-ordinators trying to ensure adequate cover to clinical areas

Recommendation(s)

Present findings to LNC, JDF and People's Committee
Ask Division of Medicine and Surgery to make junior doctor breaks as part of their governance agendas and consider placing this on the risk register
Seek feedback from Medical DMD over double bleep holding by FY1 doctors
Follow up on Orthopaedic and Obstetric rotas to ensure all hours are scheduled

Report

Hours and Rest exception reports for the year 2022 to 2023 are as follows:

General Medical 73
General Surgical 50
Accident and Emergency 4
Trauma and Orthopaedics 16
Obstetrics and Gynaecology 30
Paediatrics 9
Urology 4

Fines :

Obstetrics breach of 11 hours rest between shifts due to theatres overrunning
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Vacancies

Medicine 4 vacancies and and 3 LTFT
Surgery 2 vacancies
Paediatrics 3 vacancies and 3 LTFT
A&E 1 vacancy and 4 LTFT
T&O 1 vacancy CT1/2

This year has shown exceptions to be most in medicine and surgery. This is little surprised as these are 2 of the busiest specialities with most unscheduled intake.

Analysis of the exceptions submitted by junior doctors show that exceptions occur due to complex reasons resulting from short staffing, complex patients, large patient volume and complex multi tasking needs.

An issue that has come up throughout the year is the holding of a more senior bleep by an FY1 level doctor. This is not meant to happen as bleeps of an absent doctor should be held by an equivalent or more senior doctor. Each episode has happened in General Medicine and email communication with Divisional Medical Director Dr Stephen Guiliford has provided me with an assurance that this will be investigated and the practice will not recur. For specifics on investigations and actions, Dr Guiliford should be consulted. I thank Dr Guiliford for a prompt response.

Many exceptions quote IT equipment as a reason for staying late. In particular, during Junior Doctors' Forum, one doctor explained an issue in General Medicine: junior doctors accompany consultants, but often make written notes for time purposes. After the round, these juniors must then type up these notes and order investigations leading to a bottle neck in the ward Doctors' Room. This causes doctors to leave late and for investigations to be ordered later. During LNC, the suggestion of "robotics" and also quantifying the number of extra computers was suggested. I have met with representatives from HIS and IT and paired them with junior doctors from medicine, surgery and emergency medicine so that IT can gain a first hand understanding of the issues. A good number of the "Computer on Wheels" in the Emergency Department have since been replaced.

Despite the small number of specific Exception Reports under Urology, many trainees talk to me privately about the difficulty in covering urology shifts. Some of these are highlighted under Surgical Exceptions. An email exchange between a surgical consultant and urology consultant highlighted the difficulties that a surgical foundation trainee experienced. I was able to support the urology lead by sharing the surgical exceptions where urology was mentioned in order to help him understand the difficulties his trainees faced

2 fines have been administered: one in Obstetrics as a result of Theatres over running and a doctor breaching 11 hours of rest between shifts. This was a breach of 30 minutes and has been dealt with by the Educational Supervisor. The breach in Gastroenterology was as a result of multiple missed breaks. This doctor's educational supervisor has responded to me and noted that these missed breaks were due to winter pressures and staff sickness. Given that exceptions frequently quote missed breaks, I do believe that it is reasonable for Division of Medicine and Division of Surgery should make these issues a matter for their governance meetings. I would be happy for any actions or comments to be fed into Junior Doctors Forum.

This year, the pressure group Every Doctor produced a report and survey entitled "Barriers to Exception Reporting". This survey was presented at Junior Doctors Forum and also at the Regional Guardians Meeting by Foundation Doctors Grace Allport and Gemma Nugent. I would like to extend thanks to both doctors and also note that their presentation was very well received by both meetings. This survey, a national one showed many doctors do not exception report. The two biggest reasons were "don't know how to use the system/access issues" and "there might be negative repercussions/would be detrimentally received". "Time consuming" "I don't need to" and "there's no point" were also reasons.

Aligning this survey to Wigan, in the past, junior doctors have complained that some consultants have tried to discourage the practice of Exception Reporting. Division of Surgery have twice now had feedback to not do this. In response to this, I have given sessions at the locally held Educational Supervisors teaching to explain that an exception report does not infer poor practice on a consultant, educational supervisor or indeed a speciality, Indeed, the more exceptions that are reported, the more information is available and this shows transparency – the opposite is in fact the case. High numbers of exceptions speak better of a speciality as it shows transparency and a willingness of educational supervisors to work with junior doctors. There is excellent support at Wigan from an IT perspective, however I do acknowledge that reporting after an extended shift is time consuming. I have noticed some exceptions simply state "1 hour" or "overstayed by 1.5 hours". Whilst I do not expect junior doctors to fill lengthy reports, this type of exception is inadequate and some reasoning about why the exception happened should be filled in. I have given feedback to specific educational supervisors over this.

I noticed in the last two quarters, there has been a sudden unexpected rise in exceptions in Trauma and Orthopaedics and also Obstetrics. In obstetrics, it would appear that the work schedule does states a specific shift as 9-5 but trainees are expected to be present by 8 am. Similarly in Orthopaedics, 1 hour of mandatory teaching does not appear to included in the work schedule. If this is the case, this is wholly unacceptable practice and all work hours must be accounted for. This is being investigated by Leanne Preston.

2023 has been a year sadly marred by Junior Doctor strikes undertaken in response to pay not keeping up with inflation and also poor and unsafe working conditions (many patients are treated on corridors and remain there for excessive time periods). I have noticed this reason crop up in Exception Reporting where junior doctor roles are changed to "corridor doctor" – a very sad reflection of the current state of hospital practice nationwide. These strikes have had a very negative impact on Junior Doctors' Forum with the last two meetings being non-quorate.

From the vacancies above, one can see that shortages and sickness will impact junior doctor working and staff shortages have contributed regularly to exceptions. The Trust has responded by employing Locally Employed Doctors and International Fellows and it is hoped that this group of doctors will help to ease staff shortages and allow trainees to attend teaching.

The Medical workforce HR team have had investment within their team enabling from July to provide more capacity to support exception reporting. There will be frequent regular speciality meetings with exception reporting as a standard agenda item enabling concerns to be addressed immediately as and when they happen.

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Freedom To Speak Up Update

Tracy Boustead

20.07.2023

FTSU Update

- Guardian Service Limited contract for service will cease 31st August 2023
- WWL FTSU Guardian recruitment campaign live
- Seniority of the FTSU Guardian essential
- Greater Manchester (GM) system resilience discussion live
- Psychological support, clinical supervision and FTSU programme debriefs will continue via Steps 4 Wellness
- Transition team to be appointed by 1st August 2023
- Annual report to be presented to People Committee in September (attached)

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust

12 month Report
1st April 2022 to 31st March 2023

The Guardian Service
Here to listen

Circulation: Silas Nicholls CEO, Mark Jones Chair, Tracy Boustead Interim CPO, Claire Austin FTSU NED. For further circulation by the Interim CPO to Executive Board and People committee.

Prepared by Natalie Morgan
Freedom To Speak Up Guardian
The Guardian Service Ltd.

Date: June 2023

The Guardian Service
Here to listen

Contents

1. Executive summary

This report presents the Freedom to Speak Up Guardians' (FTSUG) Annual Report for the period 1 April 2022 to 31 March 2023 and provides an overview of the activity and themes that took place during this period.

- Staff raised 77 concerns to the FTSU Guardian. This is a marked increase on the previous year where 38 cases were reported. The current figure represents a 49% increase.

- The 3 most common themes for new concerns were Management Issues (26), System and Process (19) and Bullying and Harassment (16). There were four Patient Safety concerns raised which were escalated to the most appropriate channel for the concern with the Medical Director and Chief Nurses oversight as agreed.

- The job groups that raised the most concerns were Nursing and Midwifery (35%) Administrative and Clerical (22%) followed by an even distribution from Medical and Dental, Estates and Ancillary, Additional Clinical services and Not disclosed (all 7%)

- Medicine is the directorate with the highest number of concerns, followed by Corporate and Community. This should not be viewed negatively but as encouragement that staff are comfortable to speak up.

- 30% of staff gave permission for their concern to be escalated and 70% asked for their concern to remain confidential. This is due, in part to the fact that the nature of their concern, if raised, would reveal their identity and therefore did not want to escalate their concern. Also, some staff want to explore different options before raising the concern internally themselves.

- The majority of staff chose to speak to The Guardian Service because they believed the Trust would not take action, believed they wouldn't be listened to were fearful of reprisal.

- Monthly and quarterly meetings have been held with the Chief People Officer to discuss emerging themes. No identifiable data is shared without explicit permission from a staff member.

- There are a number of recommendations detailed at the end of this report that the Trust is asked to consider. These relate to the NHS Reflection and Planning tool relating to management communication, support, cultural awareness and promotion of a positive speaking up culture.

2. Background to Freedom to Speak Up

Following the Francis Inquiry[1] 2013 and 2015, the NHS launched 'Freedom to Speak Up' (FTSU). The aim of this initiative was to foster an open and responsive environment and culture throughout the NHS enabling staff to feel confident to speak up when things go or may go wrong; a key element to ensure a safe and effective working environment.

3. The Guardian Service

The Guardian Service Limited (GSL) is an independent and confidential staff liaison service. It was established in 2013 by the National NHS Patient Champion in response to The Francis Report. The Guardian Service provides staff with an independent, confidential 24/7 service to raise concerns, worries or risks in their workplace. It covers patient care and safety, whistleblowing, bullying, harassment, and work grievances. We work closely with the National Guardian Office (NGO) and attend the FTSU workshops, regional network meetings and FTSU conferences. The Guardian Service is advertised throughout WWL as an independent organisation. This encourages staff to speak up freely and without fear of reprisal. Freedom to Speak Up is part of the well led agenda of the CQC inspection regime. The Guardian Service supports the Trust's Board to promote and comply with the NGO national reporting requirements.

The Guardian Service Ltd (GSL) was implemented in WWL on 1st September 2021.

Communication and marketing have been achieved by meeting with senior staff members, joining team meetings, site visits, attendance at staff induction, the Intranet and the distribution of flyers and posters across the organisation. 'Speaking Up' online training is a mandatory section of the Trust induction programme with The Guardian Service contact information available alongside.

4. Access and Independence

Being available and responsive to staff are key factors in the operation of the service. Many staff members, when speaking to a Guardian, have emphasised that a deciding factor in their decision to speak up and contacting GSL was that the Guardians are not NHS employees and are external to the Trust.

5. Categorisation of Calls and Agreed Escalation Timescales

The following timescales have been agreed and form part of the Service Level Agreement.

Call Type	Description	Agreed Escalation Timescales
Red	Includes patient and staff safety, safeguarding, danger to an individual including self-harm.	Response required within 12 hours
Amber	Includes bullying, harassment, and staff safety.	Response required within 48 hours
Green	General grievances e.g. a change in work conditions.	Response required within 72 hours
White	No discernible risk to organisation.	No organisational response required

[1] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

Open cases are continually monitored and regular contact is maintained by the Guardian with members of staff who have raised a concern to establish where ongoing support continues to be required. This can be via follow up phone calls and/or face to face meetings with staff who are in a situation where they feel they cannot escalate an issue for fear of reprisal. Guardians will also maintain contact until the situation is resolved or the staff member is satisfied that no further action is required. Where there is a particular complex case, setbacks or avoidable delays in the progress of cases that have been escalated, these would be raised with the organisational lead for the Guardian Service at regular monthly meetings.

Escalated cases are cases which are referred to an appropriate manager, at the request of the employee, to ensure that appropriate action can be taken. As not all employees want their manager to know they have contacted the GSL, they either progress the matter themselves or take no further action. There are circumstances where cases are escalated at a later date by the Guardian. A staff member may take time to consider options and decide a course of action that is right for them. A Guardian will keep a case open and continue to support staff in such cases. In a few situations contact with the Guardian is not maintained by the staff member.

6. Purpose of the paper

The purpose of this paper is to give insight to the progress and development of the service and a summary of themes arising from the cases received by the FTSU Guardians.

This report provides an overview from 1 April 2022 to 31 March 2023. The report follows the guidance from the National Guardian Office (NGO) on the content FTSU Guardians should include when reporting to their Board which include: Assessment of cases, Action taken to improve speaking-up culture, and recommendations.

7. Number of concerns raised

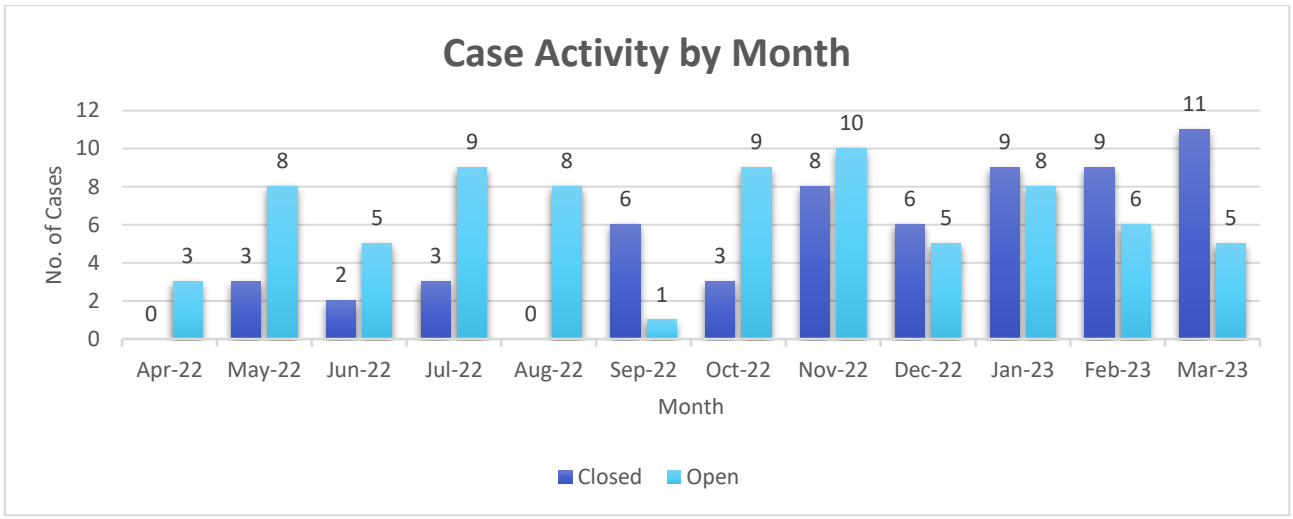
A total of 77 concerns have been raised with the FTSUG in the period 1st April 2022 to 31st March 2023, this shows a marked increase compared to previous years.

The current figure represents a 49% increase from 2021/2022 figures which saw 38 concerns being raised with a Guardian. The data below shows the distribution of cases across the year. Contacts to the Guardian vary over the months with April and September usually being quieter months and October and November usually being the busiest months due to National Speaking up Month which is promoted in October.

The rise in reported cases being brought to the Guardian indicates a potential improvement in the Trusts speaking Up culture. The increase in reported cases suggests that staff members are becoming more comfortable with speaking up about issues they encounter. This is an encouraging development as it indicates a growing trust and open communication within the organisation.

An increased occurrence of reported cases creates more opportunities for the Trust to obtain valuable feedback from the workforce which can contribute to ongoing learning and improvements. By embracing this feedback and taking appropriate actions, the Trust can create a safer, more transparent and productive working environment for all staff.

Open cases are continually monitored and regular contact is maintained by the FTSUG with the members of staff who have raised a concern to establish where ongoing support us required. Where setbacks or avoidable delays are experienced in the progress of cases, these are raised with the Chief People Officer at regular monthly meetings to review how these can be expedited.



The National Guardians Office (NGO) has published data for Quarter 1, 2 and 3 (April - Dec 22) with Quarter 4 still being collated at the time of producing this report. From this data a comparative analysis of speaking up case numbers, including those raised anonymously and with an element of patient safety/quality can be made with other organisations. The table below shows data collated for NHS Trusts the same size as WWL within the North West region. For the purpose of clarification, the organisation that are classified 'medium sized' by the NGO are those with a staff headcount ranging from 5,000 to 10,000.

Organisation	Number of cases brought to FTSUGs	Number of cases raised anonymously	Number of cases with an element of patient safety/quality
Blackpool Teaching Hospitals NHS Foundation Trust	205	12	84
East Lancashire Hospitals NHS Trust	149	1	18
University Hospitals of Morecambe Bay NHS Foundation Trust	148	42	34
Lancashire Teaching Hospitals NHS Foundation Trust	143	17	43
Bolton NHS Foundation Trust	139	4	19
North West Ambulance Service NHS Trust	80	16	13
Wirral University Teaching Hospital NHS Foundation Trust	70	2	6
Wrightington, Wigan and Leigh NHS Foundation Trust	58	3	3
Greater Manchester Mental Health NHS Foundation Trust	57	1	14
Countess of Chester Hospital NHS Foundation Trust	44	1	8
Lancashire and South Cumbria NHS Foundation Trust	35	10	7
Mid Cheshire Hospitals NHS Foundation Trust	32	2	15
St Helens and Knowsley Teaching Hospitals NHS Trust	17	2	18
Stockport NHS Foundation Trust	17	0	6

Whilst the above may serve as a broad guide for measuring how the rate of speaking up at WWL compared to similar sized Trusts within the region, caution must be exercised in relying solely on this data due to variation in staff count, culture, demographics and resources across Trusts as well as other internal and external factors that can affect the volume of concerns raised in a given period.

Confidentiality

Confidentiality	No. of concerns 22/23	Percentage
Keep it confidential within Guardian Service remit	54	70%
Permission to escalate with names	11	14%
Permission to escalate anonymously	12	16%
Total	**77**	

The majority of staff (70%) who made contact with the FTSUG within the year asked for their concerns to be kept confidential within the Guardian Service. Staff often require impartial guidance when facing work related issues and value the independence and confidentiality the service provides. The course of action to be taken is heavily reliant on the specifics of the issues and the individuals preferred approach to seeking a solution. In most cases the presence of an impartial listener who can hear their issue without passing judgement is enough to empower the person to find clarity on their issue and take their concern forward independently. In certain situations, the opportunity for staff to communicate with a FTSUG confidentiality offers them a crucial level of support. This support becomes essential in helping them navigate through challenging circumstances, while being aware of the resources and options at their disposal. By having confidential channel of communication, staff can find solace and reassurance, enabling them to persevere despite the difficulties they may face. It can empower them with a heightened awareness of the available support systems, providing them with the necessary tools to overcome challenges effectively.

Out of a total of 77 concerns, 23 staff members gave their permission for their concerns to be escalated to the Trust allowing for a closer examination of the issues at hand. Among these escalated concerns 11 were raised by individuals who consented to full disclosure, the remaining 12 concerns were escalated anonymously with the identity of the individuals kept confidential.

Of the 23 cases that were escalated to the Trust, all were responded to within agreed timeframes. The range of actions and outcomes that followed from escalated cases are summarised in the table below.

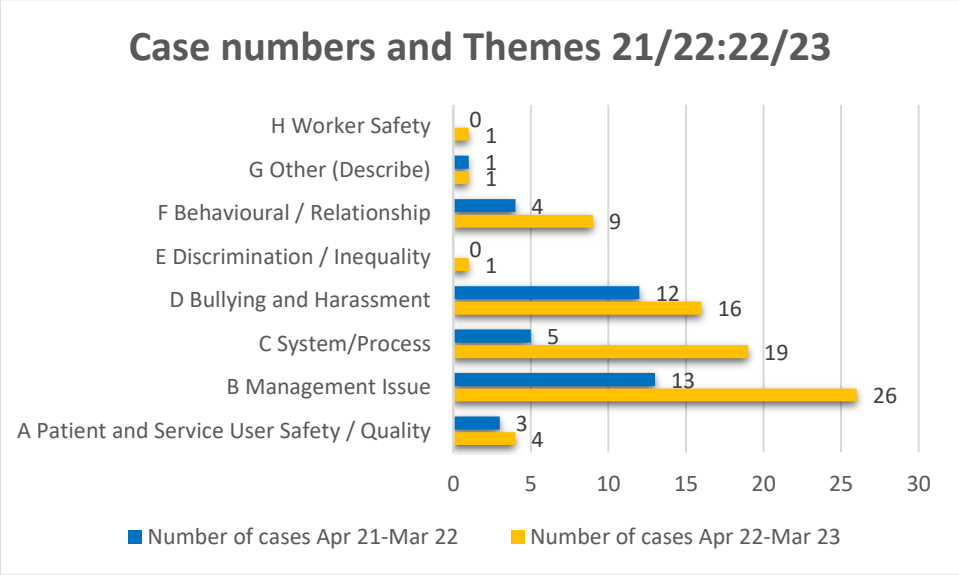
Actions taken	Outcomes
Informal meeting(s) between staff member raising concern and a line manager/ HR Business Partner/ senior manager/ Executive leader to discuss concern and explore resolution.	Plan of action developed and staff member raising concern is consulted on plans. Written or verbal feedback given directly to staff member raising concern.
Informal meeting(s) between Guardian and line manager/ HR Business Partner/ senior manager/ Executive leader to discuss concern and options for resolution.	Written or verbal feedback given to Guardian on behalf of staff member.
An informal review or 'fact find' into reported concerns.	Internal action(s) taken in response to findings of informal review or 'fact find'.
A formal investigation into the reported concerns.	Internal action taken in response to findings of formal investigation in line with relevant Trust procedures

8. Themes

Concerns are broken down into the following themes.

Theme	Number of cases Apr 22-Mar 23
A Patient and Service User Safety / Quality	4
B Management Issue	26
C System/Process	19
D Bullying and Harassment	16
E Discrimination / Inequality	1
F Behavioural / Relationship	9
G Other	1
H Worker Safety	1
Grand Total	**77**

9. Trends in Cases



The Chart above provides a breakdown of the number of concerns raised with the Guardian over the last 2 years. The Guardian Service have been in place at the Trust since October 2021.

Concerns of patient safety and worker safety have been raised in low levels for the last 2 years. This may be linked to staff confidence and familiarity with internal safety/incident reporting processes.

Although we can see an increase in volume across most themes, 'Management Issues' and 'System and Process' concerns have seen the most increase year on year with Bullying and Harassment remaining a significant theme in both years.

10. Assessment of Themes

Patient Safety/Quality

4 concerns were raised in relation to this theme. 3 staff members independently raised the same concern from Leigh Infirmary. The table below provides an overview of the concerns raised under this theme.

Site	Issue Raised	Escalated to	Status	Update/Outcome
Leigh Infirmary	Concerns for a staff members capability to carry out their job responsibilities and the impact of this to the treatment of patients.	Ward Manager and HRBP	Closed	The matter was investigated and managed through Trust policy
Royal Albert	Patient waiting times within a specific area and the lack of amenities available to them during their stay.	Divisional Director	Closed	The Divisional Director and Senior management team were aware of the issue and had put measures in place to manage the situation that lead to the concern. An after action review was completed and measures put in place to minimize impact to patients

The concerns were escalated into the Trust as a 'red concerns' on the basis of an immediate risk of harm to patients being recognised. The Trust met the required response timeframe following escalation.

Worker Safety

1 concern was raised in relation to this theme.

Site	Issue Raised	Escalated to	Update/Outcome
Royal Albert	A change in process led to a concern for risks to staff working in isolated areas.	Directorate Manager	Concerns were heard and assurances were provided. A commitment to communication was given to address any ongoing concerns to those impacted by the proposed changes.

Management Issues

26 of the 77 concerns were raised in relation to this theme, making Management Issues the leading theme for this year. Examples as described by staff:

- Lack of clarity regarding expectations and priorities causing conflict
- Fixed managerial styles negatively influence staff wellbeing & mental health
- Attitudes to staff wellbeing relating to workload and staffing issues impacting on sick leave and leavers
- Feeling that managers only communicate to deliver negative information
- Managers may not have an accurate perception of their staffs experiences because they are often removed from the day to day operations. A belief that this can lead to lack of understanding about the challenges and issues staff face and how best to support them.
- Concerns over the accessibility and visibility of leaders
- Some Managers take exception to challenge
- Insensitivity towards staff concerns and issues
- No visible action from managers to concerns negatively affecting culture
- Inconsistent communication
- Inconsistent decision making
- Lack of inclusive decision making
- Autonomy and undermining decision making
- Withholding or selectively sharing information impacting ability for collaborative working

Management communication. An overarching theme of communication came from concerns categorised as management Issue. Managers who fail to communicate effectively can create low engagement and decreased productivity, misunderstandings, misinterpretations and conflict within their teams. It is important that managers provide clear expectations, feedback and guidance to their team members.

Ther appears to be a lack of confidence in staff to raise concerns to their manager. This could be attributed to breakdown in communication, relationship issues and where the managerial style acts as a barrier. In some instances, staff have expressed they feel unheard by their managers. Additionally, there have been experiences where concerns were raised by the staff member directly but they received little to no feedback or follow up actions from managers.

Management Support. Management support is a recurring theme in concerns raised within the context of management issues. Employees often express their expectations for supportive actions from managers in various areas. These include situations where staff members feel that managers have not provided adequate support during sickness absence and upon returning to work, for staff development and training initiatives, in relation to individuals mental health and well-being, understanding workload pressures, fostering a culture of idea-sharing, and ensuring the visibility and availability of managers.

System/Process

19 of the 77 concerns were raised in relation to this theme, making System and Process the second leading theme for this year. Examples as described by staff:

- Lack of communication around formal process and decision making, specifically Trust investigations, Grievance and Dignity at work complaints.
- Support given to staff involved in formal process - All staff involved
- Responsiveness to Datix's
- Feedback and learning not being shared from Datix reporting
- Perceived fairness and management influence over recruitment selection and interview process
- Confidentiality
- Unnecessary steps in absence reporting system

- Uniform policy – clarity on uniform during warmer weather
- Loss of confidence in objectivity and effectiveness of formal process based on communication, timescales and investigation outcomes
- Inconsistent application of flexible working policy
- Working from home giving perception that colleagues are less easily accessible
- Access to bank shifts

Bullying and Harassment

16 concerns were raised in relation to this theme. In 7 out of 16 cases the alleged bully is a line manager or person of seniority, in 9 out of 16 cases allegations of bullying were raised against colleagues. Examples as described by staff:

- Inappropriate language, including name calling, comments intended to belittle.
- Unfair treatment
- Threats of retribution for challenging decisions
- Aggressive communication shouting/swearing
- Blaming a person for problems they did not cause
- Talking openly about other staff members, lack of confidentiality
- Ignoring attempts to make contact – emails and meeting requests
- Unreasonable and threatening behaviour
- Intentional division of teams by colleagues e.g. exclusion from meetings, social activities,
- Repeatedly dismissing a person's views, professional opinions, or contributions in a group setting.
- Lack of support when busy, reluctance to help and make decisions
- Repeated reminders of errors and providing feedback in a manner that is not constructive
- Malicious gossiping

In the majority of cases reported under this theme, staff members reached out to the FTSUG because they believed that the Trust would either not take action or because they feared facing negative consequences for speaking up. In certain cases, employees felt that the Trust was aware of their situation, but failed to provide the necessary support to address the issues at hand. Furthermore, in some instances, actions that were recommended or suggested were not effectively implemented or followed through by the Trust.

In 11 out of 16 cases raised staff members chose for their concern to remain confidential with the FTSUG; some choosing to take concerns forward independently following discussion with the FTSUG, some wanted emotional support and to discuss options, others chose not to pursue their concerns either due to a change in circumstances, unwillingness to move forward or due to change of mind or resignation. 5 cases were escalated into the Trust allowing for themes of concerns to be raised with the Chief People Officer for support and guidance and for HRBPs to provide assurances around processes. 3 concerns remain open with the contacts continuing to pursue informal resolution with ongoing support from the FTSUG.

It is important to acknowledge that some concerns related to bullying and harassment in the workplace may arise from differing interpretations of behaviours influenced by culturally accepted norms and differences. Cultural backgrounds can shape individuals' communication styles, personal boundaries, and perceptions of appropriate conduct. When these cultural nuances are not understood or appreciated by colleagues from different backgrounds, it can lead to misunderstandings, conflict, and potential instances of bullying or harassment.

Discrimination/Inequality

1 case was raised relating to this theme.

The discrimination/inequality case raised during this period related to a staff members' perception that their career, learning and progression is being unfairly hampered for reasons related to a protected characteristic and that they have been treated differently by colleagues and managers.

The staff member engaged in meeting with the Directorate Manager facilitated by the FTSUG during which the staff member was able to be supported to articulate their concerns. The Directorate manager provided support and gained an insight to the staff members experience. The staff member decided not to pursue their concerns further following the meeting.

Behavioural/Relationship

7 concerns were raised in relation to this theme. Examples as described by staff:

- Views and values don't align causing issues
- Nepotism
- Communication breakdowns
- Power imbalance and lack of respect

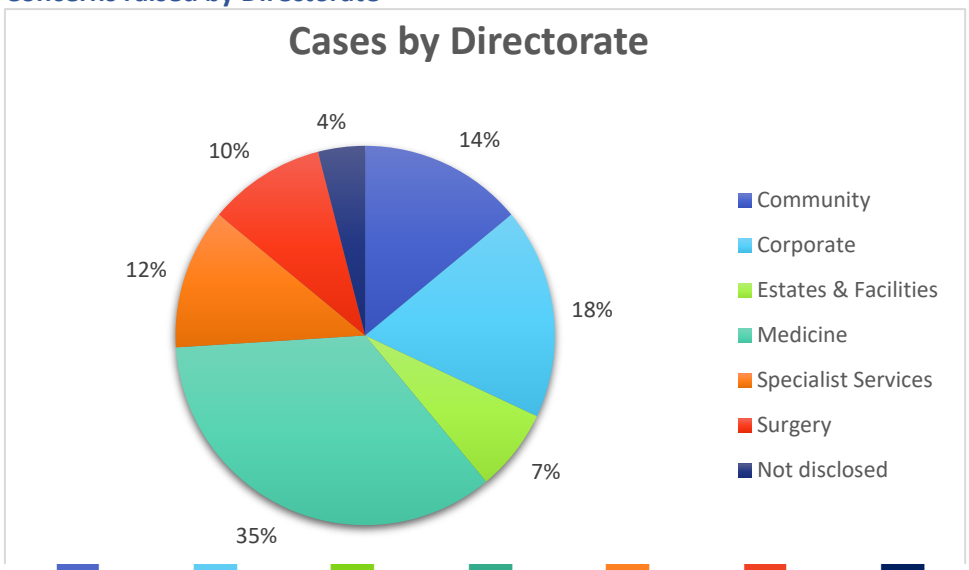
Tensions frequently emerge when there are behavioural and relationship issues in the workplace. The unwillingness to communicate, share experiences, and embrace diverse viewpoints often exacerbates the situation, leading to additional complexities that make rebuilding relationships more challenging.

Other

Fraud – FTSUG supported the escalation of 1 concern to the Fraud Specialist Manager (FSM). A review was undertaken by the FSM which concluded that no fraud had taken place, however recommendations from the FSMs report have been shared with the HRBP and Line Manager for further action.

11. Statistical Graphs

Concerns raised by Directorate

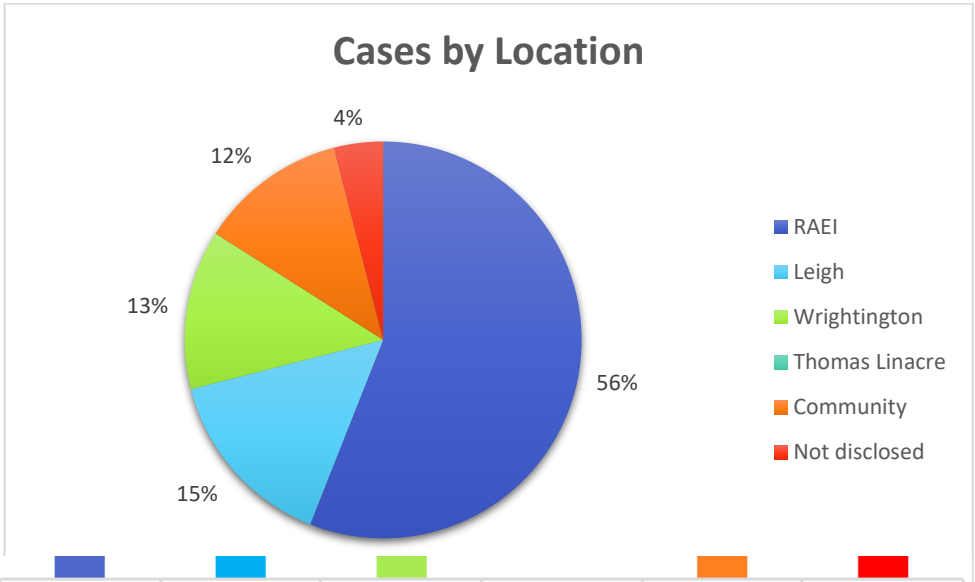


Community	Corporate	Estates & Facilities	Medicine	Specialist Services	Surgery	Not disclosed
11	14	5	27	9	8	3

Increases in concerns raised were shown across all directorates from 21/22 to 22/23

The Medicine directorate for a second consecutive year received the most concerns with 35%.

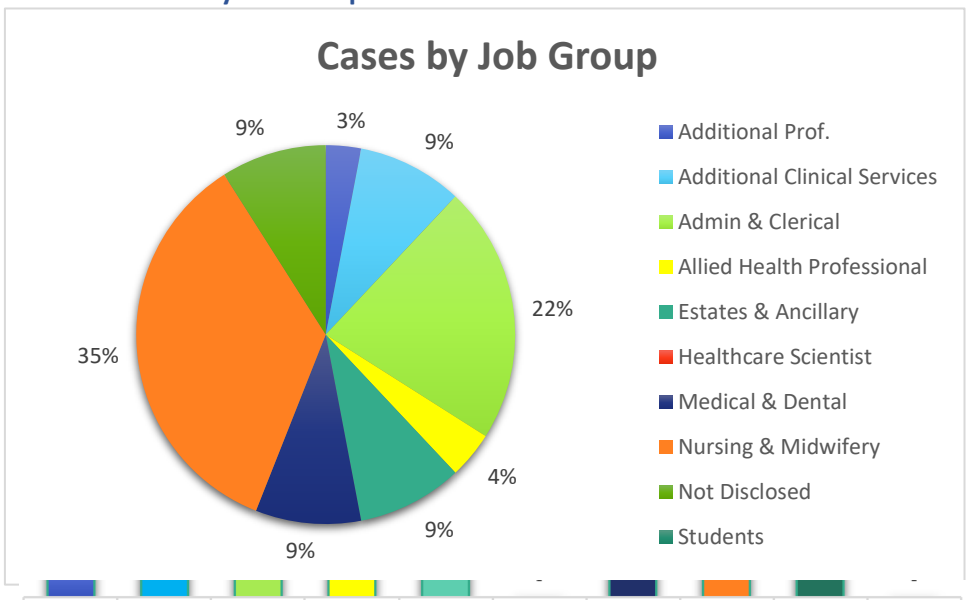
Concerns raised by Location



RAEI	Leigh	Wrightington	Thomas Linacre	Community	Not disclosed
43	12	10	0	9	3

Royal Albert Edward Infirmary for a second consecutive year is the location reporting the most concerns with 56%. Leigh has seen a significant increase in concerns with an 87% increase in concerns in this reporting period.

Concerns raised by Job Group



Additional Prof.	Additional Clinical Services	Admin & Clerical	Allied Health Professional	Estates & Ancillary	Healthcare Scientist	Medical & Dental	Nursing & Midwifery	Not Disclosed	Students
2	7	17	3	7	0	7	27	7	0

22/23 has seen a significant increase in concerns from Nursing and Midwife with 35% of all cases coming from this job group compared to 11% in the last reporting year.

In the previous reporting year, concerns raised in Medical and Dental accounted for 37% of concerns and Admin and Clerical for 34% of concerns which were the largest job groups reporting concerns but have seen a reduction in this reporting year.

Concerns raised by Professional Level

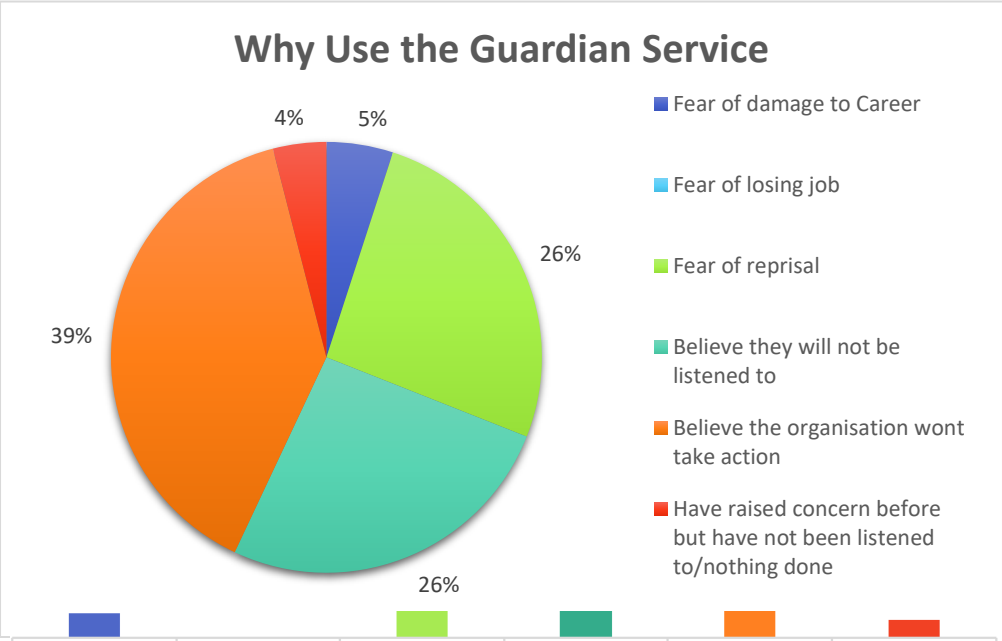
Professional Level	21/22	22/23
Senior Leader	5	5
Manager	5	21
Worker	27	43
Not disclosed	1	8

The table above shows a comparison of the number of concerns that have been raised in 21/22 and 22/23 according to professional level.

Whilst staff at worker level remains the highest proportion of staff reporting concerns through FTSU, 22/23 has seen a considerable increase of concerns from a management level. Managers opting to approach a FTSUG rather than utilizing internal routes is an emerging trend. This shift indicates a growing recognition of the importance of providing alternative avenues for staff with people management responsibilities who are seeking the confidentiality, impartiality, and an independent perspective that the FTSUG is able to provide

12. Why do staff use The Guardian Service?

The Table below shows an overview of the reasons staff use the Guardian Service to support with their concerns.



Fear of damage to Career	Fear of losing job	Fear of reprisal	Believe they will not be listened to	Believe the organisation wont take action	Have raised concern before but have not been listened to/nothing done
4	0	20	20	30	3

The reason for staff contacting the Guardian Service is recorded for all contacts. The responses given by staff over the last 2 years is recorded below.

Reasons for contact	21/22	22/23
Fear of damage to Career	2	4
Fear of losing job	2	0
Fear of reprisal	11	20
Believe they will not be listened to	11	20
Believe the organisation won't take action	8	30
Have raised concern before but have not been listened to/nothing done	4	3

It can be seen from the table that WWL staff are predominantly driven to make contact with the FTSUG because they believe that the Trust will not take action as a result of them raising their concerns. Perceptions of poor organisational listening and fear of reprisal have also been prominent reasons for contacting The Guardian Service in the past 2 years.

Staff may develop a belief that the Trust will not address their concerns due to several factors which have been identified through discussion with the FTSUG. Overall staff perceptions are belief that their concern will be perceived as unimportant thereby assuming their concerns will not provoke any action. That there would be a sense of insignificance when compared to other known concerns within the Trust. Perception is also impacted by the belief that if managers are achieving results that action against them won't be

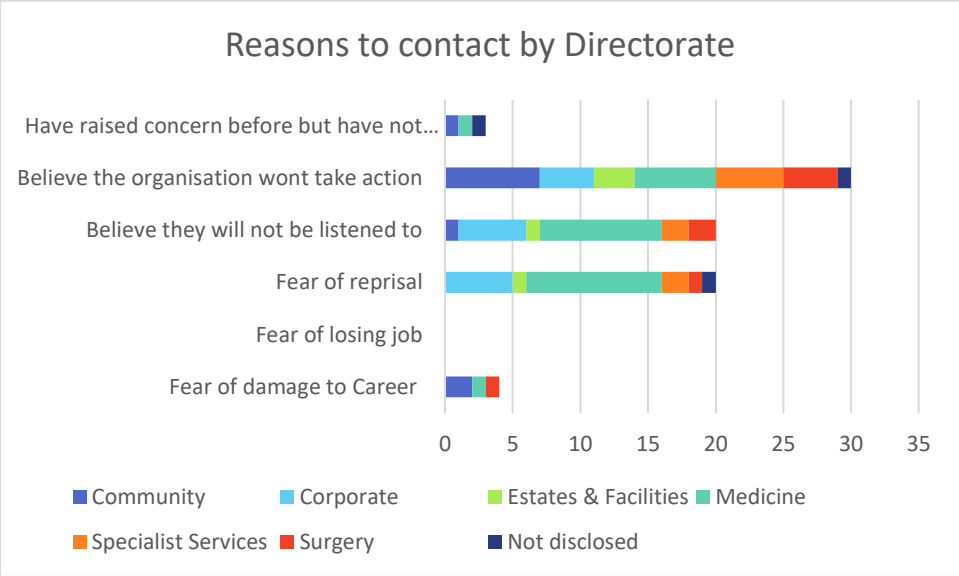
taken, more favourable treatment of managers, and the perception that they wouldn't be believed, communicated to or concerns acted upon without the involvement of the FTSUG.

Reasons for contact	22/23	GSL average 22/23
Fear of damage to Career	5%	9%
Fear of losing job	0%	5%
Fear of reprisal	26%	14%
Believe they will not be listened to	26%	24%
Believe the organisation won't take action	39%	20%
Have raised concern before but have not been listened to/nothing done	4%	28%

NGO data collection does not include the capture of reasons staff choose to share their concern with a FTSUG. In order to benchmark I have used an average valuation for the reasons staff contact the Guardian service across the 15 other Trust as supported by The Guardian Service Limited.

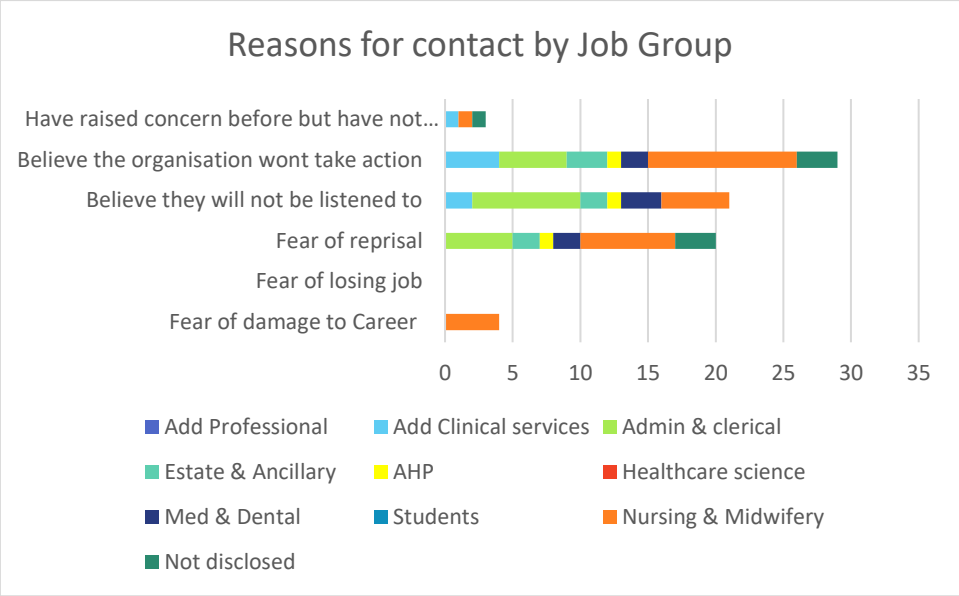
As illustrated in the table above WWL staff report significantly higher than the average in two areas, 'Believe the organisation won't take action' and 'Fear of reprisal', yet contact to the FTSUG because they feel they 'Have raised concern before but have not been listened to/nothing done' is significant lower than the average.

The below table illustrates the reasons for contact to the FTSUG broken down by Directorate.



It can be said from the report that staff within the Medicine and Corporate directorates share concerns for Fear of reprisal should they speak up and that they believe they will not be listened to. Community, Specialist Services and Surgery largely share a belief that the organisation won't take action.

The below table illustrates the reasons for contact to the FTSUG broken down by Job Group.



It can be said from the report that staff within Nursing and Midwifery and Additional Clinical roles believe that the organisation won't take action as the main reason for contacting the FTSUG.

The leading factor for Admin and Clerical staff contacting the FTSUG is a belief that they will not be listened to.

The below table illustrates the reasons for contact to the FTSUG broken down by Job Group.

It can be said form the report that workers leading reason for contacting the FTSUG is due to their belief the organisation won't take action and because they believed that they won't be listened to. Managers are fairly evenly distributed between belief the organisation won't take action, believing that they will not be listened to and fear of reprisal. Senior leaders showed more concern for fear of damage to their career. Staff who did not disclose their professional level mainly feared reprisal and a belief the organisation won't take action.

Other reasons for contact that has been captured were;

- Someone impartial, outside of their situation to talk to.
- Curious about the support the FTSU Guardian could provide
- An alternative option
- Because they wanted someone to listen

13. Detriment

Although, there has been no report of detriment suffered because of speaking up through the Guardian Service channel, staff have reported instances of detriment that they feel has occurred as a result of speaking up directly to their manager or colleague. Detriments reported include:

- Subject to unwarranted internal investigations
- Micromanagement
- Threats of retribution
- Ostracised from meetings
- Coercion of colleagues against them
- Denying annual leave
- Denying access to development opportunities
- Impacting consideration for job opportunities
- Denying access to additional shift work

A number of callers were so fearful that this would happen they decided to withhold their name from the Guardian, were fearful about any details being shared with the Trust that would identify them or took the decision not to pursue their concern.

Detriment is a major concern associated with speaking up and has a huge influence on FTSU culture. Fear of detriment has a huge impact on staff raising concerns through internal routes at the Trust which can lead to lack of innovation, poor communication and collaboration, decreased morale and engagement. To foster a healthy and productive work environment staff should be actively be encouraged and protected at all levels to speak up. Creating effective channels for feedback, addressing concerns promptly and promoting a culture of psychological safety promotes a positive speaking up culture.

The FTSUG will not close cases without approval of the staff member. The staff member is encouraged to keep the lines of communication open throughout their case and following closure any perceived detriments should be advised to the FTSU Guardian to highlight to the Trust as a concern.

14. Action taken to improve the Freedom to Speak Up Culture

- Monthly meetings with the Director of Workforce, to talk through the monthly activity reports which includes themes and outcome of cases. No individual can be identified by the discussion of themes therefore maintaining staff confidentiality.

- Regular meetings with the FTSU NED to talk through the monthly activity reports which includes themes and outcome of cases. No individual can be identified by the discussion of themes therefore maintaining staff confidentiality.

- Regularly meetings held with CEO to discuss emerging themes and learning points.

- Meetings with HR leads within all directorates to share emerging themes and trends of cases. This has been scheduled to occur on a quarterly basis.

- The FTSUG attends sessions for clinical staff, non-registered staff, 1st year nursing, student nursing and kick start staff inductions to brief staff on The Guardian Service support and to promote a positive speaking up culture.

- The FTSUG conducts walkabouts, visiting wards and offices to speak to staff about The Guardian Service and to distribute promotional materials at different locations. The Guardian holds briefings with teams and attend meetings to talk about the service and encourage a culture of speaking up for all staff and managers.

- The FTSUG has attended and had planned to regularly attend future meetings of The FAME , LGBTQ+ and All Abilities network meetings to brief staff on the service and encourages sharing of lived experiences of speaking up and barriers faced by these groups.

- The FTSUG promotes the use of informal resolution strategies where parties are in conflict to support relationship building and restoration as well as individual growth and reflection while also seeking to mitigate the risk of issues escalating to formal channels.

- The FTSU Guardian listens and supports staff to enable them to raise their own concerns. Exploring ideas & options for using existing tools, such as facilitated meetings, peer facilitation, formulating e-mails to managers, verbal communication and preparation for staff attending facilitated or one to one meetings.

15. Learning and Improvements

- The FTSUG attends fortnightly “Listen and Learn” meetings with other FTSU Guardians within The Guardian Service where complex concerns are raised and discussed, and learning is embedded via shared good practices. Reflecting on practice informs continual learning.

- The FTSUG attends North West Regional meetings, workshops, events and conferences organised by the NGO. This, in addition to the NGO Bulletins, enables Guardians to keep abreast of developments in the field which in turn support the effective handling of concerns.

- The FTSUG’s role is complex, and the landscape is constantly evolving. To ensure best practice, the FTSUG completes annual refresher training provided by the NGO to support learning and development needs on changes. The NGO also provides regular updates to the Freedom to Speak Up landscape.

- The FTSUG is a Mental Health First Aider. This is valuable when liaising with staff who may be experiencing poor mental health. The skills learned enable the FTSUG to signpost a person to appropriate support. The FTSUG has also received training in Resilience and Facilitation which are crucial to the role.

- The FTSUG attends quarterly supervised meetings held by a qualified mental health first aid instructor and an ambassador for MQ: Mental Health Charity. This is part of an ongoing GSL ‘Practice Enhancement Training’ schedule.

- FTSU monthly reports as well as annual reports are now shared with the Trusts Senior organisational Psychologist and Staff Engagement and Development Team to allow for FTSU data

to be triangulated and reported with other sources of staff intelligence to create a more rounded view of staff experience across the Trust.

16. Comments & Recommendations

- NHS England have published an updated Freedom to Speak up guidance and reflection tool and FTSU Policy. These address the thinking and language around healthy speaking up cultures for primary care and NHS trusts. The Trust has already revised the FTSU policy but should consider Trust-wide communication to promote the policy and encourage managers to discuss the policy at local level. This would raise awareness of all of the routes to speaking up across the Trust with staff and could be used as an opportunity to have a conversation that encourages speaking up and about the speaking up culture within their teams.

  By 31st January 2024 Trust Boards should evidence:
  - ❖ Local FTSU policy reflecting the updated national template.
  - ❖ Assessment of their organisation's FTSU arrangements against revised guidance.
  - ❖ Assurance of progress aligned with the FTSU improvement plan.

- Address communication issues to improve the workplace culture. It is important for WWL to prioritize effective communication at all levels. Managers should be encouraged to foster open and transparent communication, provide regular feedback and recognition, listen actively to staff, and ensure that information flows freely throughout the Trust. Additionally, implementing training programs and establishing clear communication channels can help enhance communication skills and promote a positive and inclusive workplace culture.

- Managers and leaders play a crucial role in setting the tone for inclusive and respectful behaviour. They should lead by example, demonstrating cultural sensitivity and promoting an environment where diverse perspectives are valued. By actively addressing any concerns or conflicts arising from cultural differences, managers can foster a supportive and inclusive workplace culture. Consideration to providing cross-cultural training and support: Offer specific training programs or resources that focus on cross-cultural communication and understanding. This can help managers develop the skills needed to effectively navigate cultural differences and adapt their leadership approach accordingly.

- Promote cultural awareness and sensitivity: Provide training and workshops that enhance employees' understanding of diverse cultures and promote cultural sensitivity in the workplace. This can help staff to gain insights into different cultural perspectives and norms, fostering empathy and reducing misunderstandings.

- To foster a speaking-up culture, workers need assurance that their concerns will be supported and heard. However, recent cases indicate a lack of confidence among the workforce in the Trust's ability to address and take action on raised concerns. It is crucial to ensure that all elements of speaking up, listening up, and following up are functioning effectively. If any indication of organizational shortcomings arises, a proactive approach should be taken to identify and address problems. Gathering data from various sources such as staff surveys, exit interviews, and informal conversations can provide a broader understanding. If there is a lack of trust in the Trust's ability to listen and act on feedback, conducting listening interventions throughout the workforce can help identify issues and themes. Sharing themes of concerns and what learning points the Trust are taking forward as a result should be considered. This not only demonstrates a commitment to staff and their concerns but is an opportunity for learning to be shared trust wide.

- Civility & Psychological Safety training & strategy – How staff treat each other at work does have an impact on engagement, teamwork, safety, staff wellbeing and patient care. The NHS's People Plan sets out a commitment to support trusts in creating a positive workplace culture. There are toolkits available on the NHS website that can be used to help in this regard.

- Staff involved in the Trust's formal processes have expressed concerns about the negative impact on their mental health and well-being, both during and after the process. It is important to continually assess individuals' well-being and make them aware of available support options. Additionally, aftercare should be considered, including regular check-ins with staff following the outcomes of formal processes, to ensure effective coping strategies are in place for both the accuser and the accused.

- To ensure that employees in less active directorates are aware of how to voice their concerns and are familiar with the available support channels for speaking up within the Trust, it could be advantageous to enhance the promotion of the FTSU in these areas.

17. Staff Feedback

"We need to ensure that everyone, every worker needs to feel safe and confident and comfortable to always speak up"

"This helped me put the situation into perspective. I think I already knew what I had to do, but by speaking to a third person confidentially, this really helped me as the person was impartial, it gave me confidence. Thank you"

"Thank you so much for coming to meet us, much appreciated, and we both felt a lot better having spoken to you"

"It was a good presentation. Made me feel confident to speak up if I needed to."

"Thanks so much for organising a meeting. I cannot tell you how much this means to me"

"Being able to talk openly helped me to get clarity on my situation and helped me to move forward'

"I was glad that there was someone that I could speak to, outside of trust and the independence made me feel confident to speak openly and honestly without feeling judged ad I think it made all the difference in being taken seriously"

"Without your support and escalation of my concerns I don't think I would have been listened to, all trusts should think about the difference someone independent can make when it comes to Guardians'

NHS England North West
Medical Directorate
Professional Standards Team

2022-2023 Annual Submission to NHS England North West:

Appraisal and Revalidation and Medical Governance

Contents

Introduction:
The Annual Organisational Audit (AOA) has been stood down for the 2022/23 year. A refreshed approach is in development. It still remains a requirement for each Designated Body to provide assurance to their Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for assurance visits to Designated Bodies.

Amendments have been made to Board Report template (Annex D) with the intention of making completion of the submission straightforward whilst retaining the goals of the previous report:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

This template for an Annual Submission to NHS England North West should be used as evidence for the Board (or equivalent management team) of compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) or appended to your own board report where a local template exists.

This completed document is required to be submitted electronically to NHS England North West by **31st October 2023** and should be sent to england.nw.hlro@nhs.net

Section 1: General

2022-2023 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	**Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust**
What type of services does your organisation provide?	**Acute NHS Trust**

	Name	**Contact Information**
Responsible Officer	Prof Sanjay Arya	sanjay.arya@wwl.nhs.uk
Medical Director	Prof Sanjay Arya	sanjay.arya@wwl.nhs.uk
Medical Appraisal Lead Medical Appraisal Lead MCh/ITF	Prof Ayaz Abbasi Prof Raj Murali	ayaz-ahmed.abbasi@wwl.nhs.uk raj.mural@wwl.nhs.uk
Appraisal and Revalidation Manager	Kathryn Heffernan	Kathryn.heffernan@wwl.nhs.uk
Additional Useful Contacts Deputy Medical Director	 Prof Nirmal Kumar	 nirmal.kumar@wwl.nhs.uk

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

No

If yes, who is this with?

Organisation: **Please describe arrangements for Responsible Officer to report to the Board:** **Date of last RO report to the Board:** **Action for next year:**

Section 2a: Appraisal Data

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Total number of doctors with a prescribed connection as at 31 March 2023?	453
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023?	260
Total number of agreed exceptions granted between 1 April 2022 and 31 March 2023? (eg: appraisal not due, sick leave, maternity leave)	143
Total number of missed appraisals* between 1 April 2022 and 31 March 2023?	50 As of 21 June = 11
Total number of appraisers as at 31 March 2023?	97

*A missed appraisal is an appraisal that is not completed and no exception has been granted in that appraisal year (1 April 2022-31 March 2023).

Section 2b: Revalidation Data

Timely recommendations are made to the General Medical Council (GMC) about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Total number of recommendations made to the GMC between 1 April 2022 and 31 March 2023?	**71**
Total number of positive recommendations submitted between 1 April 2022 and 31 March 2023?	57
Total number of recommendations for deferral submitted between 1 April 2022 and 31 March 2023?	13
Total number of recommendations for non-engagement submitted between 1 April 2022 and 31 March 2023?	0
Total number of recommendations submitted after due date between 1 April 2022 and 31 March 2023?	1

Section 3: Medical Governance
Concerns data

How many doctors have been through the Maintaining High Professional Standards (MHPS) or equivalent process between 1 April 2022 and 31 March 2023?	3 Dr A – conduct; Dr B – ill Health Capability; Dr C – conduct
How many doctors have been referred to the GMC between 1 April 2022 and 31 March 2023?	0 by WWL Other = 1 (Dr C was referred by safe guarding)

How many doctors have been referred to the Practitioner Performance Advice Service (PPA) between 1 April 2022 and 31 March 2023?	0
How many doctors have been excluded from practice between 1 April 2022 and 31 March 2023?	0

Organisational Policies

List your policies to support medical appraisal and revalidation	Implementation date	Review date
Appraisal & Revalidation Policy	October 2019	October 2022 This was placed on hold due to Trust Handbook being developed, which has now not going ahead, hence the policy requires updating by Oct 2023.
Remediation Policy	October 2019	July 2023 (work in progress)

List your policies to support MHPS and managing concerns	Implementation date	Review date
MHPS	June 2020	July 2023
Disciplinary Policy	June 2021	June 2024

Other relevant policies	Implementation date	Review date

How do you socialise your policies?
All WWL policies are available on the Trust Intranet under Policy Library.

Section 4: General Information

The board / executive management team can confirm that:

4.1 An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes
Action for next year (1 April 2023 – 31 March 2024). Prof Sanjay Arya will continue to be Responsible Officer for next year, supported by Associate Medical Director (RO), Prof Nirmal Kumar, Appraisal Lead WWL, Prof Ayaz Abbasi, Appraisal Lead MCH/ITF, Prof Raj Murali and Medical Appraisal & Revalidation Manager, Kathryn Heffernan.

4.2 The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

No
If No, please provide more detail: Single Appraisal & Revalidation Manager in place with no back up/admin support. No resilience in the current system. This is being looked into.

4.3 An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained?

Yes
If yes, how is this maintained? The Appraisal & Revalidation Manager monitors and updates the connection list with all starters and leavers and monitors all new connections. All inappropriate or incorrect connections are reviewed and where appropriate declined by the Appraisal & Revalidation Manager. Any issues identified are referred to the GMC Connect if clarification is required.
If no, what are you plans to implement a record keeping process? (Action for next year (1 April 2023 – 31 March 2024).

4.4 Do you have a peer review process arranged with another organisation?

If yes, when was the last review?
No current plans, however, Responsible Officer attends NHSE RO Events and Appraisal & Revalidation Manager chairs regional peer group (x 4 meetings per year).

4.5 Is there a process in place to ensure locum or short-term placement doctors working in the organisation are supported, including those with a prescribed connection to another organisation?

Yes

When notified, the Appraisal & Revalidation Manager contacts all locum or short-term placement doctors to make sure they are aware of the appraisal process and requirements. All are invited to meet the Manager for training on appraisals. For those with a prescribed connection to WWL as their designated body, the doctors will undertake an annual appraisal and be supported through revalidation by the Trust if required. For those doctors without a prescribed connection, we offer any support required for revalidation and this varies on a case-by-case basis.

New in-house locum bank system called TempRe has been set up. A & R Manager is emailed any new bank doctors from the TempRe admin team who then contacts the individual doctor to inform and train on the requirements of appraisal and revalidation.

4.6 How do you ensure they are supported in their continuing professional development, appraisal, revalidation, and governance?

All are encouraged to attend departmental/divisional meetings.

All have allocated study leave.

Section 5: Appraisal Information

5.1 Have you adopted the Appraisal 2022 model?

Yes

If no, what are your plans to implement this? (Action for next year (1 April 2023 – 31 March 2024).

WWL doctors can use the Appraisal 2022 model or the standard appraisal form. Some doctors prefer to still use the standard form and report their CPD points and reflections.

5.2 Do you use MAG 4.2?

No (delete as applicable)

If yes, what are your plans to replace this? (Action for next year (1 April 2023 – 31 March 2024).

5.3 Please describe any areas of good practice or improvements made in relation to appraisal and revalidation in the last year (1 April 2022 to 31 March 2023).

Appraisal Update Meetings held twice a year (attended by 60+ consultants). Held in May 2022 and Nov 2022 – invited Dr Chris Moulton, Past Vice President of RCEM, GIRFT Lead on Emergency & Urgent Care, Works for NHSE and NHSI ED congestion and its effects on patient mortality and morbidity.

5.4 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

Appoint Deputy Medical Director to work alongside MD/RO Work on improving resilience in the department (admin) Deputy Medical Director will review random selection of completed appraisals with RO

5.5 How do you train your appraisers?

All new appraisers attend a ½ day online training course run by Miad.

5.6 How do you Quality Assure your appraisers?

Every year the Appraisal Lead reviews two appraisals per appraisee using the PROGRESS Tool form. Feedback is sent to each appraiser at the end of the cycle. Every year the Appraisal Lead and Appraisal & Revalidation Manager run two Appraiser Update Sessions which is monitored by the Responsible Officer. Attendance at these sessions is monitored. Each appraiser must attend one session per year to ensure they are up to date with their role. Appraisers who are unable to attend are provided with content of the presentation.

5.7 How are your Quality Assurance findings reported to the board?

This report is submitted every year to the People's Committee then to the Trust Board.

5.8 What was the most common reason for deferral of revalidation?

Non completion of patient or colleague surveys

5.9 How do you manage doctors that are difficult to engage in appraisal and revalidation?

Escalation process in place which is highlighted by the A & R Manager then to the following – Appraisal Lead – Deputy Medical Director – Medical Director/Responsible Officer

Section 6: Medical Governance

6.1 What systems and processes are in place for monitoring the conduct and performance of all doctors?

Medical Director/Responsible Officer, Associate Medical Director (RO) and the Appraisal & Revalidation Manager have regular meetings with the GMC ELA (every 4 months). If required, discussions are held with the Practitioner Professional Advise Services to discuss individual cases. All doctors are requested to add relevant information in their appraisal. In addition, the Responsible Officer, Appraisal & Revalidation Manager, Associate Medical Director (RO), Chief People Officer and Strategic HR Lead hold a Doctors Concerns Meeting every two months to discuss and review any issues with our current doctors.

6.2 How is this information collated, analysed and shared with the board? (Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors).

Reports are produced using our medical tracker via our governance lead and provided to the Board at set intervals as requested – currently monthly with reference to any exclusions and restrictions. MHPS summary information is reported to the Board as per the annual reporting timeline. Minutes from Medical Director led Doctor Related Concerns meetings, held Bi-monthly are recorded for any audit purposes if required.

6.3 How do you ensure that any concerns are managed with compassion?

The Trust has a Maintaining High Professional Standards Policy which provides a process around all steps and considerations for when a concern arises in relation to a medical practitioner. The Responsible Officer applies compassion when any staff is involved in an incident and ensures any action is fair and proportionate.

6.4 How do you Quality Assure your system for responding to concerns?

System for recording concerns is long established via excel tracker held confidentially within HR system – tracker is updated in line with updated requirements of Board, local and national reporting as required. Bi-monthly Doctor Related Concerns meetings take place to discuss all informal and formal concerns raised to Medical Director or HR to ensure consistency and appropriate advice sought to agree any action. Meeting attendees are Medical Director, Deputy Medical Director (RO), Chief People Officer, Strategic HR Lead.

6.5 How if this Quality Assurance information reported to the board?

HR do not report assurance to the Board aside from advising on any restrictions/exclusions so they have oversight.

6.6 What is the process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility)?

RO to RO communication is completed via the Medical Practice Information Transfer (MPiT) form via email.

6.7 What safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination?

All cases where a concern has been raised by doctors practice are reviewed by the appropriate personnel. If a formal investigation is undertaken a case manager and independent case investigator with HR Support are appointed.

6.8 Please describe any areas of good practice or improvements made in relation to medical governance in the last year (1 April 2022 to 31 March 2023)?

We have continued to quality assure our appraisers through the Appraiser Lead and will now be carrying out further quality assurance through the Deputy MD and RO. We will also continue to hold twice a year Appraiser Update Meetings where we shall invite external speakers to talk about issues regarding appraisal and revalidation.

6.9 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

Three training sessions on Complaints to be set up for doctors in how to respond to complaints. This will be run by the PALS Department. Peer review visit to set up and organised late 2023/early 2024.

Section 7: Employment Checks

What is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties?

Pre-employment checks are carried out by the Medical HR Dept. All doctors are recruited to the Trust (whether substantive or fixed term) are subject to the same pre-employment checks as defined by NHS Employment Check Standards. All references are reviewed by the Deputy Medical Director (RO). References for the MCh/ITF Doctors are reviewed by the GTEC Team.

Do you collate EDI data around recruitment and /or concerns information?

Yes
If yes, how do you use this information?' EDI data is held confidentially within HR systems and only used for demographic and governance processes, such as comparison and assurance reports for the Board or as part of national/local reporting requirements and Freedom of Information requests, that meet the legal criteria for disclosure.

Section 8: Summary of comments and overall conclusion

Please use the table below to detail any additional information that you wish to share.

The Trust is compliant in all areas of appraisal and revalidation over the 2022/2023 appraisal cycle.

Section 9: Statement of Compliance:
The Board of Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body
[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body:
Wrightington, Wigan & Leigh Teaching Hospitals NHS Foundation Trust

Name: Mr Silas Nicholls

Role: Chief Executive

Date: ……..

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Statutory, mandatory and recommended posts
Presented to:	Board of Directors
On:	2 August 2023
Presented by:	Not applicable – consent agenda
Prepared by:	Paul Howard
Contact details:	T: 01942 822027 | E: paul.howard@wwl.nhs.uk

Executive summary

There are a number of posts set out in legislation that a foundation trust is required to have. Additionally, there are a number of posts that are required by regulators or which have been recommended as a result of inquiries, investigations or as best practice.

A table summarising the various requirements and the respective post holders is attached to this report as appendix 1.

Link to strategy

There is no direct link to the organisation's strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with this report.

Financial implications

There are no financial implications associated with this report.

Legal implications

The content of this report covers legal requirements for foundation trusts and serves to provide assurance that all statutory requirements have been satisfied.

People implications

There are no people implications arising from this report.

Wider implications

This report is intended to ensure that the organisation complies with best practice in corporate governance.

Recommendation(s)

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

Appendix 1

Post	Description	Required by	Post holder
STATUTORY POSTS			
Accounting Officer	The Chief Executive must be designated as the Accounting Officer	Schedule 7, paragraph 16(1)(a) to the National Health Service Act 2006	Silas Nicholls, Chief Executive
Director of Infection Prevention and Control	An individual with overall responsibility for infection prevention and control and accountable to the registered provider in NHS provider organisations.	Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance	Rabina Tindale, Chief Nurse
Responsible Officer for Revalidation	A medical practitioner, at the time of appointment and for the preceding 5 years, who must remain a medical practitioner during the course of their appointment. Duties set out in the regulations	The Medical Profession (Responsible Officers) Regulations 2010	Sanjay Arya, Medical Director
Executive lead for safeguarding	A senior board level lead to take leadership responsibility for the organisation's safeguarding arrangements	Section 11, Children Act 2004 and Working Together to Safeguard Children 2015 (mandatory guidance)	Rabina Tindale, Chief Nurse
Authorised Officer in relation to removing person causing nuisance or disturbance	Any English NHS staff member authorised to exercise powers which are conferred or an authorised officer in respect of English NHS premises	Section 120, Criminal Justice and Immigration Act 2008	Ian Bradley, Interim Security and Car Parks Manager
Accountable Emergency Officer	Board-level director responsible for EPRR with executive authority and responsibility for ensuring that the organisation complies with legal and policy requirements and to provide assurance to the Board.	Section 252A National Health Service Act 2006	Mary Fleming, Deputy Chief Executive
Accountable officer for controlled drugs	A fit, proper and suitably experienced person who satisfies the requirements as to seniority, reporting arrangements and activities	Section 8 The Controlled Drugs (Supervision of Management and Use) Regulations 2013	Mike Parks, Director of Pharmacy

Post	Description	Required by	Post holder
Chair	There must be a Chair of the organisation	Schedule 7, paragraph 16(1)(a) to the National Health Service Act 2006	Mark Jones, Chair
Chief Executive	There must be a Chief Executive of the organisation	Schedule 7, paragraph 16(1)(a) to the National Health Service Act 2006	Silas Nicholls, Chief Executive
Designated Individual	Duty to secure that suitable people and suitable practices are used in the course of carrying out the licensed activity and that the conditions of the licence are complied with.	Human Tissue Act 2004	Rabina Tindale, Chief Nurse
Data Protection Officer	To inform and advise on legal obligations, on the carrying out of data protection impact assessments, to act as the point of contact for the ICO and to monitor compliance with personal data policies.	Section 69 Data Protection Act 2018; General Data Protection Regulation	Natalie Baxter, Head of Information Assurance and DPO
Chief Finance Officer	There must be a finance director on the board	Schedule 7, paragraph 16(1)(a) to the National Health Service Act 2006	Tabitha Gardner, Chief Finance Officer
Registered medical practitioner or dentist as a director	One of the executive directors must be a registered medical practitioner or dentist	Schedule 7, paragraph 16(2) to the National Health Service Act 2006	Sanjay Arya, Medical Director
Registered nurse or registered midwife as a director	One of the executive directors must be a registered nurse or midwife	Schedule 7, paragraph 16(2) to the National Health Service Act 2006	Rabina Tindale, Chief Nurse
Nominated individual	Responsible for supervising the management of the carrying on of CQC regulated activities.	Regulation 6, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	Rabina Tindale, Chief Nurse
Named doctor for safeguarding children	To support other professionals in their agencies to recognise the needs of children. This should be explicitly defined in job descriptions.	The Children Act 1989 and 2004; Working Together to Safeguard Children 2015 and 2018 (statutory guidance)	Vineeta Joshi, Paediatric Consultant
Designated doctor for child death	To take a lead in coordinating responses and health input into child death review processes across the locality.	Child Death Review: Statutory and Operational Guidance (England), October 2018	Vineeta Joshi, Paediatric Consultant

Post	Description	Required by	Post holder
Designated Doctor for Safeguarding Children	To support other professionals in their agencies to recognise the needs of children. This should be explicitly defined in job descriptions. To provide Safeguarding Supervision to the Named Doctor for Safeguarding Children.	The Children Act 1989 and 2004; Working Together to Safeguard Children 2015 and 2018 (statutory guidance)	Shirley Castille (provided via CCG commissioning arrangements)
Named Doctor for safeguarding adults	To support other professionals in their agencies to recognise the needs of adults. This should be explicitly defined in job descriptions.	The Care Act 2014	Dr Muhammad Akram, ED Consultant
Named Doctor for Looked After Children	To advocate and ensure that looked after children's issues are reflected in policies and service delivery across the organisation.	The Care Act 2014	Dr Felvira Godinho
Named nurse for safeguarding adults	To support other professionals in their agencies to recognise the needs of adults at risk. This should be explicitly defined in job descriptions	The Care Act 2014	Paula Johnson, Named Nurse for Safeguarding Adults
Named nurse for safeguarding children	To support all activities necessary to ensure the organisation meets its responsibilities to safeguard/protect children and young people. This should be explicitly defined in job descriptions	The Children Act 1989 and 2004; Working Together to Safeguard Children 2015 and 2018 (statutory guidance)	Sarah Rhodes, Named Nurse for Safeguarding Children
Named midwife for safeguarding	To support other professionals in their agencies to recognise the safeguarding needs of pregnant women and the unborn/newborn child. This should be explicitly defined in job descriptions	The Children Act 1989 and 2004; Working Together to Safeguard Children 2015 and 2018 (statutory guidance)	Kerry Ryan, Named Midwife for Safeguarding
Responsible Person	To ensure the correct processing of blood or blood components, including storage and distribution and providing information as required	Blood Safety and Quality Regulations 2005	Jim Wesson, PAWS
Medical Physics Expert (Nuclear medicine) Radiation Protection Advisor (Ionising Radiation and Lasers)	An individual with the knowledge, training and experience to act or give advice on matters relating to radiation physics applied to exposure	Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R)	Tony Hughes and Christie Theodorakou, Medical Physics Experts

Post	Description	Required by	Post holder
Radiation protection supervisor	To secure compliance with the regulations in respect of work carried out in areas made subject to local rules.	Part 3, Section 14 Ionising Radiation Regulations 2017 and Health and Safety Executive Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R)	Lee Unsworth (lead RPS, with specific RPSs for different modalities)
MANDATORY POSTS			
Caldicott Guardian	A senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly	Health Service Circular HSC 1999/012	Sanjay Arya, Medical Director
Guardian of Safe Working Hours	To oversee work schedule review process and to address concerns relating to hours worked and access to training opportunities	2016 terms and conditions of service for doctors and dentists in training	Shams Khan, A&E Consultant
Accredited Security Management Specialist	Focal point for the local delivery of professional security management work carried out to a high standard within a national framework	Direction to NHS bodies on Security Management Measures 2004	Ian Bradley, Interim Security and Car Parks Manager
Accredited Local Counter-Fraud Specialist	To manage fraud, bribery and corruption risks across the organisation and ensure the Trust is compliant with the NHS Counter Fraud Authority (NHS CFA) requirements and the expectations detailed in the Government's Functional Standards (GovS 013), relating to Fraud, Bribery and Corruption.	NHS Counter Fraud Authority (NHS CFA) requirements and the expectations detailed in the Government's Functional Standards (GovS 013) 2021	Collette Ryan, Fraud Specialist Manager
Senior Information Risk Owner	Executive director or member of the senior management board with overall responsibility for an organisation's information risk policy, accountable and responsible for information risk across the organisation.	David Nicholson letter dated 20 May 2008 (Gateway reference 9912)/Data Security and Protection Toolkit	Richard Mundon, Director of Strategy and Planning

Post	Description	Required by	Post holder
Senior Independent Director	To provide a sounding board for the Chair and to serve as an intermediary for other directors when necessary. Should be available to governors if they have concerns that contact through the normal channels of chairperson, chief executive, finance director or secretary has failed to resolve or for which such contact is inappropriate.	Provision A.4.1 NHS Foundation Trust Code of Governance	Rhona Bradley, NED
Named nurse for looked after children	A registered nurse with additional knowledge, skills and experience that has a particular role with looked after children and is the lead professional for these children	Looked After Children: Knowledge, Skills and Competences of Health Care Staff (Intercollegiate Role Framework March 2015)	Michelle Nicholls, Named Nurse for Children in Care
Company Secretary	The secretary of the foundation trust or any other person appointed to perform the duties of secretary	Foundation Trust Constitution	Paul Howard, Director of Corporate Affairs
Resuscitation Officer	Responsible for coordinating the teaching and training of staff in resuscitation. One WTE per 750 members of clinical staff is recommended.	Resuscitation Council (UK) Quality Standards for cardiopulmonary practice and training	Louise Saynor, Matt Sawyer, Lynsey Appleby, Darren Foster
Medication error lead	A board-level director to have the responsibility to oversee medication error incident reporting and learning	Patient Safety Alert NHS/PSA/D/2014/005 MHRA/NHS England March 2014	Sanjay Arya, Medical Director
UK Visa and Immigration Authorising Officer	Senior and competent person responsible for the actions of staff and representatives who use the Sponsorship Management System	UK Visas and Immigration	James Baker, Deputy Chief People Officer
Health inequalities lead	Named executive board member responsible for tackling inequalities	Bullet C4(4), letter from Simon Stevens and Amanda Pritchard dated 31 July 2020 (“Phase 3 letter”)	Sanjay Arya, Medical Director

Post	Description	Required by	Post holder
RECOMMENDED POSTS			
Learning from Deaths Champion	To ensure that processes are robust, focus on learning and can withstand external scrutiny, that quality improvement becomes and remains the purpose of the exercise and that the information published is a fair and accurate reflection of achievements and challenges	National guidance on learning from deaths (National Quality Board, March 2017)	Martin Farrier, Associate Medical Director
NED Lead for Freedom to Speak Up	A nominated non-executive director to receive reports of concerns directly from employees (or from the Freedom to Speak Up Guardian) and to make regular reports on concerns raised by staff and the organisation's culture to the Board	Freedom to Speak Up Review 2015	Clare Austin, NED
NED maternity board safety champion	To ensure unfettered communication from 'floor to board'	Safer Maternity Care 2016, and Ockenden Review 2020	Terry Hankins, NED
Designated board member for Maintaining High Professional Standards (MHPS)	Representations may be made to the designated Board member in regard to exclusion, or investigation of a case if these are not provided for by the NHS body's grievance procedures. The designated Board member must also ensure, among other matters, that time frames for investigation or exclusion are consistent with the principles of Article 6 of the European Convention on Human Rights.	Maintaining High Professional Standards in the Modern NHS (2003)	Francine Thorpe, NED
Wellbeing Guardian	To look at the organisation's activities from a health and wellbeing perspective and act as a critical friend, while being clear that the primary responsibility for our people's health and safety lies with Chief Executives or other accountable officers.	NHS People Plan	Ian Haythornthwaite, NED
MRI responsible person	A person with day-to-day responsibility for safety in the MRI centre	MHRA guidance	Barry Burgess, Cross-Sectional Imaging Manager

Post	Description	Required by	Post holder
Freedom to Speak Up Guardian	A person appointed by the organisation's Chief Executive to act in a genuinely independent capacity	Freedom to Speak Up Review, Feb 2015	The Guardian Service
Freedom to Speak Up Executive Lead	At least one nominated executive director to receive and handle concerns	Freedom to Speak Up Review, Feb 2015	Juliette Tait, Chief People Officer
Medication Safety Officer	A person notified to the Central Alerting System to support local medication error reporting and learning and to act as the main contact for NHS England and MHRA.	Patient Safety Alert NHS/PSA/D/2014/005 MHRA/NHS England March 2014	Kim Ferguson, Medicine Safety Officer
Board-level lead for Net Zero	Board-level lead	Delivering a Greener NHS, 2021	Richard Mundon, Director of Strategy and Planning