Board of Directors - Public Meeting

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

Boardroom Trust Headquarters

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Agenda

13:15 - 13:16
1 min

11. Declarations of Interest

Information *Mark Jones*

Verbal item

13:16 - 13:17
1 min

12. Minutes of Previous Meeting

Approval *Mark Jones*

- 12. Minutes_Board of Directors - 1 Feb 2023 - Public Meeting.pdf (5 pages)
- 12. Public - Minutes Mar 2023 - Board of Directors - Year end items.pdf (2 pages)

13:17 - 13:22
5 min

13. Chair's Opening remarks

Information *Mark Jones*

Verbal Item

13:22 - 13:32
10 min

14. Chief Executive's report

Information *Mary Fleming*

- 14. Board Report_CEO_April_2023_FINAL.pdf (3 pages)

13:32 - 13:52
20 min

15. Committee chairs' reports

Information *Non Executive Directors*

15.1. Research

Clare Austin

- 15.1 AAA - Research - March 2023.pdf (2 pages)

15.2. Finance and Performance

Rhona Bradley

- 15.2 AAA F&P - 29 Mar 2023.pdf (2 pages)

15.3. People

Lynne Lobley

- 15.3 AAA _ People - Mar 2023.pdf (2 pages)

15.4. Quality and Safety

Francine Thorpe

15. AAA QSfeb.23.pdf (3 pages)

15.5. Audit

Ian Haythornthwaite

15.5 AAA Audit - Feb 2023.pdf (2 pages)

13:52 - 14:02
10 min

16. Board assurance framework 2022/23 closing report

Decision *Paul Howard*

16. BAF Report Board April 2023.pdf (29 pages)

14:02 - 14:17
15 min

17. Corporate Objectives 2023/24

Decision *Richard Mundon*

17. Corporate Objectives 2023-24 - Trust Board 06-04-23 Final v2.pdf (12 pages)

14:17 - 14:32
15 min

Break

14:32 - 14:52
20 min

18. Staff Survey report

Discussion *Tracy Boustead*

18. NSS 2022 Results Board of Directors April 2023 290323.pdf (5 pages)

14:52 - 15:07
15 min

19. Integrated performance report

Discussion *Sanjay Arya/Mary Fleming/Rabina Tindale*

19. Board of Directors M11 2223 Scorecard_v1.1.pdf (7 pages)

15:07 - 15:17
10 min

20. Finance Report

Discussion *Tabitha Gardner*

20. Trust Financial Report 22-23 February Month 11 Board.pdf (10 pages)

15:17 - 15:32
15 min

21. Safe nurse staffing quarterly report

Discussion *Rabina Tindale*

21. Safe Staffing 2022 - 2023 Q3 Update Report for Trust Board.pdf (12 pages)

15:32 - 15:42
10 min

22. 7-day services report

Decision *Sanjay Arya*

22. Seven Day Services Audit 2022-23 Final report SAv.pdf (8 pages)

15:42 - 15:52
10 min

23. Annual sustainability report

Discussion *Richard Mundon*

23. Board and Committee sustainability report 22 23.pdf (7 pages)

15:52 - 15:54
2 min

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

Approval *Paul Howard*

24. Statement of responsibilities.pdf (6 pages)

15:54 - 16:00
6 min

25. Consent Agenda

25.1. Revised committee terms of reference

Approval

25.1. Committee ToRs.pdf (3 pages)
25.1. DRAFT ToR - Audit Committee 2023.pdf (7 pages)
25.1. DRAFT Research Committee - ToR 2023 NG RM CA.pdf (3 pages)
25.1. DRAFT ToR - CTC - 2023 NG SM.pdf (3 pages)
25.1. DRAFT ToR - People Committee 2023.pdf (4 pages)
25.1. DRAFT F&P Committee ToR 2023.pdf (4 pages)

25.2. Infection Prevention and Control Board Assurance Framework

Information

25.2. IPC BAF for Trust Board April 2023.pdf (23 pages)

25.3. Joint clinical academic workforce strategy

Ratification

25.3 Joint Clinical Academic Workforce Strategy v2.pdf (6 pages)

16:00 - 16:00
0 min

26. Date, time and venue of next meeting

Information *Mark Jones*

Wednesday 07 June 2023, 1:15 - 4.15pm

Board of Directors - Public Meeting

Wed 01 February 2023, 13:30 - 16:15

Boardroom, Trust Headquarters

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Attendees

Present:

Mr M Jones	Chair (in the Chair)
Prof C Austin	Non-Executive Director
Mr T Boustead	Chief People Officer
Lady R Bradley	Non-Executive Director
Dr S Elliot	Non-Executive Director
Mr M Guymer	Non-Executive Director
Mr I Haythornthwaite	Non-Executive Director
Mr P Howard	Director of Corporate Affairs
Mrs K Knowles	Acting Chief Finance Officer
Mrs L Lobley	Non-Executive Director
Mrs AM Miller	Director of Communications and Stakeholder Engagement
Mr R Mundon	Director of Strategy and Planning
Mr S Nicholls	Chief Executive
Mrs F Thorpe	Non-Executive Director
Ms R Tindale	Chief Nurse

In attendance:

Mr P Desai	Divisional Director of Operations for Surgery (item 17 only)
Prof N Kumar	Associate Medical Director
Ms T Gardner	Chief Finance Officer Designate
Mrs N Guymer	Deputy Company Secretary (minutes)
Ms C Stanford	Divisional Director of Midwifery and Neonates (item 22 only)
Mrs C Wannell	Divisional Director of Operations for Surgery (item 17 only)

Members of the public: 3 present

Meeting minutes

12. Declarations of Interest

Information
Mark Jones

No declarations of interest were made.

13. Minutes of Previous Meeting

Approval
Mark Jones

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

13. Minutes_Board of Directors Public Meeting_071222.pdf

13. Public Board Action Log - Dec 2022.pdf

14. Chair's Opening remarks

Information

Mark Jones

The Chair begun by acknowledging the increasing acuity of patients; continuing increase in medically optimised patients; a decrease in availability of step down facilities; the shortage of nurses and the current ongoing strike action across both healthcare and non healthcare sectors. He emphasised how grateful himself and the other non-executives are for the work of the executive directors, particularly throughout this period. He followed by advising that meetings involving the executive team will now move to be held virtually, to allow the executives more flexibility to deal with pressures and balance their individual work commitments, which have now become more demanding.

He went on to announce that Dr S Elliot will be resigning from his role as a Non Executive Director (NED) with WWL at the end of April 2023.

Finally, he turned his focus to the work which he had been involved with recently at local level and emphasised the importance of considering how the myriad of challenges which he had described at the start of the meeting can be tackled in different and more effective ways

Lastly, he reported back positively on his recent meeting with local MP for Leigh, James Grundy, who attended the ground-breaking of the Community Diagnostic Centre at the Leigh site.

15. Chief Executive's report

Information

Silas Nicholls

The Chief Executive provided a summary of the report which had been circulated in advance of the meeting, highlighting the pressures which had begun before December 2022, due to an increase of patients admitted because they were suffering with COVID-19, high numbers of flu patients and ongoing challenges with discharging medically optimised patients, presenting a challenging set of circumstances for the Trust and resulting in recent declaration of a four day critical incident. He expressed thanks to all colleagues working over that period for their hard work and commitment.

15. Board Report_CEO_February_2023_FINAL.pdf

16. Committee chairs' reports

Information

NEDs

The Chair emphasised that all of the papers providing for noting, including those under the consent agenda have already been reviewed by relevant sub committees and have received appropriate scrutiny in those forums.

He introduced the reports which would be provided by the NED chairs of the Board's committees. A summary of each paper was provided by its respective chair.

16.1. Research

Clare Austin

16.1 AAA - Research - Dec 2022 1.pdf

16.2. Finance and Performance

Mick Guymer

16.2 F&P Committee AAA summary report - Jan 2023.pdf

16.3. People

Lynne Lobley

The Chair queried the progress with identifying funding for the Equality Diversity and Inclusion Lead position.

The Chief People Officer advised that this is currently going through the business case process and that a decision has not yet been made. In response to a query from Lady R Bradley, she advised that there are a number of other temporary or fixed term posts which are also being similarly reviewed and which will also require funding to be identified in order to become permanent.

16.3 AAA _ People - 10 Jan 2023 - awaiting ETM approval.pdf

16.4. Quality and Safety

Francine Thorpe

Mrs F Thorpe, Chair of the Quality and Safety Committee (Q&S) highlighted the data lag and that all of the reports from the last meeting of the Committee were from quarter two. She therefore cautioned that the meeting set to take place in the following week would be likely to see a deterioration in some areas.

The Board received and noted the reports provided.

16.4 AAA Q&S December 22.pdf

17. Integrated performance report

Discussion
Claire Wannell/Rabina Tindale/Tracy Boustead

The Divisional Directors of Operations for Surgery and Medicine joined the meeting.

She provided a summary of the report, noting the ongoing critical incident and that support is being provided from the system as a whole, through meetings attended by senior leads from all system partners, up to 5 times a day. She reported upon the positive results which this had yielded but that it had been difficult to maintain.

She highlighted that in the report the patient 'did not attend' (DNA) rate looks like it has deteriorated but that December is never a comparable month and that an increase is expected to be seen now that the text reminder service has been switched on again.

Mrs L Lobley asked whether the independant sector is undertaking any activity and whether this may be increased.

The Director of Operations for Surgery advised that Buckshaw Village Hospital is providing services in some areas albeit not for surgery, however she advised that there are negotiations about tariff payment and discussions around the independent sector's ability to track the patient journey are currently taking place with other independent providers.

The Committee received and noted the paper and the update provided.

The Divisional Directors of Operations for Surgery and Medicine left the meeting.

18. Performance Report - Community Division Performance Report - Jan 23.pdf
18. Performance Report - Elective Recovery Jan 23.pdf
18. Performance Report - Urgent E Care Jan 23.pdf
18. Board of Directors M9 2223 Scorecard_v1.pdf

18. Board assurance framework

Decision
Paul Howard

The Director of Corporate Affairs summarised the changes to the document since the last meeting and asked the lead executives for each area whether they had any comments to make.

In respect of ‘patients’, the Chief Nurse noted that the Trust is on track to achieve the target in respect of pressure ulcers, however, the increase in complaints shown in the documents means that it is unlikely to achieve in this area.

The Chair asked whether complaints are mainly a result of the standard of care and the current potion of the A&E department.

The Chief Nurse advised that in may cases these are the reasons, whether it be around discharge and the delays here or delays in the time taken to be seen at A&E.

In respect of 'performance', the Acting Chief finance Officer highlighted that all performance related risks have reduce, noting PR13 and PR10 in particular

The Director of Strategy and Planning advised in respect of 'partnerships', that the risk for partnership working with the CCG would need to increase as well as the risk to achievement of CO16 and university hospital status, which is due to a lack of consultants in post who have a substantive contract with Edge Hill University.

The Board **APPROVED** the risk ratings set out in the report and agreed that they provided an accurate representation of the current risks to delivery of the Trust's strategic objectives.

17. BAF Report Board 1 Feb 2023 final version.pdf

19. Finance Report

Discussion
Kelly Knowles

The Acting Chief Finance Officer provided a summary of the report which had been circulated in advance of the meeting. She highlighted that the Trust is currently reporting an actual deficit of £14.3m against the planned deficit of £5.9, however, this includes £4.0m transacted in month 9, in respect of the funding of cycle lanes, done through thre Community Health Investment Plan, with the council and that the external auditors have advised that this should be reported as an impairment,
therefore excluded from the adjusted financial performance, which is used to measure system performance. The adjusted financial performance is a deficit of £10.1m.

The Board recieved and noted the report.

19. Trust Financial Report 22-23 December month 9 Board.pdf

20. Risk appetite statement 2022/23

Decision
Paul Howard

The Director of Corporate Affairs introduced the item by advising that the previous year's risk appetite statement has now been reviewed and revised and has been presented for approval.

The Board reviewed and **APPROVED** the Trust's risk statement for 23/24, along with the recommendations outlined within the report.

21. Risk Appetite - Board Final 1 Feb.pdf

21. Well-Led action plan

Decision
Paul Howard

The Director of Corporate Affairs summarised the report and its recommendations. He added that, regardless of when the actions set out are closed, the Board had previously agreed that it would commission an 18 months review, followed by a 3 year review of its position.

Mrs F Thorpe queried whether the report could negatively impact on a CQC inspection, given that completion of some actions is currently delayed and that 'well led' is one of their key lines of enquiry.

The Director of Corporate Affairs noted that the review was carried out to comply with an NHSE requirement and the are results therefore reported to them. The recommendations were not set by the CQC so it is unlikely that they would have a negative view of progress against the action plan, he felt that they would be more likely to consider this as evidence that the Board has had 'well led' under regular review and therefore in a positive light.

The Board accordingly **APPROVED** the closure of actions associated with recommendations 1, 13 and 14, as well as the extension of timescales associated with recommendations 4 and 5.

22. Well-led action plan - Feb 2023.pdf

22. Maternity

Decision
Rabina Tindale

The Chief Nurse introduced the Deputy Divisional Director of Midwifery and Neonates Maternity and Child Health, who had joined the meeting to present the maternity reports.

22.1. Report on Clinical Negligence Scheme for Trusts (CNST) compliance - including annual declaration

Decision
Rabina Tindale

The Chief Nurse reminded the Board of their previous decision that they would take assurance from the Q&S Committee who have had a more detailed oversight of how the Trust complies with delivery of the 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. She noted that where any requirement has not technically been fulfilled, the team have reviewed the actions that the Trust has taken and can assure the Board that these are adequate to discharge the essence of what is required.

Mrs L Lobley pointed out that page 13 of the CNST report notes the requirements of what a trust's Board should have sight of and asked whether this can be used going forwards to shape what is presented to WWL's Board.

The Board agreed that despite that not all of the information had been reviewed by them specifically, assurance had been provided that the Trust are performing as required by both the Ockenden report and the CNST report. Members agreed that they had also received adequate assurance from the Q&S Committee, which had been provided with more granular detail. They therefore **RECOMMENDED** the document for sign off by the Chief Executive.

20.1 ATAIN ACTION PLAN UPDATED Jan 2023.pdf
20.1 Trust Board – Maternity Incentive Scheme Update.pdf
20.1 Letter GMEC LMNS_CNST Sign off by ICB 20.12.22.pdf
20.1 MIS_SafetyAction_2023_V13 1.pdf

22.2. Maternity Dashboard

Information
Rabina Tindale

The Board received and noted the dashboard.

20.2 Maternity Dashboard report December 22.pdf
20.2a December 22 Maternity dashboard.pdf

22.3. Maternity Perinatal quality surveillance

Information
Rabina Tindale

The Board received and noted the report and its recommendations.

The Deputy Divisional Director of Midwifery and Neonates Maternity and Child Health left the meeting.

20.3a December 2022 Perinatal Dashboard.pdf
20.3 Maternity Perinatal Quality Surveillance Q3(For Board).pdf

23. Consent agenda

The Board having previously consented to these items appearing on the consent agenda, **RESOLVED** as follows:

23.1. Infection prevention and control board assurance framework

Information

THAT the report be received and noted.

23.1 FINAL IPC BAF for Board 1.2.23.pdf

23.2. Standing Financial Instructions

Approval

THAT the changes to the document, which had been recommended by the Audit Committee be **APPROVED**.

23.2 SFI Changes Trust Board.pdf

23.2a SFIs Sept 2022 after changes.pdf

24. Date, time and venue of next meeting

Information

Mark Jones

5 April 2023, Boardroom, Microsoft Teams, 1:15pm - 4:15pm

Board of Directors - Year end items

Wed 29 March 2023, 13:00 - 14:30

Microsoft Teams

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Attendees

Present:	
Mr M Jones	*Chair (in the Chair)*
Prof S Arya	*Medical Director*
Prof C Austin	*Non-Executive Director*
Mr T Boustead Lady	*Chief People Officer*
R Bradley	*Non-Executive Director*
Dr S Elliot	*Non-Executive Director*
Ms M Fleming	*Deputy Chief Executive*
Mr M Guymer	*Non-Executive Director*
Mr I Haythornthwaite	*Non-Executive Director*
Mr P Howard	*Director of Corporate Affairs*
Ms T Gardner	*Chief Finance Officer*
Mrs AM Miller	*Director of Communications and Stakeholder Engagement*
Mr R Mundon	*Director of Strategy and Planning*
Mr S Nicholls	*Chief Executive*
Mrs F Thorpe	*Non-Executive Director*
Ms R Tindale	*Chief Nurse*
In attendance:	
Mrs N Guymer	*Deputy Company Secretary (minutes)*

Meeting minutes

25. Chair and Quorum

Information
Mark Jones

The Chair opened the meeting, noted that a quorum was present and declared the meeting duly convened and constituted.

26. Apologies for Absence

Information
Mark Jones

Apologies had been recieved from Mrs L Lobley, Non Executive Director.

27. Declarations of Interest

Information
Mark Jones

No declarations of interest were made.

28. Gender pay gap report

Approval
Tracey Boustead

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

The Medical Director expressed his support for further reduction in the gender pay gap, which he acknowledged is in the main amongst the medical consultant workforce. He has taken positive action to encourage the female members of this workforce to apply for leadership positions across WWL and was keen to work with the Chief People Officer moving forwards, to reduce the gap further.

Prof C Austin noted that it would be useful moving forwards to compare WWL with neighbouring trusts.

Lady R Bradley asked whether there is any action is being taken through the current strike negotiations in respect of NHS workers' pay, to rectify the gender pay gap.

The Chair clarified that the queries raised would fall to be addressed by the executive team in the first instance, with oversight maintained by the People Committee, where appropriate.

The Board of Directors **APPROVED** the gender pay gap report, as presented, to meet the legal obligation to publish this data on both WWL's website and the NHS national website.

04. Gender Pay Gap report 2022 (published 2023).pdf

29. Modern slavery Statement 2023/24

Approval
Paul Howard

The Director of Corporate Affairs presented the report and attached statement, which had been shared in advance of the meeting.

The Board of Directors **APPROVED** the statement, as presented.

05. Modern slavery statement 2023-24.pdf

30. Use of common seal FY2022/23

Noting
Paul Howard

The Director of Corporate Affairs presented the report, which had been shared in advance of the meeting, outlining the occasions on which the foundation trust's common seal has been applied during the financial year 2022/23.

The Board of Directors recieved and noted the report.

06. Use of the common seal.pdf

31. Resolution to exclude members of the press and public

Approval
Mark Jones

The Board **RESOLVED** to exclude any members of the press and public present.

33. Date, time and venue of next meeting

Information
Mark Jones

Wednesday 5 April 2023, 12:15 - 4:15pm, Boardroom, Trust Headquarters

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Chief Executive's Report
Presented to:	Board of Directors
On:	05/04/23
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

A phenomenal Trust-wide effort has been made over the past two months to tackle the ongoing operational pressures we have now been seeing for a prolonged period. A joined-up, cross-divisional and partnership approach to providing our critical and emergency services for patients who need it most, has been essential to the way we have met our recent challenges. I would like to thank everyone involved, from our teams here at WWL, to our partners in primary care, the local authority and Trusts within Greater Manchester (GM). We have a strong focus to make the necessary improvements to our discharge and flow process, along with our partner support and input, which will help alleviate the pressure experienced within our Emergency Department and I will update the Board at regular points on this improvement work.

As a Trust, we had to work in a different way in March to ensure patient safety when our Doctors in Training took part in the British Medical Association industrial action against the Government. All but our essential services were stepped down during the three-day period. I would like to thank our patients for their understanding during this time, as we needed to make some temporary changes to our services and reschedule appointments, to ensure we could support those patients in our care or who needed us in an emergency.

The annual National Staff Survey results were released last month, and I am delighted to report that we experienced a significant uplift in our response rate, rising 6% to provide the Trust with its highest ever response rate at 35%. A lot of hard work went into encouraging staff to complete the survey, and we are committed to further increasing this figure when the 2023 survey comes around later in the year. From the feedback we received, WWL ranked number one in GM compared to all other Acute and Community Trusts for morale, putting us in the top 10 nationally, as well as first in GM for the second year in a row when it comes to our staff recommending our Trust as a place to work. We also ranked first in the North West for flexible working, first in GM for feeling safe and healthy, and second in GM for staff engagement. Equality and diversity, and motivation also scored highly this year. It is crucial that not only do we celebrate the things we are getting right for our workforce, but that we continue to focus on key areas of development for the year ahead and beyond; this is being driven by a Trust-wide staff engagement and culture programme called ‘Our Family Our Future Our Focus’. This focuses on five key pillars: Culture, Leadership, Wellbeing, Professional Development and Communications.

The working environment created at the Trust is crucial to driving us forward, particularly when engaging with potential staff and showcasing WWL and the benefits of working here during the recruitment process. We recently held an excellent recruitment event for theatre roles at our Orthopaedics Centre of Excellence at Wrightington Hospital, recruiting for posts in theatres across all three of our sites. The turnout was very encouraging, with more than 60 people attending, including a mix of qualified Nurses and Operating Department Practitioners, third year students and local people looking to apply to our Theatre Assistant vacancies. Events like this will continue throughout the year, such as our Midwifery recruitment event at the Royal Albert Edward Infirmary in May, designed to inform future midwife qualifiers about working in Wigan, with information about our services and how we can support and develop their careers. Not only are we looking for the professionals of today, but we continue to plan for the future, highlighted at a recently held catering insight day at Leigh Infirmary for students from local high schools, giving young people an idea of the different types of careers available in the NHS.

Shortly before our last Board meeting, we made further improvements to the way we engage with the Armed Forces community by introducing a guaranteed interview scheme, meaning members of this community who apply for roles within WWL, will now be offered interviews when all essential job criteria laid out in job descriptions and specifications are met. The scheme supports the pledges in the Armed Forces Covenant and the Trust’s accreditation as a ‘Gold Award’ employer. By providing guaranteed interviews, we will be helping veterans across the Wigan Borough to demonstrate their skills beyond the initial application stage and pave the way for greater employment opportunities for the Armed Forces community at WWL. The scheme does not offer a

guaranteed job but does allow veterans, reservists, and their families a better chance to find work, especially when it can be hard for them to transition to civilian life and secure employment.

Innovation, improvement and integration are key to the success of Our Strategy 2030, the Trust's shared vision for the future set out in 2021. In the last two months, I have seen great examples of all three of these strategic priorities. At our virtual All Staff Team Brief session in March, innovations in the way we care for our patients with a dementia diagnosis, and their families was highlighted by our Lead Admiral Nurse, Mark Oakley, who spoke about our Admiral Nurse Service, which was launched in October 2021. Referrals to the service continue to grow in tandem with the innovative ways Mark and his team are caring for patients, including the delivery of the RITA (Reminiscence Interactive Therapy Activity) system across a number of wards. This system provides a screen and tablet to patients, allowing colleagues to empower patients to engage more, especially when they are unable to communicate. Working with one of our Dental Nurses, the service has also helped to bring a product called Jelly Drops to WWL to improve appetite, hydration and urine output in patients with a dementia diagnosis. By using this confectionary item, we can give patients 400-500 millilitres of extra fluid.

Earlier this month, Ms Yvonne Forvargue, MP for Makerfield, officially opened our new Clinical Research Hub based in the community of Ashton-in-Makerfield. The opening of the Research Hub achieves a key objective within the first year of the Trust's recently published five-year research strategy, 'Research for All' and will improve visibility of WWL's research in a community setting, being centrally located and covering a wider area across the Wigan Borough. It will also offer more opportunities to integrate with the Healthier Wigan Partnership (health and care providers across primary, community, mental health, social care, and secondary and specialist care) and schools. I'm very proud of our new facility and delighted that we have around 100 studies currently being undertaken across WWL and more in the pipeline. The Trust was also able to purchase new and essential clinical research equipment for the new facility, thanks to a grant provided by The Greater Manchester Clinical Research Network (GMCRN).

I'd like to take the opportunity to put on record my thanks to our Chief Nurse, Rabina Tindale, who is soon due to retire from the NHS. Interim arrangements will be in place when Rabina leaves WWL and, in line with all Board appointments, a rigorous recruitment process will take place to find Rabina's permanent successor. I would also like to officially welcome Tabitha Gardner to the Board of Directors. Tabitha joined the Trust in March, having held the role of Director of Finance at Rochdale Care Organisation, part of the Northern Care Alliance NHS Foundation Trust.

Finally, I would also like us to take a moment to reflect and remember our retired colleague Andrew Foster CBE, who sadly passed away in March. Andrew was a strong and influential leader at WWL, being Chief Executive for over 12 years and prior to this as Chairman for five years. Andrew made such a significant contribution, not just to WWL, but to the wider Wigan Borough, Greater Manchester and beyond. His principal focus was on quality and staff engagement, with a particular desire to learn from the best hospitals in the world. Under his leadership, WWL, developed a significant reputation, winning many national awards including Provider Trust of the Year in 2014. Andrew was a great advocate for engaging with staff and created a culture of openness, honesty and transparency at WWL and his legacy lives on at the Trust to this day. He was a great Chief Executive and friend to many who will be sadly missed.

Committee report

Report from:	Research Committee
Date of meeting:	7 March 2023
Chair:	Clare Austin

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

ALERT

- The committee wish to alert the Board to the change in requirements to achieve University Hospital Status with the Trust now requiring 6% of consultant staff to be clinical academics, which is equivalent to 14 consultants although the exact numbers will need to be confirmed since there is a lack of clarity as to whether the consultant numbers also include locums, for example.
- Whilst our strategy to achieve these numbers represents a continuing risk, the Committee discussed a plan on how the Trust can achieve the staffing numbers required.
- The committee were made aware that whilst for 2024/25 the Trust will achieve the £200k from the Research Capacity Funding (RCF) required to achieve University Hospital Status, the current predictions for 2025/26 are not at this level at the moment.
- Currently there are no further NHIR sponsored trials due to a recent submission for the BETTER trial being unsuccessful at stage 2.

ASSURE

- The research assurance framework presents both quantitative and qualitative information against each of the strategic objectives.
- The number of commercial trials being undertaken are back to pre-covid numbers and is the best it has been for 3 years.
- Recruitment of participants to research activity is on target.
- The committee were assured that the Clinical lead for research in the community is already actively engaged with research.
- Following the first look of a short video presentation to recruit patients to the RAPSODI trial the committee were pleased to see EDI patients being identified and promoted and are keen for the video to be presented to the Board once it has reached its final iteration promotion within clinical trials – video to be shown at board once completed.
- The committee were presented with data to show why Expressions of Interest have been declined and were assured with this transparency.
- The committee were assured by the restructuring of the research budget codes on the ledger, which provides greater clarity on the income and expenditure of individual studies. They were also assured by the strong overall financial position for R&D and, given the income related strategic objectives, particularly by the fact that overall income is

forecast to increase by 11% compared to the prior year and commercial income is projected to rise by 87%. ▪ The committee noted the increase in reported publications and were assured that research outputs were being appropriately communicated.
ADVISE
▪ The committee would like to advise the Board that the Research Hub will be officially open on the 24 March 2023 ▪ A member from Health Innovation Manchester attended the March Research Committee meeting and this relationship will now continue. ▪ The committee discussed the Research committee effectiveness review and provided feedback to the Company Secretary to complete said review. ▪ The links between the Research Agenda and the Corporate Agenda are greater.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
▪ The risk around the Clinical Academic Strategy to achieving University Hospital status has reduced.

Committee report

Report from:	Finance and Performance Committee
Date of meeting:	29 March 2023
Chair:	Mick Guymer (supported by Rhona Bradley)

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

ALERT

- The Committee noted that achievement of corporate objective CO12 around urgent care would not be achieved for 2022/23.
- The 2023/24 delivery plan is heavily predicated on the delivery of the system response to reducing the no right to reside figures.
- WWL is currently £4.5m above the agency ceiling.
- The 2023/24 financial plan was presented at a £37.1m deficit and the risks discussed and recognised. The challenges to achieving the plan were noted.

ASSURE

- The Committee felt assured that the 2022/23 deficit of £1.4m would be achieved and that the full capital allocation would be utilised.
- Assurance was affirmed around the internal controls for monitoring overheating incidents and the Committee requested that Quality and Safety Committee maintain oversight of any implications that incidents may have on patient care moving forwards.
- There was significant assurance around achievement of the elective NHS mandated waiting times.
- Assurance was provided around the ongoing discussions being had at Healthy Wigan Partnership system level around the support required for WWL as a locality in delivering the NHS constitutional standards.

ADVISE

- Recovery action planning implementation and delivery (RAPID) reviews will now be monitored at executive or management level, pending agreement from the incoming Committee Chair.
- The 2022/23 month 11 finance report was reviewed, with an increased confidence expressed given the revised deficit position of £1.4m.
- The Committee endorsed the business case for the Wrightington Theatre 11 improvements, for Board approval and then progression to the NHSE regional and national forums. The revenue risks were acknowledged and noted.

▪ The Committee's effectiveness review was carried out with agreement that the incoming Committee Chair will have the opportunity to feed in to changes to be made after around 6 months in post. ▪ The Committee approved slight revisions to the terms of reference.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
▪ The risks to the 2023/24 financial plan were noted and acknowledged. ▪ The risks around long-term finances were once again noted and the need for a longer term plan acknowledged.

Committee report

Report from:	People Committee
Date of meeting:	14 March 2023
Chair:	Lynne Lobley

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

ALERT
▪ The Committee expressed concern around some risks in respect of industrial action, including: - The potential for a full consultant strike to occur; - The potential for the junior doctors' strike to continue for a further 20 days over an undefined period. ▪ The people dashboard had not been updated due to operational pressures and therefore was included on the consent agenda for information only.
ASSURE
▪ The workplan was noted as a useful tool and the Committee acknowledged the amended scheduling of various items, including those deferred due to strike action. ▪ The Committee received an update on the junior doctors' strike, including the action taken and measures put in place by the Trust to manage this thus far. The Committee felt secure with the plans in place to maintain patient safety throughout. ▪ The Committee received the analysis of the latest National Staff Survey results and were assured by the improvement of 5.5% to a 35% response rate; as well as that morale ranks first within the Greater Manchester Health and Social Care Partnership and top ten nationally. ▪ The Committee were thankful to the work of the communications team in propelling communications around the staff survey and how this contributed to the improved response rate.
ADVISE
▪ The Committee carried out its annual effectiveness review. Amendments to the workplan were discussed, including ensuring that the Committee receives updates on the 'Our Family, Our Future, Our Focus' initiative, as well as work going on at place level. The need to ensure that the divisions and the Finance and Performance Committee are linked in where appropriate was also noted. ▪ The Committee has requested a debrief be provided following both the nurses' and junior doctors' strikes and will also hear a future staff story from a junior doctor. ▪ The Committee were happy to support the suggestions put forward in respect of the 'People' corporate objectives and related strategic measures, for the following financial year. ▪ The Committee noted how the national staff survey validated several of WWL's existing workstreams, including improving the appraisal process as well as training and

career progression. ▪ The Committee observed that the Trust has taken a caring approach towards supporting staff taking part in the junior doctors' strike.
RISKS DISCUSSED AND NEW RISKS IDENTIFIED
▪ See above.

Committee report

Report from:	Quality and Safety Committee
Date of meeting:	8th February 2023
Chair:	Francine Thorpe

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

ALERT

- It is unlikely that we will achieve a 25% reduction in mortality related to sepsis by 31st March 2023 (corporate objective (CO) 1) due to a number of factors including the sustained pressure within the emergency department (ED) leading to delays in the recognition and treatment of sepsis.
- Delay in completion of baseline audits relating to patients who die in their preferred place of death means that a target for improvement has not yet been set; therefore we are unlikely to achieve objective CO2.
- Gaps in the provision of community care for people wishing to die at home have been identified and further work is required to understand how this contributes to hospital admissions.
- Partial achievement of objective CO3 is anticipated with good progress being made in human factors training for staff. Improvements have been sustained in the prevention of pressure ulcers, however we have narrowly missed our target of zero preventable category 3 or 4 with one category 3 being reported.
- Although significant improvement has been made in complaints response times, with some divisions achieving the target, it is unlikely that we will achieve our trust target of 85% by 31st March 2023 (CO5)
- The maternity and neonatal service spotlight report highlighted 9 serious incidents (SIs) reported in Q3. Investigations are ongoing and safety summits have been held to review key themes. There is no single theme identified that links all incidents.
- 5 SIs were reported in the ED during the period of the critical incident in December. Further information has been requested in relation to actions being taken to maintain patient safety in response to the issues identified. Four incidents related to delay in diagnosis
- The committee has asked for information to be presented in relation to the effectiveness of Diabetes services provided by the Trust. SIs were reported in two different services relating to diabetic patients and it was noted that national data on diabetic outcomes places the Wigan locality in the lowest quartile

- The Q3 IPC report indicated and increase in clostridium difficile cases. The Trust will not meet the agreed trajectory for 2022/23. Comparative data across Greater Manchester (GM) and nationally has been requested for the next report.

ASSURE

- Significant progress was noted in the measures against the 5 areas for improvement highlighted as part of the ASPIRE accreditation process. Accreditation visits continue despite the ongoing challenges.
- The harm free care report was received providing assurance in relation to the ongoing reporting, monitoring and improvement work. Despite the sustained organisational pressures improvements were noted in a number of areas; training compliance continues on an upward trend.
- The spotlight report on maternity and neonatal services provided assurance against:
  - Ockenden actions
  - CNST compliance
  - Improvements in perinatal mortality (lowest stillbirth rate in GM)
  - Multidisciplinary training compliance
  - Maternity dashboard metrics (6 areas above GM average)
- The Q2 and Q3 complaints report highlighted improvements in complaint response times (45% in Q2, 59% in Q3). The Q3 report evidenced improvement in the quality of responses with a 38% reduction in "second bites"
- The Patient Experience Report highlighted assurance around the following:
  - Increased response rates for friends and family test
  - Feedback being sought through an In-house survey
  - Actions taken as a result of patient feedback
  - Progress in the development of a revised strategy
  - Targeted work being undertaken to seek feedback from under-represented groups e.g. people with a learning disability
- The safe staffing report provided assurance in relation to reduction in nursing vacancies, particularly within the division of medicine. Delays in the appointment of international recruits were noted however it is expected posts will be filled by April 2023.

ADVISE

- A Task and Finish Group has now been established to review any themes and develop actions relating to patients "being lost to follow up" which was highlighted in the serious incident report in December 2022. The committee will maintain oversight of this work through regular reports.
- An increase in red flags was noted within the safe staffing report, however these are being managed by twice daily safe staffing huddles where decisions are taken to deploy staff according to need. This does however impact negatively on the supernumery status of ward leaders which is regularly tracked.
- Four areas on the maternity dashboard were noted to be below the GM average. Further information has been requested for the next meeting in relation to audits undertaken to review the administration of steroids in premature labour as this is an area where the Trust is consistently RAG rated as red.
- Further information on the outcomes of learning disability mortality reviews (LeDeR) was requested; it was agreed that this should be taken forwards through relevant safeguarding forums.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED
• Risks relating to the board assurance framework (BAF) were discussed, the increased likelihood of non-achievement of some of our corporate objectives was noted. • There are 3 high risks relating to potential safety issues within the ED because of overcrowding and consistent high attendances. These were considered in the update provided by the Divisional Lead for Medicine.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Committee report

Report from:	Audit Committee
Date of meeting:	28 February 2023
Chair:	Ian Haythornthwaite

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

ALERT

- The external auditor's fees for the year have increased by circa £7k as a direct result of additional systems audit work required by the system. This requirement applies to all NHS Trusts.
- In the last round of internal audit reviews, the Trust received one 'limited' assurance report relating to waiting list management.
- The Committee raised concerns around the progress being made with the administration of the overseas visitors and private patients service – these have now been referred to the executive team and brought to the attention of the Chief Executive specifically.
- The Committee raised concerns around the lack of expected completion dates on some of the outstanding internal audits for 2021/22.
- The Committee wishes to alert the Board that it has agreed to defer some of the internal audit work until 2023/24:
    - SLA management
    - Safer nurse staffing

  The Committee subsequently agreed that the audit days are utilised on an audit of the Trust' 'PAS Upgrade' and on a 'Safeguarding' audit.
  It should be noted that this will not affect the year end audit opinion from the internal auditors (MIAA).

ASSURE

- Seven internal audit reports were completed in this period, one of which was 'limited' as described above, the other six were either 'moderate' or 'substantial'.
- The Committee received satisfactory assurance around the risk register, single tender waivers report and the counter fraud report.
- The Committee received assurance from the external auditors (KPMG) around the preparations that that Trust has made ahead of the year end audit.

ADVISE

- The future requirements of the Healthcare Financial Management Association checklist are currently unclear and if MIAA are expected to repeat the exercise in 2023/24 this may impact on WWL's internal audit plan.
- The Committee received an update on the accounting policies to be applied in the accounting year ending in March 2023 and recommend these to the Board for approval.
- The Committee received the; freedom to speak up tracker; counter fraud workplan; Committee workplan and minutes of its reporting groups.
- The Committee reviewed evidence which demonstrated the Trust's compliance with the NHS Foundation Trust Code of Governance and recommend to the Board that it declares such compliance in the Trust's 2022/23 annual report and accounts.
- The revised terms of reference were agreed and will be submitted to the Board for approval.

RISKS DISCUSSED AND NEW RISKS IDENTIFIED

- Not applicable.

Title of report:	Board Assurance Framework (BAF) 2022/23 Closing Report
Presented to:	Board of Directors
On:	5 April 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 closing report of the trust's key strategic risks to the achievement of the annual corporate objectives 2022/23 is presented here for approval by the Board.

Link to strategy

The risks identified within this report relate to the achievement of strategic objectives.

Risks associated with this report and proposed mitigations

This report identifies proposed framework to control the trust's key strategic risks.

Financial implications

There are three financial performance risks within this report.

Legal implications

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

People implications

There are four people risks within this report.

Wider implications

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

Recommendation(s)

The Board of Directors is 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. This is the closing report for the 2022/23 BAF.

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. The Board has reviewed the BAF on a bi-monthly basis during 2022/23.

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 closing report of the trust's key strategic risks is presented here for approval. The BAF is included in this report with detailed drill-down reports into all individual risks.

2.2 **Patients:** Current risks have been reviewed and updated in line with the 2022/23 corporate objectives prior to the Quality and Safety Committee Meeting on 8 February 2023. There are no new risks to report. All risks will be carried over to the 2023/24 BAF and aligned with the 2023/24 corporate objectives.

2.3 **People:** Current risks have been reviewed and updated in line with the 2022/23 corporate objectives prior to the People Committee Meeting on 14 March 2023. There are no new risks to report. All risks will be carried over to the 2023/24 BAF and aligned with the 2023/24 corporate objectives.

2.4 **Performance:** Current risks have been reviewed and updated in line with the 2022/23 corporate objectives prior to the F&P Committee meeting on 29 March 2023 and the following risks have been revised. Outstanding risks will be carried over to the 2023/24 BAF and aligned with the 2023/24 corporate objectives.

2.4.1 Risk ID3292 Financial Performance: Failure to meet the agreed I&E position and Risk ID3291 Financial Sustainability: Efficiency targets & Balance Sheet have both reduced from 15 to the target score of 8 and can be considered for acceptance and closure.

2.4.2 Risk ID3295 Estates Strategy - Capital Funding has reduced from 12 to the target score of 6 and can be considered for acceptance and closure.

2.4.3 Risk ID3289 Elective services - Waiting List has been reduced from 12 to 9 with the objective on track.

2.4.4 Risk ID3296 Estate Strategy - net carbon zero requirements - risk lead has been transferred from CPO and DSP.

2.5 **Partnership:** There are no new risks to report. Current risks have been reviewed and updated in line with the 2022/23 corporate objectives prior to the Board Meeting on 5 April 2023. All risks will be carried over to the 2023/24 BAF and aligned with the 2023/24 corporate objectives.

3. New Risks Recommended for Inclusion in the BAF

3.1 No new risks have been added to the BAF since the last Board meeting in February 2023. All outstanding risks will be carried over to the 2023/24 BAF and aligned with the 2023/24 annual corporate objectives and Our Strategy 2030.

4. Risks Accepted and De-escalated from the BAF

4.1 Risk ID3290 – Financial Performance - Activity not in line with the funding available - is no longer a risk and has been closed.

5. Review Date

5.1 The BAF is reviewed bi-monthly by the Board. The next review is scheduled for June 2023 and will include mapping risks to the 2023/24 corporate objectives and the 2023/24 risk appetite statement.

6. Recommendations

6.1 The Board are asked to:

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

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Board assurance framework

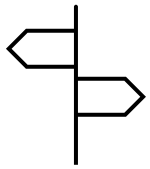
2022/23

The content of this report was last reviewed as follows:

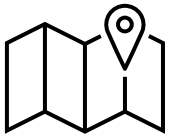
Quality and Safety Committee:	February 2023
Finance and Performance Committee:	March 2023
People Committee:	March 2023
Audit Committee:	February 2023
Executive Team:	March 2023

> **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

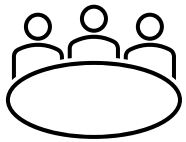


Strategy: Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and how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

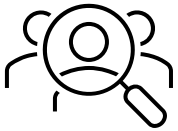


Corporate objectives: Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives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

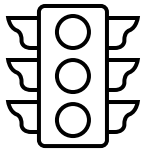
Board Assurance Framework: The board assurance framework provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains risks that are most likely to materialise and those that are likely to have the 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 create an inclusive and people-centred experience at work that enables our WWL family to flourish
Performance:	To consistently deliver efficient, effective and equitable patient care
Partnerships:	To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

FY022/23 Corporate Objectives

Patients

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

People

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

Performance

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

Partnerships

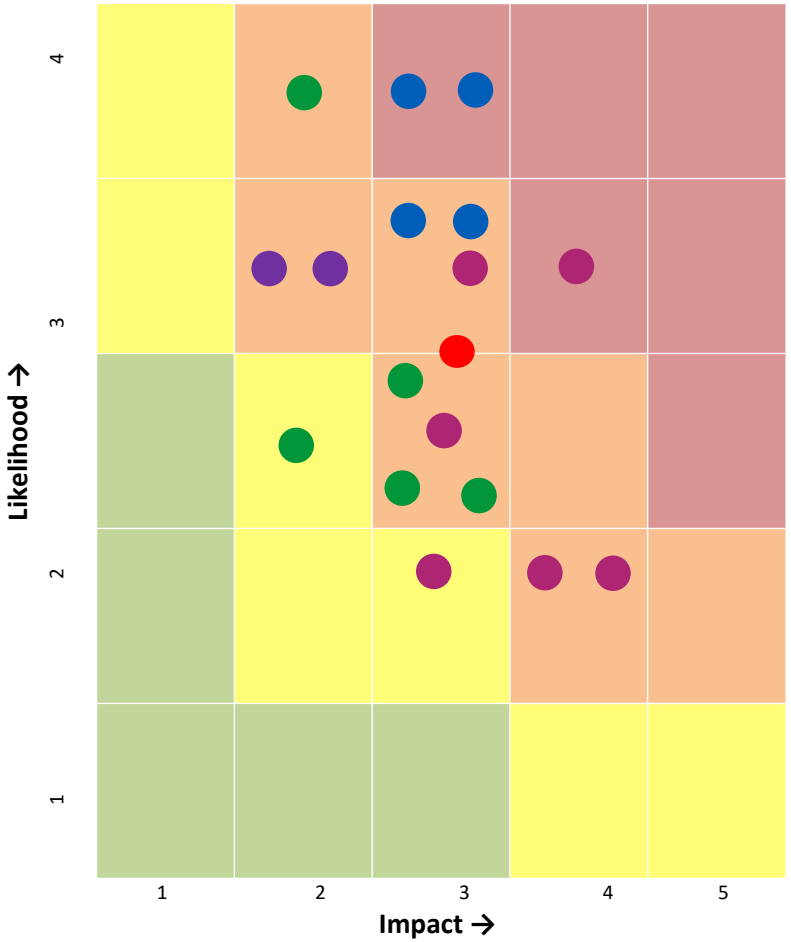
We will…
- Positively impact on the social and economic factors of our Borough
- Develop effective relationships within Wigan Borough and Greater Manchester for the benefit of our patients
- Make progress towards becoming a University Teaching Hospital

Risk management

Our risk appetite position is summarised in the following table:

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

The heat map below shows the distribution of all 17 strategic risks based on their current scores:



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

Patients

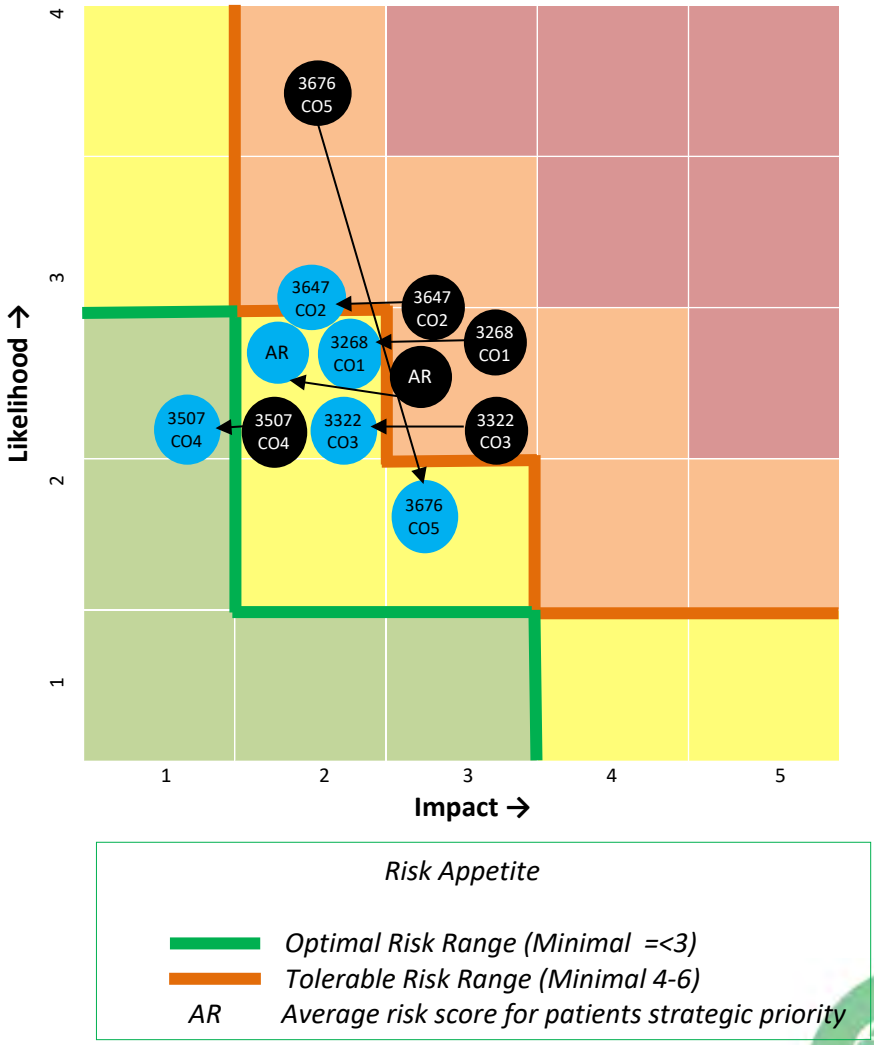
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

Monitoring: Quality and Safety Committee

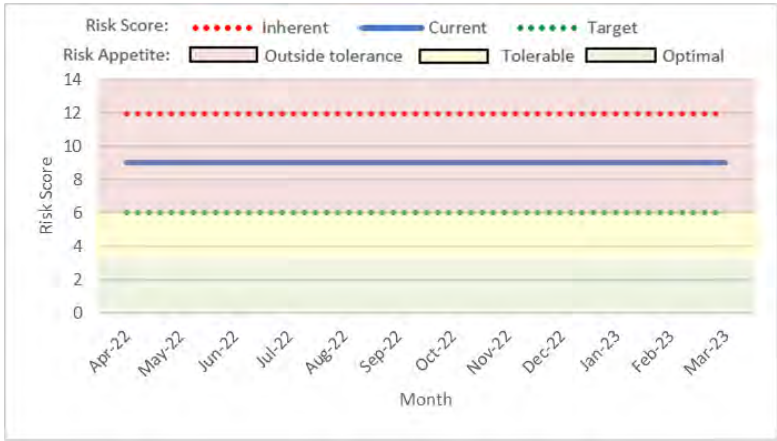
The following corporate objectives are aligned to the **patients** strategic priority:

Ref.	Headline objective
CO1	We will improve the safety and quality of our clinical services by achieving a 25% reduction in mortality related to sepsis by 31st March 2023 and sustain the improvement in mortality relating to AKI achieved during 2021/22.
CO2	We will increase the % of patients who die in their Preferred Place of Death, with a target for improvement to be set following completion of a baseline audit in the first quarter of 2022/23.
CO3	We will improve the safety and delivery of harm-free care by achieving a zero preventable category 3 and 4 pressure ulcers in both the hospital and community setting. 100% of NEWS, PEWS and MEWS will be recorded accurately reducing the risk of failure to recognise a deteriorating patient by 31st March 2023. As an enabler to this objective 400 of clinical staff will have received human factors training by the 31st March 2023.
CO4	We will improve the quality of care delivered through pursuing our journey of excellence through our accreditation programme. Seven in-patient wards will progress to achieving the silver rating in our accreditation programme, with the remaining wards maintaining their bronze rating. Additionally, the accreditation programme will be extended to see some other clinical and non-ward areas achieve the bronze rating by the 31st March 2023.
CO5	We will improve our complaint response rates by ensuring 85% of complaints received are responded to and acted upon within our agreed timeframes by the 31st March 2023.

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

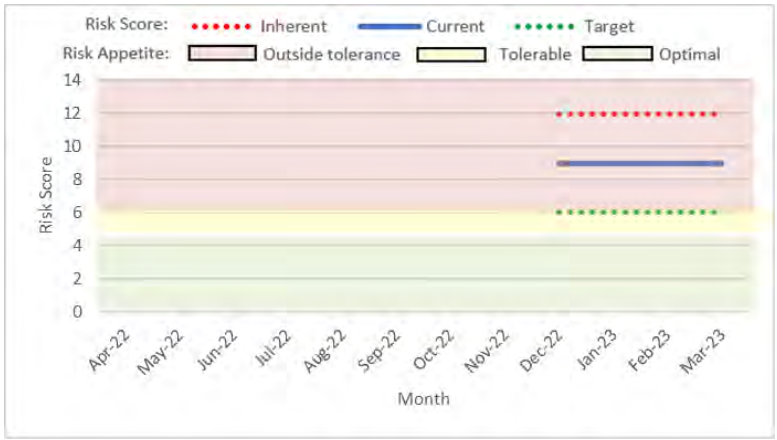


Corporate Objective: **CO1** Improve the safety and quality of clinical services							**Overall Assurance level**	**Low**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 1: Clinical Services - Recognition, screening and treatment of the deteriorating patient**						
	Risk Statement:	There is a risk that patients who are deteriorating are not appropriately clinically escalated due to non-identification of sepsis, AKI or baseline observations resulting in mortality related to sepsis and AKI.						
Lead Committee	**Quality and Safety**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal	
Lead Director	**MD**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Safety, quality of services & patient exp.	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	3270	
Date of last review	**08.02.23**	**Risk Rating**	12. High	9. High	6. Moderate	**Risk treatment**	Treat	



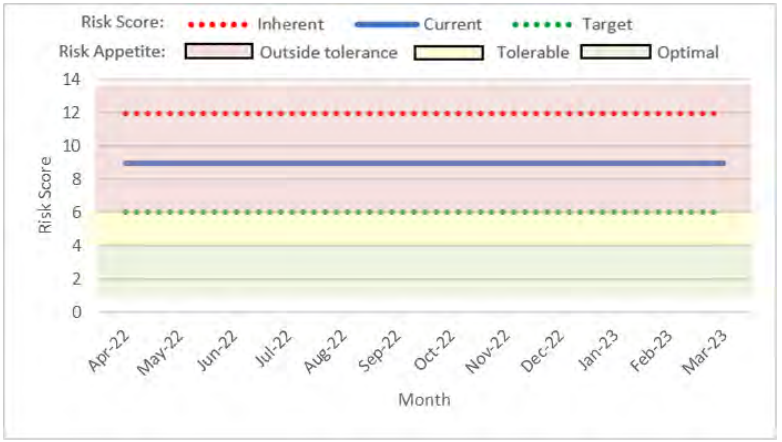
Strategic Opportunity / Threat Linked Risk	Existing controls	Gaps in existing controls	Assurances (and date last seen)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3268)** 3270 – Consultant cross cover from SRFT for AKI service	• This is a dedicated corporate objective for FY2022/23. • Rapid Improvement Group. • Sepsis QI group. • Sepsis Improvement Plan. • Sepsis live in HIS. • Visibility of AKI and Sepsis Nurse in clinical areas • AKI and sepsis audits undertaken. • Themed SIRI panel on sepsis focused on improvement work and highlighted achievements to date. • Improved AKI pathways to ensure that there is no avoidable harm caused by WWL.	• Workload demands for AKI and Sepsis nurses. • AKI Improvement Plan needs to be developed.	**2nd Line:** • Quality & Safety Committee February 2023.	• Objective will not be met within current financial year.	1. Deteriorating Patient Improvement Group continues to meet monthly.	Monthly

Corporate Objective: **CO2** Improve the percentage of patients who die in their preferred place of death							**Overall Assurance level**	**Medium**
Principal risk	**Risk Title:**	**PR 2: Preferred Place of Death**						
	Risk Statement:	There is a risk that a high proportion of our patients may not die in their preferred place of death, due to lack of community resources and increased operational pressures across all teams, resulting in patients and families not receiving their preferred personalised care in the last days of life.						
Lead Committee	**Quality and Safety**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal	
Lead Director	**MD**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Safety, quality of services & patient exp.	
Date risk opened	**13.12.22**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	-	
Date of last review	**08.02.23**	**Risk Rating**	12. High	9. High	6. Moderate	**Risk treatment**	Treat	



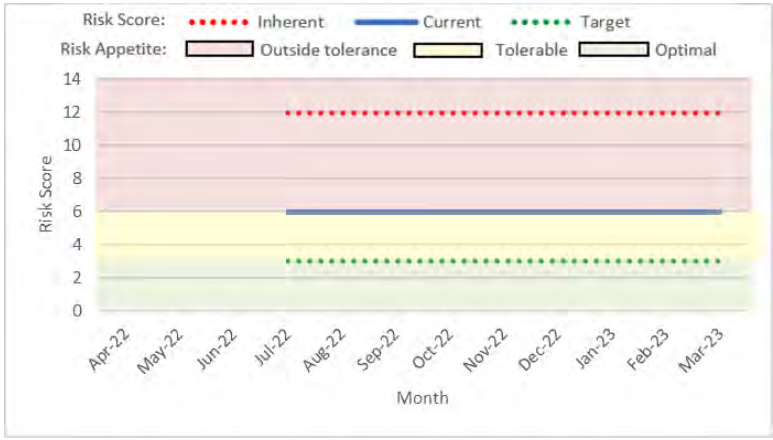
Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date last seen)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **ID 3647**	• Dedicated Palliative Care Hospital team, consisting of clinical and nursing staff and dedicated palliative care lead for community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

Corporate Objective: **CO3** Improve the delivery of harm free care								**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 3: Harm Free Care - Avoidable Pressure ulcers**							
	Risk Statement:	There is a risk that our systems and processes, coupled with challenged staffing, may not facilitate the swift identification of potentially avoidable pressure ulcers resulting in harm to our patients.							
Lead Committee	**Quality and Safety**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal		
Lead Director	**CN**	**Likelihood**	4. Likely	3. Possible	2. Unlikely	**Risk category**	Safety, quality of services & patient exp.		
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	3323		
Date of last review	**08.02.23**	**Risk Rating**	12. High	9. High	6. Moderate	**Risk treatment**	Treat		



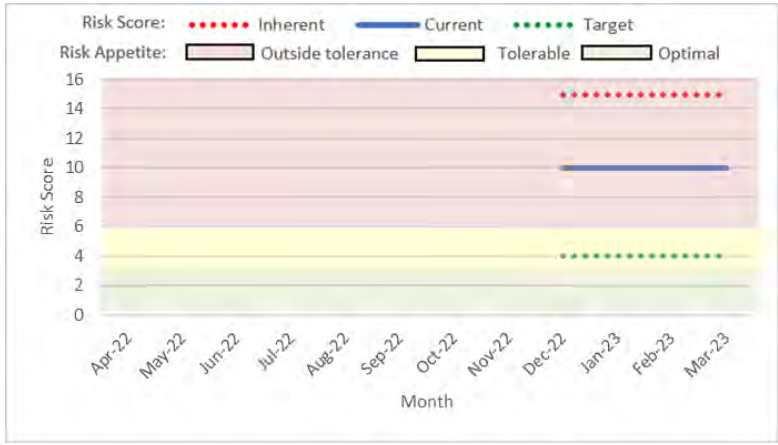
Strategic Opportunity / Threat Linked risk	**Existing controls**	**Gaps in existing controls**	**Assurances (and date)**	**Gap in assurances**	**Risk Treatment**	**Due Date / By Whom**
Threat: **(ID 3322)** 3323 – Tissue viability team capacity	• Pressure ulcer link nurses trained within areas. • Introduced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

Corporate Objective: **CO4** Improve the quality of care for our patients								**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 4: Ward accreditation programme**							
	Risk Statement:	There is a risk that silver accreditation levels may not be achieved, due to operational pressures affecting the supernumerary status of ward leaders and the single person service having paper based scoring and reporting, resulting in a reduction in the speed of the roll out.							
Lead Committee	**Quality and Safety**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal		
Lead Director	**CN**	**Likelihood**	4. Likely	2. Unlikely	1. Rare	**Risk category**	Safety, quality of services & patient exp.		
Date risk opened	**20.07.22**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	-		
Date of last review	**08.02.23**	**Risk Rating**	12. High	6. Moderate	3. Low	**Risk treatment**	Treat		



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

Corporate Objective: **CO5** Listening to our patients to improve their experience								**Overall Assurance level**	**Low**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 5: Complaint response rates**							
	Risk Statement:	There is a risk that complaints received may not be responded to and acted upon within our agreed timeframes, due to operational pressures and COVID backlog resulting in missed targets, unresolved complaints and adverse publicity.							
Lead Committee	**Quality and Safety**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal		
Lead Director	**CN**	**Likelihood**	5. Almost certain	5. Almost certain	2. Unlikely	**Risk category**	Safety, quality of services & patient exp.		
Date risk opened	**24.01.23**	**Impact**	3. Moderate	2. Minor	2. Minor	**Linked risks**	-		
Date of last review	**08.02.23**	**Risk Rating**	15. Significant	10. High	4. Moderate	**Risk treatment**	Treat		



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3676)**	• Complaints SOP in place with defined roles, processes and timescales. • How to respond to a complaint training is being delivered with further sessions planned. • Patient relations team provide support and guidance.	• Releasing staff to attend training.	**2nd Line:** • Quality & Safety Committee February 2023	**2nd Line:** • Objective will not be met within current financial year.	1. Complaints backlog to be addressed. 2. Further training for staff to be arranged with staff given time to attend the training.	April 2023 CN April 2023 CN

People

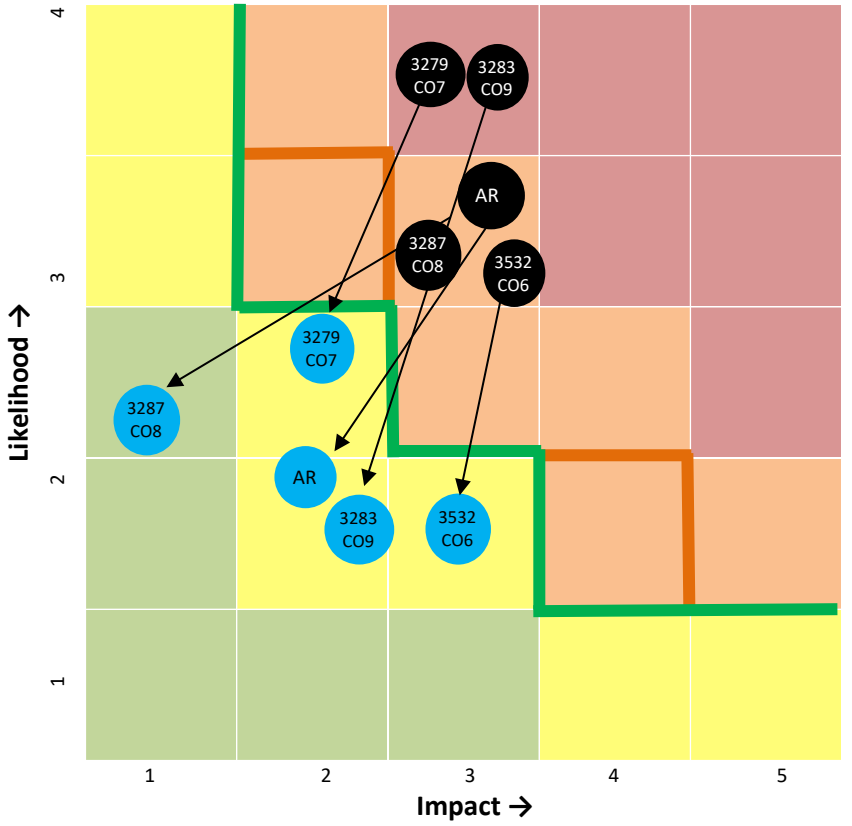
To create an inclusive and people-centred experience at work that enables our WWL family to flourish

Monitoring: People Committee

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

Ref.	Detailed objectives
CO6	We will advance and embed the implementation of our just and learning culture programme through leadership development, civility and team development / culture programmes that improve experience of work in a sustainable way and encourage our people to speak up.
CO7	We will support the physical health and mental wellbeing of our WWL family by ensuring we have a range of wellbeing activities and services that are accessible to our colleagues, supported by real time and accurate absence data.
CO8	We will improve the equality, diversity and inclusion of our Trust by increasing diversity and accessibility, reducing inequality and improving the experience of protected groups.
CO9	We will prioritise personal and professional development to enable our people to flourish, making full use of all available funding sources by aligning our programmes to the learning needs analysis and strategic aspirations such as university teaching hospital status.

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



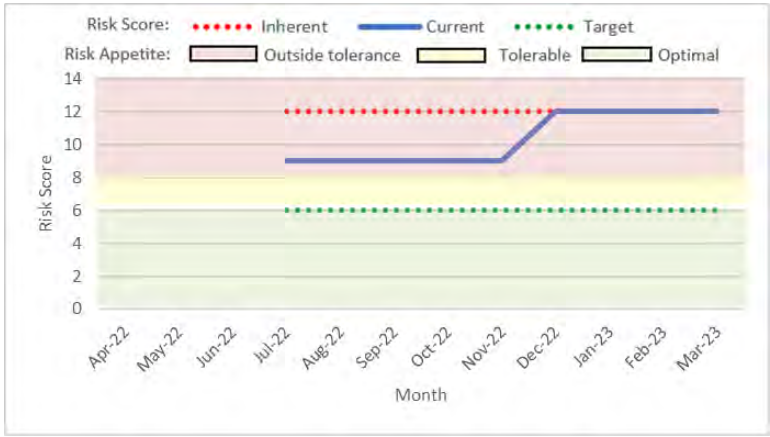
Risk Appetite

Optimal Risk Range (Cautious =<6)

Tolerable Risk Range (Cautious =<8)

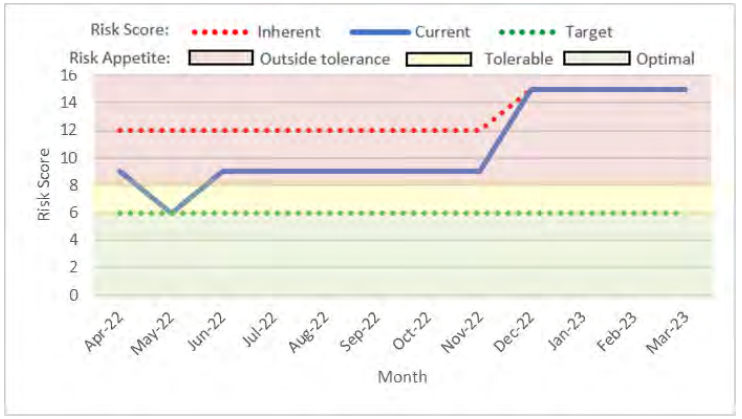
AR *Average risk score for people strategic priority*

Corporate Objective: CO6 Make working at WWL a positive experience, where everyone has a voice that matters						**Overall Assurance Level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 6: Person centred people management**					
	Risk Statement:	There is a risk, given the significant culture shift required, that leaders may not have the capacity and capability to embed our just and learning culture through compassionate and person-centred people management, resulting in lower engagement levels, potential for increased turnover and a poor industrial relations climate.					
Lead Committee	**People**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious
Lead Director	**CPO**	**Likelihood**	4. Likely	4. Likely	2. Unlikely	**Risk category**	Staff Experience
Date risk opened	**19.08.22**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	-
Date of last review	**03.03.23**	**Risk Rating**	12. High	12. High	6. Moderate	**Risk treatment**	Treat



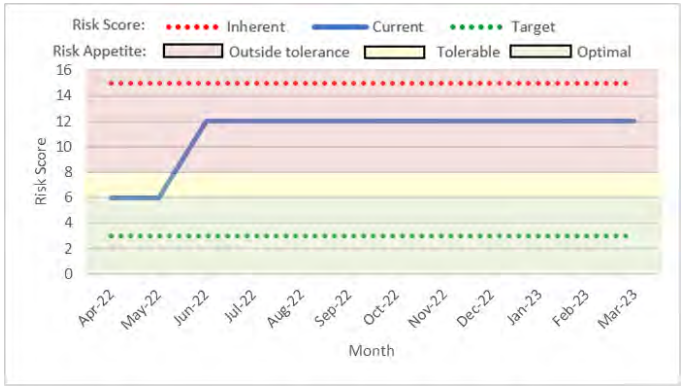
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **ID 3532**	• Civility and behaviour framework • Just & learning culture protocol • Divisional HR support • Disciplinary triage panel • Supernumerary ward leaders business case	• HR policy review – person centred policies • Full line manager & HR training programme – people centred people management.	• Feedback from line manager listening sessions (July) • ETM paper (August) – people management training proposal • Just culture & civility training programme place allocation (ETM September 2022) • Just and Learning Culture Leadership Training – options paper shared with Cultural Leadership Group and OFOFOF Steering Group to roll out training across senior leader population trust-wide (January 2023 • Our FFF culture group (November 2022) - highlighting how culture programme learning is being embedded into day to day activities. • Safe staffing report – ward leaders status (Q&S & ETM – November / December 2022)	None identified.	1. WWL HR policy development, streamlined and person centred to be phased throughout 2023/24(completed in partnership) 2. We have now agreed that WWL will not be an early adopter of the NW Wellbeing and Attendance policy. Our current Attendance Management policy and procedure will be updated. The policy and procedure will remain toolkit in style and person centred 3. NW well-being and attendance management leadership development 4. Development of WWL training programme – HR team, staff side & line managers for roll out in 2023/24 5. Agree delivery methodology for the roll out of just & learning culture training (as part of people leaders training and at induction) 6. Corporate induction review and departments to develop comprehensive and supportive local induction packages, based on learning from positive and negative experiences 7. Supernumerary ward leaders – ensure not included in the numbers	1. First policy updates by June 2023 – Strategic HR Lead 2. June 2023 – Strategic HR Lead 3. March 2023 – NW HRDs 4. March 2023 – Strategic HR Lead 5. January 2023 – Associate Director of Employee experience & well-being 6. March 2023 – Associate Director of staff experience & departmental leads 7. Chief Nurse – Date TBC

Corporate Objective: CO7 Support the health and wellbeing of our colleagues							**Overall Assurance Level**	**Low**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 7: Participation in preventative and restorative wellbeing activities**						
	Risk Statement:	There is a risk that sufficient time may not be available for staff to participate in preventative and restorative wellbeing activities within working hours, due to workload pressures and vacancies, resulting in lower engagement levels and evidence suggests this will reduce the success of the programme.						
Lead Committee	**People**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**CPO**	**Likelihood**	5. Almost certain	5. Almost certain	2. Unlikely	**Risk category**	Staff Wellbeing	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	-	
Date of last review	**03.03.23**	**Risk Rating**	15. Significant	15. Significant	6. Moderate	**Risk treatment**	Treat	



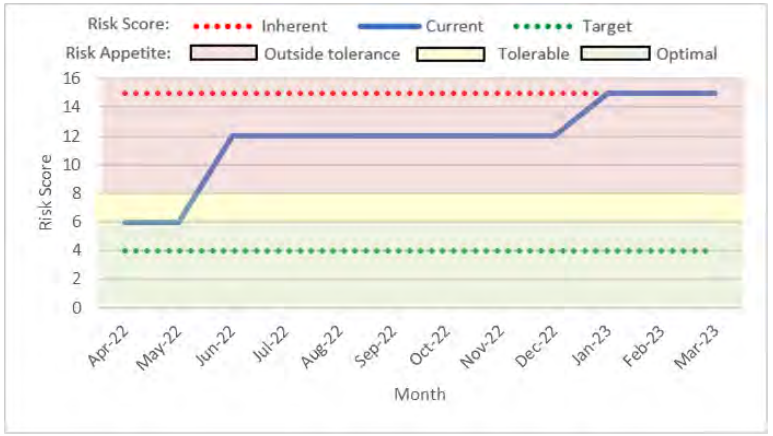
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **ID 3279**	• Your Voice Survey – well-being score. • Steps 4 Wellness Service enhancements. • Targeted in-reach activities in high-risk areas. • Wellbeing walkabouts. • Re-prioritisation and amendment of offers.	• Commitment to roster time for people to be released as needed. • Recruitment & retention update (People Committee October 2022 and January 2023) • Increasing operational pressures impacting on release	**2nd Line:** • All staff Team Brief session (July 2022) • Team stress management pilot completion (evaluation at People Committee September) • Well-being update (staff engagement steering group September 2022) • Divisional well-being plan pilot completed in Medicine (November) – roll out to other Divisions commences w/c 21/11 • Divisional assurance meetings (October & November) sickness absence levels • People dashboard (ETM) and Our FFF (November) – issues of turnover in Band 2/3 roles associated with working conditions and pay level competition – deep dive using Guardian Service and task & finish group • Safe staffing report (Q&S & ETM – November / December 2022)	None identified.	1. Strategic needs assessment to be completed working with divisional teams. 2. Divisional well-being plans that are prioritised and implementation monitored through divisional assurance reviews. 3. Recruitment to B5 Nursing & HCA vacancies (including international recruitment) – performance against trajectory. 4. Develop additional offers associated to cost of living support and upskilling of S4W Champions to provide additional support in departments and in real time. 5. Staffing levels must reflect the acuity and flow of patients – biannual staffing review (to be extended to cover all clinical staff groups)	1.April 2023 - Consultant clinical Psychologist 2.April 2023 – Divisional Triumvirate & S4W team 3.April 2023 – DCN & DCPO (+ recruiting managers) 4. Complete 5. April 2023 – CNO & MD (This may slip due to absence of CNO)

Corporate Objective: **CO8** Ensure inclusion and belonging for all –ED&I							**Overall Assurance Level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 8: Fairness and compassion - workforce EDI expertise and supporting infrastructure**						
	Risk Statement:	There is a risk that EDI may not be embedded in everything we do, due to a lack of sufficient workforce awareness about EDI and we do not have substantive Workforce EDI resource, resulting in failure to deliver the EDI objectives, strategy and our statutory duties under the Equality Act.						
Lead Committee	**People**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**CPO**	**Likelihood**	5. Almost certain	4. Likely	1. Rare	**Risk category**	Staff Capacity and Capability	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks**	3231	
Date of last review	**03.03.23**	**Risk Rating**	15. Significant	12. High	3. Low	**Risk treatment**	Treat	



Strategic Opportunity / Threat	**Existing controls**	**Gaps in existing controls**	**Assurances (and date)**	**Gap in assurances**	**Risk Treatment**	**Due Date / By Whom**
Threat: **ID 3287** 3231- Culture of psychological safety, civility and compassionate leadership	• Workforce EDI specialist recruited (fixed term contract extended until June 2023). • EDI strategy approved. • Expanded staff networks supported. Training in place for network sponsors and EDI Champions. • Three independently assessed schemes approved for implementation – Rainbow Badge, Disability Confident & Race Equality Standard.	• No ongoing funding commitment	• EDI report to People Committee June 2022. • Workforce EDI objectives (People Committee – June 2022). • EDI workshop - October 2022 • EDI ER deep dive report (People Committee October 2022) • EDI workshop for leadership (31/11/22) • Trust Board EDI training (2/11/22) • EDI strategy implementation plan (ETM 17/11/2022) • EDI implementation plan approved – risk with business case recognised (People Committee December 2022) • EDI staff networks staff story (People Committee December 2022) **3rd line** Messenger review – highlights the need to improve EDI awareness and to increase diversity (June 2022).	• No substantive EDI workforce resource to support delivery against strategic aims set out in the strategy. • Workforce and leadership awareness of EDI and associated responsibilities	1. Embed colleague diversity networks. 2. Gap analyses and action plans from the three assessments. 3. Review shadow running of EDS 3 (2022) process in 2022-23. 4. Awareness and engagement programme for all (with specific focus on leadership EDI responsibilities) – Board training & senior leaders workshop. 5. EDI workforce objectives delivery. 6. Business case / business planning process regarding Workforce EDI specialist role. 7. EDI corporate objective cascade to all senior leaders.	1. Complete 2. Complete 3. Complete 4. Complete 5. Workforce EDI lead -March 2023 In year resolved. 6. Substantive business case CPO –October 2022 _ completed. Subject to approval in business planning (March 2023) 7. Workshop & board training complete – divisional objectives to be determined

Corporate Objective: CO9 Create an environment where we are always learning, and everyone flourishes							**Overall Assurance Level**	**Low**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 9: Personal Development**						
	Risk Statement:	There is a risk that the prioritised learning needs analysis cannot be delivered due to funding constraints and / or inability to release staff for training, resulting in increased turnover and / or a lack of continued professional development for colleagues.						
Lead Committee	**People**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**CPO**	**Likelihood**	5. Almost Certain	5. Almost Certain	2. Unlikely	**Risk category**	Staff Capacity & Capability	
Date risk opened	**19.10.21**	**Impact**	3. Moderat	3. Moderate	2. Minor	**Linked risks**	-	
Date of last review	**03.03.23**	**Risk Rating**	15. Significant	15. Significant	4. Moderate	**Risk treatment**	Treat	



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **ID 3283**	• Full LNA completed and prioritised. • Mandatory and job specific training requirements reviewed and updated. • Agreed principles of apprenticeship and HEE funding allocations first.	• Ability to roll forward HEE funding allocations. • Ability to release staff due to vacancies / workload pressures. • Recurrent budget for training & development aligned to LNA.	**2nd Line:** • ETM review and in principle (LNA and apprenticeship plan) – May 2022 • People Committee report – June 2022 • HEE CPD investment schedule (Education Governance -July) • 2022/23 LNA business case (ETM September) • Funded training opportunities overseen at Education Governance Committee	None identified.	1. Business case to deliver 2022-23 LNA.- further analysis with finance and staff group and divisional leads – build into business planning 2. Benchmarking review of nurse staffing establishment uplift to cover time for training. 3. Recurrent budget setting principles to be agreed as part of annual business planning round. 4. Bi-annual staffing review and matching patient acuity / flow with staffing establishment	1. January 2023 (aligned to business planning timeline) – CPO 2.TBC – CNO 3. January 2023 (aligned to business planning timeline 4. March 2023 – CNO (This may slip due to absence of CNO).

Performance

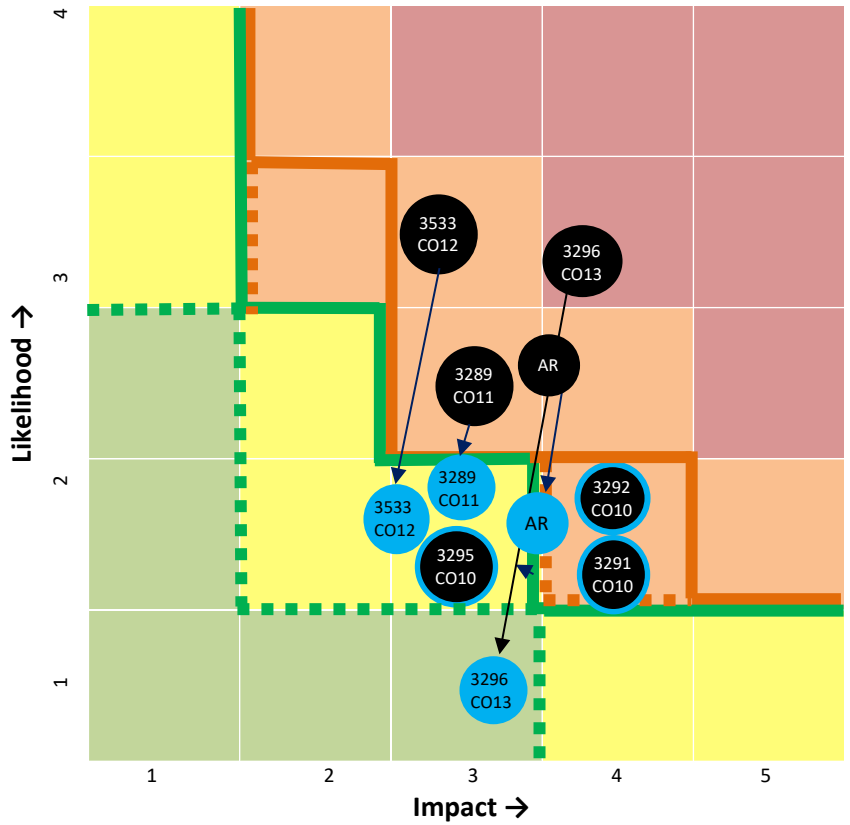
Our ambition is to consistently deliver efficient, effective and equitable patient care

Monitoring: Finance and Performance Committee

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

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

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



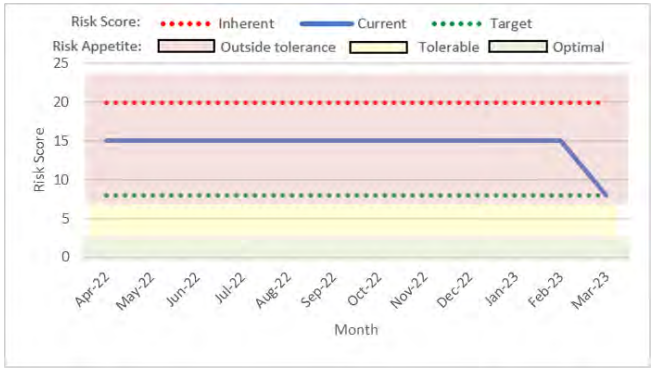
Risk Appetite

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

Tolerable Risk Range (Minimal 4-6, Cautious =<8)

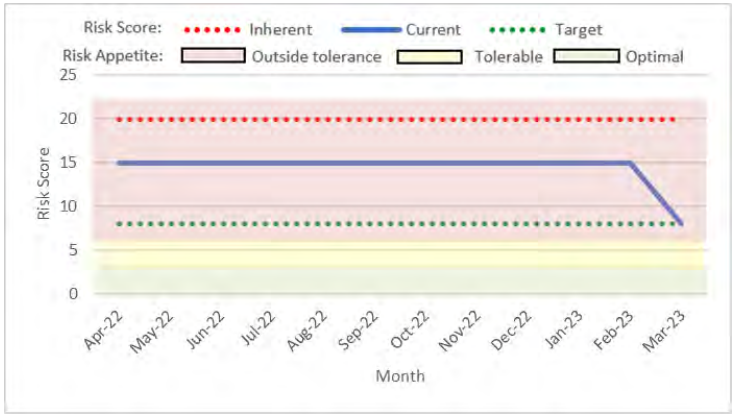
AR Average risk score for performance strategic priority

Corporate Objective: **C10** Deliver our financial plan, providing value for money services							**Overall Assurance level**	**High**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 10: Financial Performance: Failure to meet the agreed I&E position**						
	Risk Statement:	There is a risk that the Trust may fail to fully mitigate in year pressures to deliver key finance statutory duties resulting in the Trust receiving significantly less income than the previous financial year.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current**	**Target Risk**	**Risk Tolerance**	Minimal	
Lead Director	**CFO**	**Likelihood**	4. Likely	2. Unlikely	2. Unlikely	**Risk category**	Financial Duties	
Date risk opened	**19.10.21**	**Impact**	5. Critical	4. Major	4. Major	**Linked risks**	-	
Date of last review	**21.03.23**	**Risk Rating**	20. Significant	8. High	8. High	**Risk treatment**	Treat	



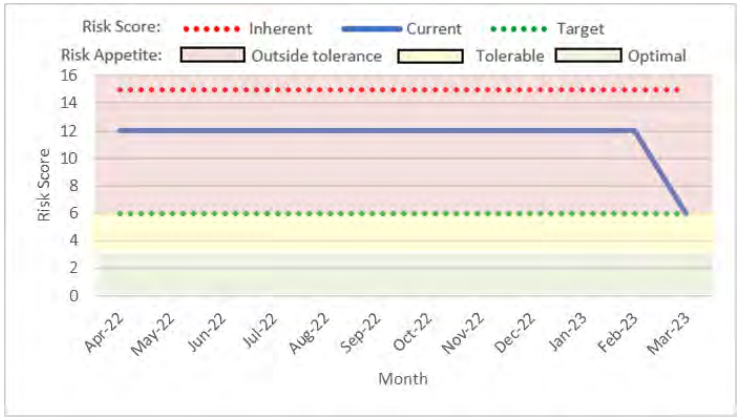
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3292)**	• Final plan signed off by Board and submitted to NHSEI - 20th June 2022 • CIP target agreed with programme for delivery and actions. • 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 & 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. • Financial Recovery Plan approved by Board Nov 22 • ICS Financial Recovery processes underway to improve GM financial position by end of year. • FRP meetings held between ICS and WWL CEO and CFO Jan 23, plus check and challenge session in March 23 • Forecast for covid spend agreed through Divisional Assurance Meetings with budget adjusted to reflect improvements. • HFMA Financial Sustainability: Getting the Basics Right review independently assessed by MIAA with specific actions identified. • Operational planning guidance for 23/24 received 23rd Dec 22 • RAPID meetings held for Medicine, Surgery, Specialist Services divisions in month 10. • 23/24 detailed finance and contract guidance received	• System and locality reporting in infancy • No additional funding received for NRTR, additional beds and escalation. • No additional funding expected to cover increased costs associated with industrial action.	**1st Line:** Monthly RAPID meetings for applicable divisions **2nd Line:** Finance & Performance Committee March 2023	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Locality discussions ongoing around additional winter funding, capacity funding and discharge funding to support NRTR, JHRU, escalation areas, etc. 2. Discussions with ICS ongoing around support required to deliver agreed I&E position. 3. PWC conducting a diagnostic into the drivers of financial and operational performance	Mar 23 CFO/CEO Mar 23 CFO Mar 23 CFO

Corporate Objective: **C10** Deliver our financial plan, providing value for money services							**Overall Assurance level**	**High**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 11: Financial Sustainability: Efficiency targets & Balance Sheet**						
	Risk Statement:	There is a risk that efficiency targets will not be achieved, resulting in a significant overspend and that there is insufficient balance sheet flexibility, including cash balances, to mitigate financial problems.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current**	**Target Risk**	**Risk Tolerance**	Minimal	
Lead Director	**CFO**	**Likelihood**	4. Likely	2. Unlikely	2. Unlikely	**Risk category**	Financial Duties	
Date risk opened	**19.10.21**	**Impact**	5. Critical	4. Major	4. Major	**Linked risks**	-	
Date of last review	**21.03.23**	**Risk Rating**	20. Significant	8. High	8. High	**Risk treatment**	Treat	



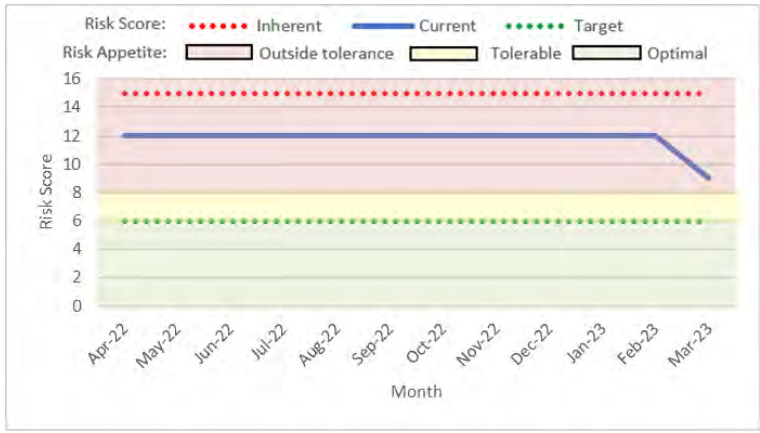
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3291)**	• Revised CIP delivery approach following review by Mersey Internal Audit Agency. • Monitored via Divisional Assurance Meetings, with additional escalation through RAPID if Divisional delivery is off plan. • Further oversight at Executive Team, 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. • In year CIP target forecast to be delivered • RAPID recovery metrics updated in Q3 to include recurrent CIP delivery. • RAPID metrics updated for Q4 to include a focus on 23/24 planning.	• High proportion of CIP is non recurrent and non-cash releasing. • High proportion of CIP is transactional. • Limited mechanisms to facilitate delivery of system wide savings. • High proportion of non-recurrent measures including balance sheet have been utilised to support the financial position.	**1st Line:** Monthly RAPID meetings for applicable divisions **2nd Line:** Finance & Performance Committee March 2023	• No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk.	1. Monthly updates on CIP presented to Executive Team, with regular updates to Divisional Teams. 2. Engagement in GM Efficiency Programme work including productivity workstream co-chaired by WWL Deputy CEO (Ext) 3. Early planning for 2023/24 CIP in recognition of high level of non recurrent CIP in 22/23	March 2023 CFO/DCEO March 2023 CFO/DCEO March 2023 CFO/DCEO

Corporate Objective: C10 Deliver our financial plan, providing value for money services							**Overall Assurance level**	**High**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 12: Estates Strategy - Capital Funding**						
	Risk Statement:	There is a risk that there is inadequate capital funding to enable priority schemes to progress. Due to uncertainties around capital funding arrangements the strategy may assume that more investment can be made than is available.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Minimal	
Lead Director	**CFO**	**Likelihood**	3. Possible	2. Unlikely	2. Unlikely	**Risk category**	Financial Duties	
Date risk opened	**19.10.21**	**Impact**	5. Critical	3. Moderate	3. Moderate	**Linked risks**	-	
Date of last review	**21.03.23**	**Risk Rating**	15. Significant	6. Moderate	6. Moderate	**Risk treatment**	Treat	



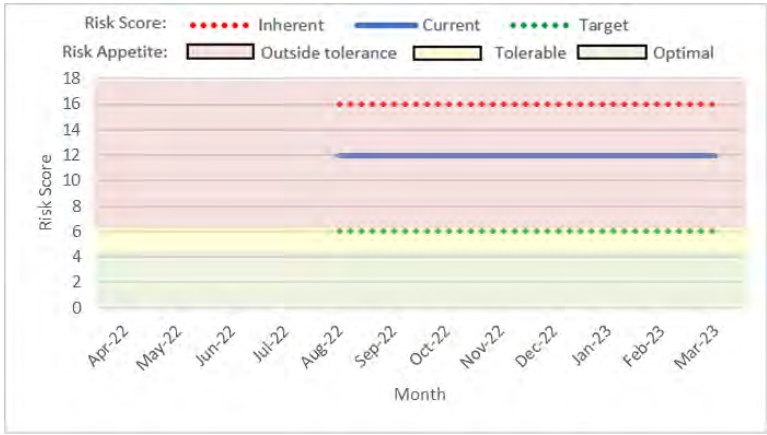
Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3295)**	• Lobbying via Greater Manchester • Capital Priorities agreed by Executive Team & Trust Board. • Cash for Capital investments identified. • Bids formally approved for centrally funded Community Diagnostic Centre and TIF Additional theatre at Leigh Hospital and MOU's received. • 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. • Capital plan forecast to deliver in full. • Programme Boards established for major capital schemes – CDC & Leigh Theatre. • Weekly GM capital planning group with provider leads closely monitoring ICS capital position and forecast. • Received notification of formal approval of frontline digitalisation and approved to progress at risk. • Initial work started to look at allocation of 23/24 CDEL across GM providers. • All MOU's for in year capital schemes received	• Impact of cost of living rise in terms of project costs and timescales • Final confirmation of 23/24 CDEL allocations not yet received and significant demand for capital across GM	**1st Line:** Monthly Capital Strategy Group **2nd Line:** Finance & Performance Committee - March 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	March 2023 CFO Q4 CFO

Corporate Objective: **CO11** To minimise harm to patients through delivery of our elective recovery plan							**Overall Assurance level**	**High**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 13: Elective services - Waiting List**						
	Risk Statement:	There is a risk that demand for elective care may increase beyond the Trust's capacity to treat patients in a timely manner, due to challenges of restoring services, workforce and IPC measures, increase in cancer referrals, no right to resides backlog and late repatriations from the independent sector, resulting in potentially poor patient experience, deteriorating health, more severe illness and late cancer diagnosis.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**DCE**	**Likelihood**	5.Almost Certain	3. Possible	2. Unlikely	**Risk category**	Performance Targets	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	3. Moderate	3. Moderate	**Linked risks IDs**	3136,3432, 3020,3572	
Date of last review	**21.03.23**	**Risk Rating**	15. Significant	9. High	6. Moderate	**Risk treatment**	Treat	



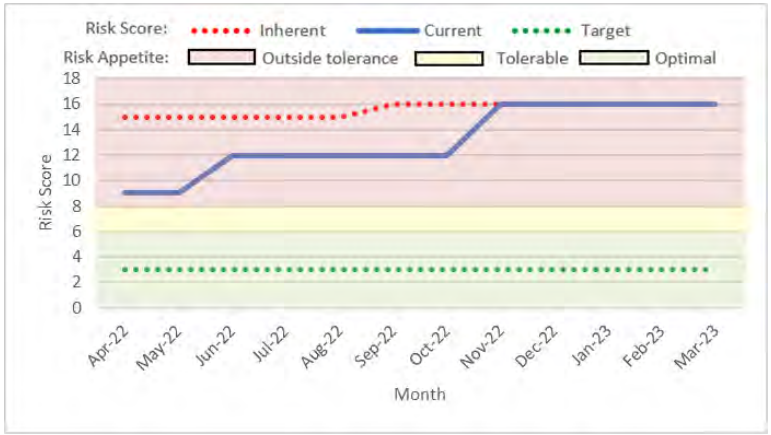
Opportunity / Threat Linked Risks	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: (ID 3289) **3136** Symptomatic breast imaging waiting times **3432** Counselling waiting times **3020** Waiting list Dermatology **3572** Industrial action	• Working with partners in the Wigan Borough to tackle pressures. • Wrightington discharge lounge and community assessment units up and running. • Stepped down selective elective care to support urgent care and we continue to do this to support during industrial action. • Streamlining referral process from hospital to out of hospital colleagues. Transformation work to reduce admin burden to slicker services. • Community Diagnostic Centre at Leigh Infirmary. • Currently on track for cancer waiting times. • National waiting list guidance - Text reminder service switched on with digital facility to electronically validate appointments. Picked up in MIAA Audit. • Care navigation hub pilot.	• Increase in cancer referral rate. • Lack of capacity to undertake reviews of allocated risk stratification across all specialties. • Meeting new care demands such as increasing cancer referral rates and reduced bed capacity due to covid admissions and number of no right to reside patients awaiting discharge. • Addressing care backlogs as a direct consequence of the pandemic, specifically the increase in the backlog of patients on follow up waiting lists, DNAs and patient cancellations. • Late repatriations from the independent sector.	**2nd Line:** • Finance & Performance Committee January 2023.	•No gaps in assurance - objective on track.	1. Continue with existing controls applied to 104 week wait to identify the most clinically at risk patients and eliminate 78 weeks wait. 2. Continue with actions applied to improve 52 week position. 3. Monitor number of P2 on the waiting list through Financial and Performance Report 4.Monitor number of no right to reside patients - see Urgent and Emergency Care risk	March 2023 DCE March 2023 DCE Bi-monthly DCE Bi-monthly DCE

Corporate Objective: CO12 Improve the responsiveness of urgent and emergency care							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 14: Urgent and Emergency Care**						
	Risk Statement:	There is a risk to urgent and emergency care delivery, due to the nursing and care home sector being unable to accept patients, resulting in the number of no right to reside patients substantially increasing, lack of capacity, longer waits, delayed ambulances and reduced patient flow.						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current**	**Target Risk**	**Risk Tolerance**	Cautious	
Lead Director	**DCE**	**Likelihood**	4. Likely	4. Likely	2. Unlikely	**Risk category**	Performance Targets	
Date risk opened	**05.09.22**	**Impact**	4. Major	3. Moderate	3. Moderate	**Linked risks IDs**	3500, 3423	
Date of last review	**21.03.23**	**Risk Rating**	16. Significant	12. High	6. Moderate	**Risk treatment**	Treat	



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3533)** **3500** Prolonged stay in the ED waiting room **3423** ED – Increase in attendances and insufficient patient flow	• **Worst Case Scenario Planning** - Risk stratification – treating in clinical priority order and long waits. • **Additional Capacity** – Local authority commissioned 10 complex beds in February 2023. • Discharge and flow is one of the key programmes of the Healthy Wigan. Partnership System Board of which the Integrated Delivery Board is the operational arm. • **Admission avoidance** - virtual hub, same day emergency care (SDEC), falls pilot with NWAS. • Part of national hospital only discharge programme. • Escalation areas including corridor to safely de-escalate A&E • GMMH – urgent care centre commissioned in February 2023. • Monthly A&E drop in sessions. • Wellbeing and resilience - 150 dedicated wellbeing champions delivering Steps4Wellness programme. Daily system escalation calls. • In hospital and out of hospital discharge and flow programme.	•12 hour wait not improving. •Delayed ambulance turnover times improved in Jan 23, but still require further improvement. •Number of no rights to reside are not improving.	**1st Line:** • Sickness and turnover monitored at divisional assurance meetings. • Safe staffing reports. **2nd Line:** • Finance & Performance Committee January 2023	Objective will not be met within current financial year.	1. Work closely with colleagues in Wigan locality to reduce no right to reside by 20% and reduce 12 hour waits.	March 2023 DCE

Corporate Objective: C13 Progress towards becoming a Net Zero healthcare provider							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 15: Estate Strategy - net carbon zero requirements**						
	Risk Statement:	There is a risk that Net Zero may not be delivered, due to investment not being available, resulting in failure to deliver the Green Plan and legislative requirements						
Lead Committee	**Finance & Performance**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**DSP**	**Likelihood**	4. Likely	4. Likely	1. Rare	**Risk category**	Sustainability /Net Zero	
Date risk opened	**19.10.21**	**Impact**	4. Major	4. Major	3. Moderate	**Linked risks**	-	
Date of last review	**21.03.23**	**Risk Rating**	16. Significant	16. Significant	3. Low	**Risk treatment**	Treat	



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

Partnerships

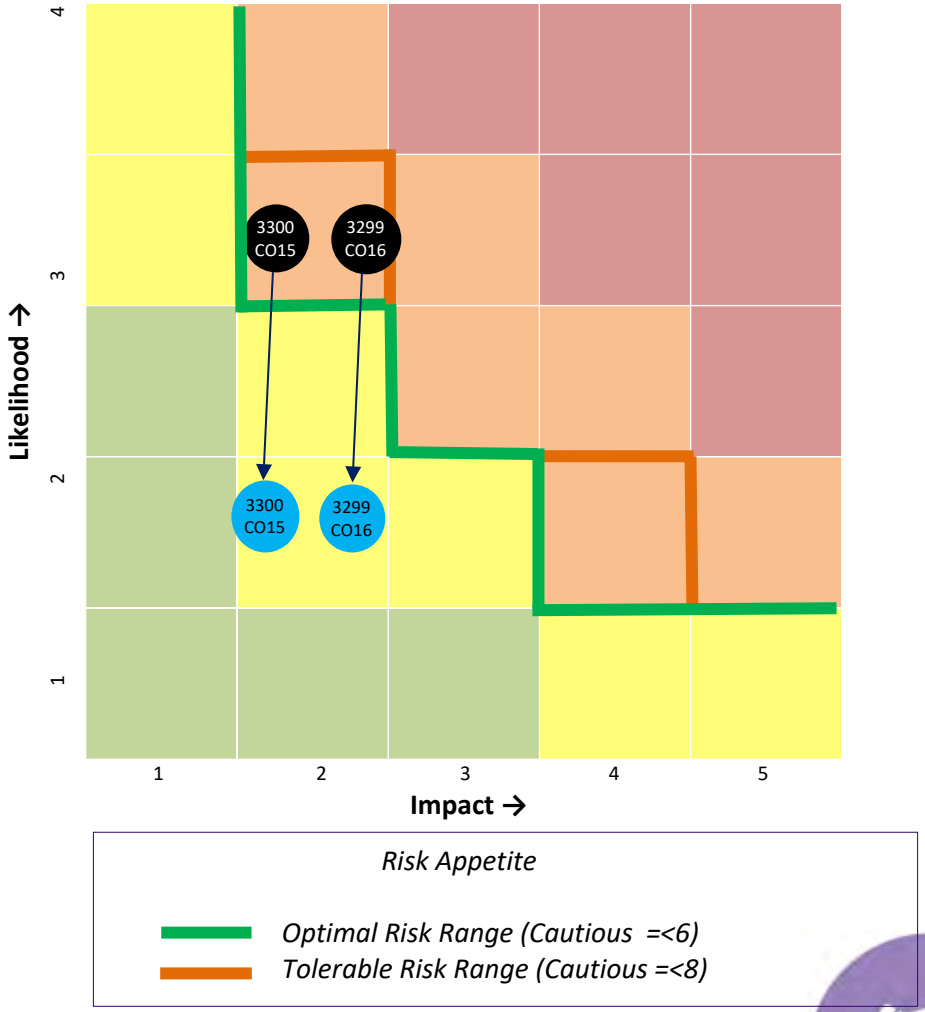
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

Monitoring: Board of Directors

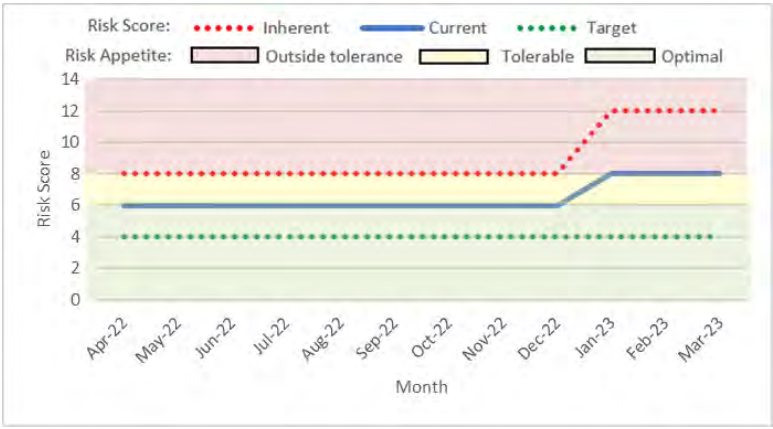
The following objectives are aligned to the **partnerships** strategic priority:

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

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

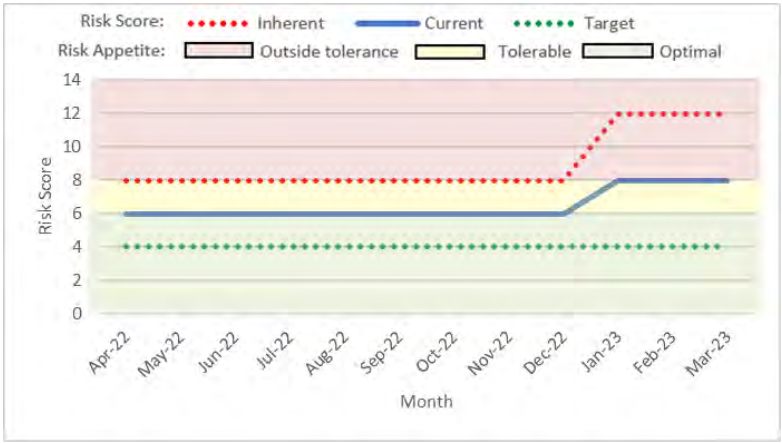


Corporate Objective: **CO15** Develop effective relationships within Wigan Borough and Greater Manchester for the benefit of our patients							**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic	**Risk Title:**	**PR 16: Partnership working - CCG changes**						
	Risk Statement:	There is a risk that staff with local knowledge and understanding may be lost due to the changes within CCGs, resulting in uncertainty regarding partnership working.						
Lead Committee	**Board of Directors**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious	
Lead Director	**DSP**	**Likelihood**	4. Likely	4. Likely	2. Unlikely	**Risk category**	Strategy	
Date risk opened	**19.10.21**	**Impact**	3. Moderate	2. Minor	2. Minor	**Linked risks**	-	
Date of last review	**24.01.23**	**Risk Rating**	12. High	8. High	4. Moderate	**Risk treatment**	Treat	



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

Corporate Objective: **CO16** Make progress towards becoming a University Teaching Hospital								**Overall Assurance level**	**Medium**
Principal risk What could prevent us achieving our strategic objective	**Risk Title:**	**PR 17: University Teaching Hospital - University Hospital Association criteria**							
	Risk Statement:	There is a risk that all the criteria that the University Hospital Association have specified may not be met, due to two key areas which we may find difficult to achieve, resulting in a potential obstacle towards our ambition to be a University Teaching Hospital.							
Lead Committee	**Board of Directors**	**Risk rating**	**Inherent Risk**	**Current Risk**	**Target Risk**	**Risk Appetite**	Cautious		
Lead Director	**MD**	**Likelihood**	4. Likely	4. Likely	2. Unlikely	**Risk category**	Strategy		
Date risk opened	**19.10.21**	**Impact**	3. Moderate	2. Minor	2. Minor	**Linked risks**	-		
Date of last review	**20.03.23**	**Risk Rating**	12. High	8. High	4. Moderate	**Risk treatment**	Treat		



Strategic Opportunity / Threat	Existing controls	Gaps in existing controls	Assurances (and date)	Gap in assurances	Risk Treatment	Due Date / By Whom
Threat: **(ID 3299)**	• Project documentation including action log in place. • 1 colleague confirmed as meeting the minimum criteria of 0.40wte affiliation to EHU.	•A core number of university principle investigators. There must be a minimum of 6% of the consultant workforce (for WWL likely to be between 9 and 12 PIs) with substantive contracts of employment with the university with a medical or dental school which provides a non- executive director to the Trust Board. These individuals must have an honorary contract with the Trust in question. •No new NIHR grants have been awarded. We are not achieving the criteria currently (2 years' average of £200k/annum).	**2nd Line:** • Board of Directors • University Hospital Group – October 2022.	• University Hospital Group due to meet on 28th March 2023.	1. The key actions for key principle investigators are for the Head of Research to provide a list of those we currently have and the research and HR teams are going to look at contractual options with a view to increasing the number of PIs that we have. 2. Our target for 2023/24 is to submit a minimum of 3 NIHR grant applications to be able to attract another NIHR award, which should enable achieving the £200k in 2025/26 which will achieve this target.	MD April 2023 MD April 2023

Title of report:	2023/4 Corporate Objectives
Presented to:	Board of Directors
On:	05 April 2023
Presented by:	Richard Mundon
Prepared by:	Dan Smith, Project Manager, Strategy and Planning
Contact details:	Dan.smith@wwl.nhs.uk

Executive summary

The report outlines the proposed corporate objectives for 2023/24.

The corporate objectives set out what the Trust plans to achieve during the financial year 2023/24 and what the organisation will prioritise and focus on during the year to progress the longer-term ambitions within the strategy.

The corporate objectives have been refined over the last few weeks reflecting the discussions at the Trust Board workshop on the 1st March and the subsequent Executive Team Meeting on 21st March. The key changes since the version presented to Trust Board are as follows.

- Reviewing the wording of all objectives to reflect feedback and to ensure their scope and focus align with the Trust priorities.
- Inclusion of an additional objective in the "Patients" domain: focussing on improving diabetes care for our population. Key to this objective is establishing a Multidisciplinary Diabetic Foot Team (MDFT) clinic and measuring a comprehensive range of metrics to measure our improvements made. It is acknowledged, as this a new objective baselining and benchmarking of our performance against these metrics is required in 2023/24 in order to further focus our programme of work.
- Creating a separate objective around promoting a strong safety culture within our organisation, embedding human factors awareness and increasing psychology safety for our staff.
- Ensuring our objective to improve quality of care for our patients considers the impact of corridor care and escalated areas within the Trust.
- Objective 13 relating to improving the responsiveness of urgent and emergency care has been updated to include the correct KPI regarding ambulance handovers.
- Strengthening the role of effective partnership working within a number of the objectives.

- Adding specific targets/measures and considering the balance of input/process measures with outcomes measures across all objectives.

The objectives are presented under the four Ps and mapped against the 3I's, therefore ensuring effective oversight of the delivery of the corporate objectives through the committee structure, with an allocated director for each, and assurance to Board being provided through the committee structure. Where there are specific KPIs referenced within the corporate objectives, the intention is that these are brought into the Integrated Performance report which is currently being refreshed to support the new objectives.

Link to strategy

The corporate objectives outline the priorities for 2023/24 to progress the longer-term ambitions within the strategy.

Risks associated with this report and proposed mitigations

None

Financial implications

None

Legal implications

None

People implications

None

Wider implications

None

Recommendation(s)

The Board of Directors are recommended to approve the proposed corporate objectives for 2023/24.

Patients		Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience						
Purpose of the Objective		Scope and focus of the objective	How will be know if it has been achieved?	Lead Exec.	How will assurance be provided ?	Improve	Integrate	Innovate
1	**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.	• Improvement in proportion of patients with suspected sepsis having blood culture to over 50% by the end of March 2024 • Improvement in proportion of patients with suspected sepsis having serum lactate to over 75% by the end of March 2024 • Improvement in the proportion of patients with suspected sepsis receiving IV Antibiotics within one hour to over 95% by the end of March 2024 • Improvement in Appropriate Care Score for Sepsis patients by 25% compared to 2022 data as per Advancing Quality annual report.	SA	Q&S Committee	✓		
2	**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).	• To increase the number of patients referred into the District Nursing Team for end-of-life care by 25% • To increase from 89% to 95% of all patients referred into the District Nursing Team dying at home or in hospice • To audit deaths in the borough with a view to identifying the number of patients who should have been referred to the District Nursing Team for end-of-life care - identify barriers and the resource needed to enable this to happen	SA	End of Life Care Committee reporting to Q&S	✓	✓	

Patients		Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience						
Purpose of the Objective		Scope and focus of the objective	How will be know if it has been achieved?	Lead Exec.	How will assurance be provided ?	Improve	Integrate	Innovate
3	**To improve diabetes care for our population**	✓ Work with our partners across primary care to deliver the diabetes transformation programme.	• Ensure all WWL Diabetes patients they have a footcare pathway with adequate capacity to enable early referrals of people at risk of diabetic foot disease to foot protection teams and people with active disease to multidisciplinary footcare teams." • Following establishment of the MDFT clinic, the following measures will be captured as per national guidance: • % of patients seen by MDFT within 2 weeks of presentation • % of patients who still have an active ulcer 12 weeks after presentation • % of patients who are deceased within 12 weeks of presentation • % of patients who required vascular input • % of patients who required an amputation	SA	WWL Divisional assurance Q&S Committee Wigan borough Diabetes Programme board Wigan borough Integrated Delivery Board Wigan Borough HWP System Board	✓	✓	

Patients		Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience						
Purpose of the Objective		**Scope and focus of the objective**	**How will be know if it has been achieved?**	**Lead Exec.**	**How will assurance be provided ?**	Improve	Integrate	Innovate
4	**To improve the delivery of harm-free care**	✓ Continue improvements Pressure Ulcer Reduction ✓ System wide improvement for reducing pressure ulcers	• Zero Hospital Acquired Category 3 , 4 and Unstageable pressures ulcers developed or worsened • Zero Community Acquired Category 3, 4 and unstageable pressure ulcers developed or worsened for patients on the District Nursing Caseload • Establish the care consortium to facilitate prevention of pressure ulcers in patients own homes on the District Nursing Caseload	RT	Q&S Committee	✓	✓	
5	**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	• A total of 700 clinical staff to have completed human factors training by end of March 2024	RT	Q&S Committee	✓		

Patients		Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience						
Purpose of the Objective		Scope and focus of the objective	How will be know if it has been achieved?	Lead Exec.	How will assurance be provided ?	Improve	Integrate	Innovate
6	**To improve the quality of care for our patients**	✓ Continue and build upon the accreditation programme and to include escalated areas within ED	• At least one ward achieving Gold • 8 Wards to achieve Silver • Maintain Bronze for all areas within existing assessment framework • Go live with accreditation assessment of scoped area within ED to achieve Bronze • Expand scope of programme to Paediatrics and Maternity	RT	Q&S Committee	✓		✓
7	**Listening to our patients to improve their experience**	✓ Deliver timely and high quality responses to concerns raised by patients, friends and families	• 85% of complaints responded within our agreed time frame • 5% improvement on in-house in patient survey on involved in care • 50% reduction in complaints related to loss of patient property • 5% improvement in patients recommending WWL as a place to receive care.	RT	Q&S Committee	✓		

People		To ensure wellbeing and motivation at work and to minimise workplace stress.						
Purpose of the Objective		**Scope and focus of the objective**	**How will be know if it has been achieved?**	**Lead Exec.**	**How will assurance be provided ?**	Improve	Integrate	Innovate
8	**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	• An increased number of our people telling us there are enough people at WWL for them to do their job properly to 38% • Improved NHS People Promise score for we are compassionate and inclusive • We will sustainably reduce the number of colleagues off long term sick between 28-90 days	TB	Integrated performance report through People Committee	✓		
9	**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	• Improved NHS National Staff Survey (NSS) response rate of 40% or higher • Improved Staff Engagement Score • Improved Staff Morale Score • The appraisal helped me to improve how I do my job (NSS target 21%) • The appraisal helped me agree clear objectives for my work (NSS target 29%) • The appraisal left me feeling that my work is valued by my organisation (NSS target 29%)	TB	Integrated performance report through People Committee	✓	✓	

People		To ensure wellbeing and motivation at work and to minimise workplace stress.						
Purpose of the Objective		**Scope and focus of the objective**	**How will be know if it has been achieved?**	**Lead Exec.**	**How will assurance be provided ?**	Improve	Integrate	Innovate
10	**To develop system leadership capability whilst striving for true placed based 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	Improved levels of autonomy, sense of belonging and contribution: • I am able to make improvements happen in my area of work • I feel values by my team • I feel that my role makes a difference to patients/service users Staff feeling happy with the standard of care at WWL if a friend or relative needed treatment (NSS 67%)	TB	Integrated performance report through People Committee	✓	✓	

Performance		Our ambition is to consistently deliver efficient, effective and equitable patient care						
Purpose of the Objective		Scope and focus of objective	How will be know if it has been achieved?	Lead Exec.	How will assurance be provided ?	Improve	Integrate	Innovate
11	**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.	• Delivery of agreed I&E position in view of an ICB approved plan • Ensure maximum revenue received under the contracting arrangement including Elective Aligned Payment Incentive. • Delivery of the efficiency plan. • Delivery of the prioritised capital investments in year within the CDEL allocation as agreed with the ICB. • The cash balance is sufficient to fund ongoing revenue commitments and planned capital investments. • Engage and communicate within the organisation to promote the Importance of sound financial management. • A finance strategy with a strong emphasis on financial transformation and providing value for money services to our population.	TG	Integrated performance report through Finance and Performance Committee	✓	✓	✓

Performance		Our ambition is to consistently deliver efficient, effective and equitable patient care						
Purpose of the Objective		Scope and focus of objective	How will be know if it has been achieved?	Lead Exec.	How will assurance be provided ?	Improve	Integrate	Innovate
12	**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.	• Eliminate waits of over 65 weeks for elective care by March 2024. Reduce waits of over 52 weeks by 50% by March 2024 to support elimination of 52 week waits by March 2025. • Deliver the system specific activity targets (agreed through the operational planning process) • Reduce the number of cancer patients waiting over 62 days to 21 by March 2024 • Meet the cancer faster diagnosis standard of 75% by March 2024	MF	Integrated performance report through Finance and Performance Committee	✓	✓	✓

Performance		Our ambition is to consistently deliver efficient, effective and equitable patient care						
Purpose of the Objective		Scope and focus of objective	How will be know if it has been achieved?	Lead Exec.	How will assurance be provided ?	Improve	Integrate	Innovate
13	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.	• Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 • Achieve 100% of ambulance handovers within 60 minutes • Aspire to reduce adult general and acute (G&A) bed occupancy to the 92% national target by March 2024, achieving a minimum improvement to 98% or below, acknowledging the system wide challenges in this area. In conjunction, aspire to reduce NRTR numbers to the GM expectation of 58 or less by March 2024, achieving a minimum improvement to 75. • Consistently meet or exceed the 70% 2-hour urgent community response standard	MF	Integrated performance report through Finance and Performance Committee	✓	✓	✓

Partnerships		To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester						
Purpose of the Objective		**Scope and focus of the objective**	**How will be know if it has been achieved?**	**Lead Exec.**	**How will assurance be provided ?**	Improve	Integrate	Innovate
14	**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.	• Increasing the % of influenceable non-pay spend made locally; • Increase the number of Wigan residents employed by WWL through further development of our Education and Skills Partnership • Support partners in developing a Joint Strategic Needs Assessment • Ensure a focus on health inequalities in our performance reporting, taking action to reduce inequalities where they are identified	RM	Six monthly report to Trust Board	✓	✓	
15	**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.	• Ensuring our reporting to Board and its committees reports on WWL performance and its contribution to that of the system and locality • Alignment of our transformation and delivery plans with locality and GM partners • Understanding how we are perceived as a partner through seeking feedback and then demonstrating improvement against this baseline.	RM	Six monthly report to Trust Board		✓	

Partnerships		To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester						
Purpose of the Objective		**Scope and focus of the objective**	**How will be know if it has been achieved?**	**Lead Exec.**	**How will assurance be provided ?**	Improve	Integrate	Innovate
16	**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	• Specific measurables to be refined based on deliverables for 2023/24	RM	Six monthly report to Trust Board	✓		
17	**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 and 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).	• Submit a minimum of 2 NIHR funding applications in Year 3 (2023/24) – aiming for a minimum of 1 successful application to achieve the RCF target in year 2024/5/6. • Increase the number of consultants holding substantive contracts of employment with EHU and honorary contracts with WWL – achieving a minimum of 3% of workforce identified and/or appointed.	SA	University Hospital group reporting to Trust Research Committee			✓

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	National Staff Survey Results 2022
Presented to:	Board of Directors
On:	5th April 2023
Item purpose:	The purpose of the paper is to present the 2022 NHS Staff Survey key results in context to previous performance and the sector benchmarking insights.
Presented by:	Tracy Boustead, Chief People Officer
Prepared by:	Angelique Hartwig, Head of Staff Experience
Contact details:	Angelique.Hartwig@wwl.nhs.uk

Report

Purpose

The purpose of the paper is to present the 2022 NHS Staff Survey key results to the Board and ask for support from the Board for the recommendations.

Introduction

The National Staff Survey (NSS) is the most important national NHS staff feedback mechanism. It enables us to understand our staff's experience working for our WWL family, what matters most to them, and what would make the greatest difference in improving their experience at work.

Methodology

Pre survey preparation featured Executive vlogs, Manager preparation packs, letter from CEO. On the 30th September 2022, our people received their annual invitation to take part in the survey which stayed open for eight weeks until 26th November 2022.

During the eight weeks the survey was live, the following communication and engagement initiatives were in play:

- A poster campaign featured a WWL NHS Staff Survey QR code
- Newsletter spotlights on each of the seven NHS People Promises

- Weekly response rate infographic
- FAQ & A
- All staff team briefs, leader's forum and vlog's promoting the WWL way (i.e., OF OF OF; You Said We, We Did; local engagement approach)
- Local team meetings, staff networks, partnership forum supported by OD colleagues

The survey results have been analysed by our contractor IQVIA and the following presentations and reports have been received:

- IQVIA 2022 National NHS Staff Survey Results report for WWL mapped against 62 Acute and Acute & Community, received and presented by Elaine Potts, Senior Consultant, to OF OF OF on 27th February 2023
- Survey Coordination Centre NHS Staff Survey Benchmark report 2022, received on 21st Feb 2023
- Survey Coordination Centre NHS Staff Survey Breakdown report 2022, received on 21st Feb 2023
- IQVIA 2022 National NHS Staff Survey Results comments report for WWL, received on 9th March 2023

On 7th March 2023, the Executive Management Team received the headline results for discussion focussed around three questions, including what strikes them about the results, what are the implications for that and what are they going to do about this. They have supported the recommendation for the OFOFOF steering group to continue to sponsor the programme of work and have oversight for actions plans for 2023/24.

On 14th March 2023, People Committee received the headline results for discussion. The committee were assured by the 5.5% improvement to a 35% response rate and noted that a) nearly all regions saw a decline in their 2022 response rate in comparison to 2021. B) the NW region response was 43.4% (-1% since 2021). Additional assurance noted with the staff morale ranking of 1st in Greater Manchester and top 10 nationally.

On 10th March 2023, Partnership Forum received the headline results for discussion. The forum acknowledged that the improved response rate provided a better representation of views meaning more meaningful changes can be made based on staff feedback. Nevertheless, further improvement is required and supported by staff side.

On 21st March 2023, LNC received the headline results for discussion. The committee gave commitment to support the mutual desire for improvement in medical workforce response rate.

On 22nd March 2023, Leaders Forum received the headline results and shared ideas on how we improve our response rate further in 2023 noting the proposed 2023/24 corporate target of 40%.

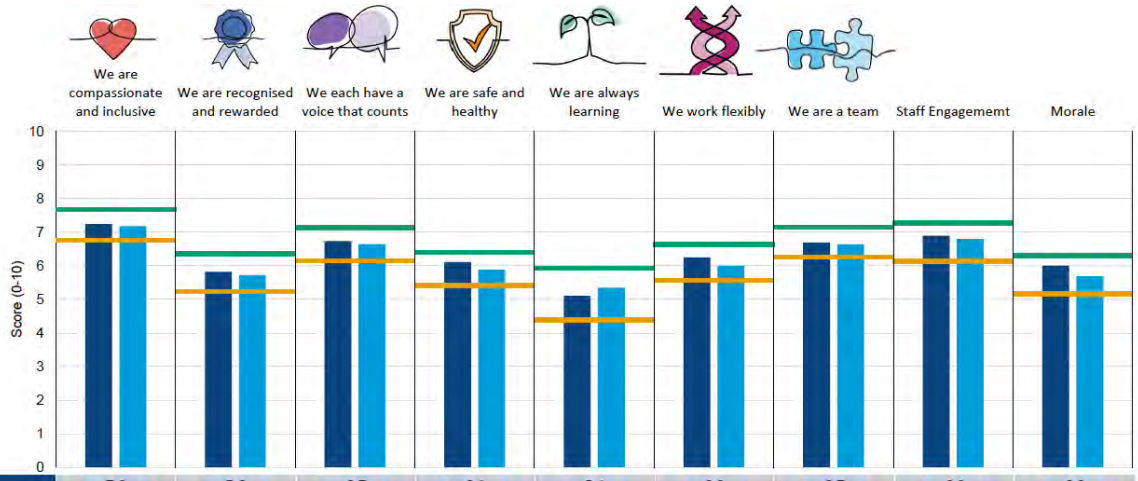
12th April 2023, our All-Staff Team Briefing will receive the headline results.

The Executive Team will receive further analysis work, on 27th April 2023. This presentation will feature the trust analysis of the 62-page document of pseudo anonymised comments received from our survey provider IQVIA. We are waiting on these comments to be uploaded to the online dashboard called SOLAR, where will then be able to filter them by people promise theme. This was meant to be available by now but has been delayed.

Summary of Key Themes

The survey has been recently redesigned to align with the seven NHS People Promises (e.g., We each have a voice that counts) which contribute to a positive, compassionate, and inclusive work culture. Listening to our staff's survey feedback, enables us to continuously improve our people's experience at work and, ultimately, our patients' care and safety.

Figure 1. WWL People Promises and Staff Engagement performance against benchmarking group (124 organisations) in 2022



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.2	5.8	6.7	6.1	5.1	6.3	6.7	6.9	6.0
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	2416	2410	2392	2399	2276	2397	2406	2416	2416

Successes to Celebrate

- Response rate has improved to 35%, showing increased engagement with the survey.
- We score higher than other Acute & Community Trusts in 2 People Promises: We are safe and healthy and We work flexibly
- Our Morale score is in the Top 10 for the 62 sector organisations
- We score positively for incidences of physical violence and harassment, bullying and abuse, and an improvement in reporting of those incidents showing the impact of work underway on Freedom to Speak Up and increasing psychological safety
- We score better than other Acute & Community Trusts on Diversity and equality

Areas for Focus for OF OF OF 2023

Our areas of focus this year will be:

- Showing how we are acting on concerns raised by staff and patients/service users using We Said We Did messages
- Roll out revised Route Plan Appraisal strategy, with focus on strengthening goal setting and alignment with strategic objectives cascade
- Continue to strengthen awareness of and access to personal development solutions and career pathways at WWL including WWL Talent Programme

- Building on the success of our culture programme, continue developing the work on civility, respect and just culture with teams and leaders

Summary of findings

WWL achieved a 35.0% response rate (2,417 respondents) in the survey, a 5.5% increase from 2021. Whilst there is still work to do to increase the response rate in future surveys (sector average 44.7%), this is excellent progress and the highest response rate at WWL in 5 years. Communication of the key messages and You Said We Did updates should be shared regularly to show staff that WWL is acting on the results (a key driver of increasing future response rates).

The results from the National Staff Survey revealed that all the People Promise scores and Themes are similar to 2021, with no significant local changes since 2021 (see Appendix 1). This suggests a stable picture over the past 12 months which can be viewed positively, given the wider context the Trust is working in.

Two People Promise scores are significantly better than the sector 'We are safe and healthy' (6.12) 1st in Greater Manchester and 'We work flexibly' (6.24) 1st in North-west region. 9 sub scores are significantly better than the sector.

As in 2021, the highest scoring People Promise for 2022 is 'We are compassionate and inclusive' (7.24) and the lowest 'We are always learning' (5.13), with the latter being the only significantly worse People Promise score compared to the sector. However, there has been a significant increase in staff accessing the right learning and development opportunities and having an appraisal in the past 12 months, demonstrating that WWL has made progress in both areas and that work should continue to further improve this score.

Staff Engagement (6.89) is also in line with scores for similar organisations, ranking 22nd out of 62 (14th in 2021), whilst staff 'Morale' (6.00) is significantly better than in other Trusts and ranks 8th out of 62 organisations (3rd in 2021).

Staff recommending the Trust as a place to work is higher than the sector (WWL 61%; sector 56.96%). Despite being in line with the sector, staff feeling happy with the standard of care if a friend or relative needed treatment, has significantly declined by 5% this year (WWL 62.4%; sector 62.9%).

Divisional breakdowns reveal that two divisions' scores are in line or above organisational average for all themes (Corporate and Specialist services) (Appendix 2). Surgery division score the same as the organisational average for Morale but lower than the organisational average on all other themes. Divisions scoring below organisational average on all themes include Medicine. OD colleagues are engaging with divisional leaders from Medicine Division as an opportunity to build relationships and support them in improving staff experience.

Based on the results, we identified different areas of focus for future improvements building on our areas of strength include wellbeing support, flexible working, and equality and diversity.

Areas of focus for OF, OF, OF 2023.24 include acting on raised concerns, quality of appraisals and personal development and career pathways.

Recommendation

We ask the Board to note the performance of the NSS 2022 results in context to previous performance and the sector benchmarking insights.

Link to strategy and corporate objectives

Linked to the priority themes as part of Our Family, Our Future, Our Focus and will be aligned with the new set of corporate objectives to provide assurance that the priorities for the upcoming financial year will meet staff needs to continuously improve staff experience and patient outcomes.

Risks associated with this report and proposed mitigations

N/A

Financial implications

N/A

Legal implications

N/A

People implications

The staff feedback gained from the survey will be used to shape action plans aimed to support improvements in staff experience at WWL, including engagement, well-being and organisational culture, which in turn has a strong impact on quality of care and patient safety.

Wider implications

By listening to and acting on staff feedback, we commit and contribute to the NHS People Plan which supports the national transformation of the workplace culture and staff experience in the NHS and has further implications for the strategic priorities of the Trust. Improvements in organisational culture and staff engagement have a strong impact on staff retention and sickness absence rates, performance, operational delivery, and patient outcomes.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	WWL M11 Balanced Scorecard
Presented to:	Board of Directors
On:	5 April 2023
Presented by:	Director of Strategy & Planning
Prepared by:	Data, Analytics and Assurance Team
Contact details:	BI.Performance.Report@wwl.nhs.uk

The WWL Way

Executive summary

The current iteration of the Trust's Balanced Scorecard is presented to the Board of Directors.

The Scorecard remains mostly manually populated monthly and therefore not real-time, except for 4 Key Performance Indicators (KPIs) in the Performance quadrant which have been automated and refresh daily. These are: No Right to Reside Patients (Excluding Discharges); Outpatient DNA Rates; Virtual Outpatient Consultations; Elective Recovery Plan.

As the Data Warehouse (DW) continues to migrate to the cloud, KPIs will continue to be developed using the new DW and will replace the need to populate them manually.

The interactive version on the Balanced Scorecard is available and allows you to view trend, Statistical Process Control (SPC) and year on year comparison charts (where data available) for each KPI. This functionality will be refined over the duration of the project.

The Scorecard can be accessed via this link (when connected to the Trust's WiFi or VPN :
http://wwlqliksense3.xwwl.nhs.uk/sense/app/7a161be3-c0ae-4dbd-9746-5556f04c1369
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 App or any of the Apps that the DAA Team has developed – please email DAASupport@wwl.nhs.uk to arrange.

A meeting has taken place to ensure that the Scorecard will be reflective of key metrics within the Operational Plan Guidance 2023/2024. Development of a Trust Corporate Objectives Dashboard is scheduled.

Link to strategy
Patient
Partnership
Workforce
Site and Service

Risks associated with this report and proposed mitigations
There are no known risks currently associated with the metrics within the Scorecard.

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 and note the content.

Report: M11 WWL Balanced Scorecard: February 2023

Quality & Safety (Chief Nurse & Medical Director)

ID	KPI Title	Period Covered	Total	Target	On Target	Trend	YTD
1	Never Events	Feb-23	0	0	●	-	3
2	Number of Serious Incidents	Feb-23	6	0	●	▼	87
3	Sepsis - Screening and Antibiotic Treatment (IN DEV)	-	-	-		-	-
4	STEIS Reportable Category 3, 4 & Unstageable Pressure Ulcers	Feb-23	1	0	●	▼	15
5	STEIS Reportable Serious Falls	Feb-23	0	0	●	-	4
7	Complaints Responses	Feb-23	72.22%	85%	●	▲	81.83%
9	Patient Experience (FFT)	Feb-23	89.22%	TBC		▲	88.66%
52	Methicillin-Resistant Staphylococcus Aureus (MRSA)	Feb-23	0	0	●	-	1
53	Methicillin-Susceptible Staphylococcus Aureus (MSSA)	Feb-23	5	0	●	-	37
54	Clostridium Difficile (CDT)	Feb-23	10	0	●	▲	102
78	SHMI Rolling 12 Months	Nov-22	114	100	●	▼	114

People (Chief People Officer)

ID	KPI Title	Period Covered	Total	Target	On Target	Trend	YTD
10	Vacancy rate	Feb-23	6.10%	5%	●	▼	8.50%
13	Rate card adherence (Medical)	Feb-23	60.48%	80%	●	▲	54.20%
14	Rostering timeliness	Feb-23	67.57%	75%	●	▲	53.42%
15	% Turnover Rate	Feb-23	9.46%	10%	●	▼	10.18%
16	Your Voice Score (QTR) - Engagement score	Jun-22	3.94	4	●	▼	3.94
18	Your Voice Score (QTR) - Wellbeing score	Jun-22	3.35	3.5	●	▼	3.35
19	Mandatory training compliance	Feb-23	93.85%	95%	●	▼	90.73%
21	Sickness - Sage time lost	Feb-23	5.51%	4%	●	▼	6.19%
50	Usefulness of Trust wide communication	Apr-22	82.00%	70%	●	▼	82.00%
51	Leaders Forum reach (Number of Leaders attending the Forum)	Feb-23	110	110	●	▼	1,312
62	Number of outputs per month (LF, ASTB, Executive Vlogs, CEO Vlog / Blog)	Feb-23	6	6	●	▲	68
63	FTSU contacts	Feb-23	6	n/a		-	72
64	Your Voice Score (QTR) - Psychological Safety	Jun-22	3.71	3.75	●	▼	3.71
65	Appraisal	Feb-23	79.19%	90%	●	▼	78.11%

Performance (Deputy Chief Executive)

ID	KPI Title	Period Covered	Total	Target	On Target	Trend	YTD
60	Ambulance handovers 60+ minutes delay	Feb-23	189	0	●	▼	2,981
59	Ambulance handovers under 30 minutes	Feb-23	68.37%	95%	●	▲	68.32%
58	Ambulance handovers under 15 minutes	Feb-23	46.57%	65%	●	▲	46.72%
32	Reduce 12hour waits in EDs	Feb-23	18.11%	10%	●	▼	13.42%
25	G&A Bed Occupancy - Acute Adult Inpatient Wards	Feb-23	97.57%	85%	●	▼	97.84%
33	No Right to Reside Patients (excluding Discharges)	Feb-23	144	50	●	▲	104
75	Cancer Referrals - 115% of pre-covid averages	Feb-23	1,625	1310	●	▲	17,500
31	Cancer - waits longer than 62 days	Feb-23	65	35	●	▼	N/A
24	Patients waiting over 104+ weeks (except patient choice & clinically complex)	Feb-23	0	0	●	-	N/A
42	Patients waiting over 78 weeks	Feb-23	119	26	●	▼	N/A
28	Outpatient Utilisation (IN DEV)	-	-	-		-	N/A
68	Outpatient DNA Rates	Feb-23	8.08%	6%	●	▼	9.42%
67	Virtual Outpatient Consultations	Feb-23	25.73%	25%	●	▼	27.65%
23	Elective Theatre Utilisation	Feb-23	77.52%	85%	●	▲	79.92%
41	Elective Recovery Plan	Feb-23	93.61%	100%	●	▲	85.44%
76	Total Waiting List - RTT position	Feb-23	48,395	-	●	▲	N/A

Finance (Chief Finance Officer)

ID	KPI Title	Period Covered	Total	Target	On Target	Trend	YTD
30	Surplus /Deficit (£'000s)	Feb-23	8,137	(647)	●	▲	(7,024)
34	Adjusted Financial Performance (£'000s)	Feb-23	8,152	(831)	●	▲	(2,836)
35	Capital Expenditure (£'000s)	Feb-23	4,891	4,296	●	▲	12,188
36	Cash (£'000s)	Feb-23	42,691	37,966	●	▲	389,385
39	Agency Expenditure (£'000s)	Feb-23	1,893	692	●	▼	12,163
47	Cost Improvement Programme (CIP) (£'000s)	Feb-23	1,596	1992	●	▲	12,360
48	Better Payment Practice Code (BPPC)	Feb-23	91.32%	95.00%	●	▲	98.18%

Quality & Safety (Chief Nurse & Medical Director)

Latest Commentary - **Feb-23**

Patient Safety
Within the month of February, 5 incidents were reported to StEIS. 1 incident of a fall with fracture was reported, 1 incident of hospital acquired pressure ulcer, 1 incident of delay in diagnosis, 1 maternity incident and 1 incident relating to management of sepsis. The Trust is reworking the sepsis improvement plan and linking closer with the work of the Deteriorating Patient Group to ensure that improvements are made. A new Sepsis Lead nurse also commenced in post who is leading this work.

Complaints
Within the month of February, the Trust response percentage improved to 72.2%, the highest recorded for over 24 months. Although the target of 85% set within the quality priorities, work has been done by both Division and the central teams to streamline the system, as well as ensuring that complaints are prioritised. This has resulted in an increase in the complaints performance over the last 4 months and we expect this to continue to increase.

People (Chief People Officer)

Latest Commentary - **Feb-23**

Wellbeing: Cost of living group well established now offering financial advice sessions, discounted staff public transport and reduced cost of free food and drink from our outlets.
Focus on colleagues to keep themselves well in light of operational pressures, encouraging self-care and for them to prioritise as much as possible their basic needs for food, water and rest first whilst at work.
Psych Support Team – digital system to manage referrals providing single point of access. Increase in referrals has doubled in last 6mths with majority from surgical, medical divisions and E&F
Leadership & teams: Analysis and qualitative review of national staff survey commentary being prepared for ETM
New Route Plan Appraisal training available for leaders in Q1
131 requests (trust-wide) for staff to undertake an apprenticeship programme supporting their personal development
Culture: EDI Champion Network launch events face to face and virtually
Scored 'outstanding' for our WRES action plan, which is the maximum score - Good range of interventions with support from leadership
YVS – Coming in April
Comms and visibility: All Staff Team Brief (ASTB) – 188 in attendance, quarterly usefulness survey completed in November
Personal development: Review of My Route Plan Appraisal – launch Q1
Mandatory Training – National 93.9%, local compliances are steadily increasing. M&H level 2 & IPC level 2 need improvements on compliance rates
Medics mandatory training compliance now aligned to appraisal dates – great progress here which allows for accurate reporting
Wellbeing: Cost of living group well established now offering financial advice sessions, discounted staff public transport and reduced cost of free food and drink from our outlets.
Focus on colleagues to keep themselves well in light of operational pressures, encouraging self-care and for them to prioritise as much as possible their basic needs for food, water and rest first whilst at work.
Psych Support Team – digital system to manage referrals providing single point of access. Increase in referrals has doubled in last 6mths with majority from surgical, medical divisions and E&F
Leadership & teams: Analysis and qualitative review of national staff survey commentary being prepared for ETM
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131 requests (trust-wide) for staff to undertake an apprenticeship programme supporting their personal development
Culture: EDI Champion Network launch events face to face and virtually
Scored 'outstanding' for our WRES action plan, which is the maximum score - Good range of interventions with support from leadership
YVS – Coming in April
Comms and visibility: Executive Vlogs – Decision to stand down 8th Feb vlog due to RCN industrial action taking place. All Staff Team Brief (ASTB) – 197 colleagues in attendance and positive engagement to guest speaker stories
Personal development: Review of My Route Plan Appraisal – launch Q1
Mandatory Training – National 93.9%, local compliances are steadily increasing. M&H level 2 & IPC level 2 need improvements on compliance rates
Medics mandatory training compliance now aligned to appraisal dates – great progress here which allows for accurate reporting

Performance (Deputy Chief Executive)

Latest Commentary - **Feb-23**

Please see Appendix 1.

Finance (Chief Finance Officer)

Latest Commentary - **Feb-23**

Surplus/Deficit
The Trust reported an actual surplus of £8.1m in month 11 (February 2023), favourable to plan. The year to date position is an actual deficit of £7.0m, which is £0.6m favourable to the planned deficit of £7.6m.

Adjusted Financial Performance
The adjusted financial performance is a deficit of £2.8m year to date, which is £4.6m favourable to plan. The year to date position has significantly improved due to additional funding of £9.0m agreed by GM wide system which has been recognised in month.

Capital Expenditure
Capital expenditure is £4.9m in month 11 which is £0.6m below plan. Year to date, capital spend is £12.1m which is £4.0m below the planned expenditure of £16.1m. Of which, £2.0m relates to internal CDEL backed capital spend and £2.0m relates to external PDC funded schemes (of which £1.5m is Frontline Digitisation).

Cash
Cash at the end of the period totalled £42.7m. This has improved by £11.2m from the previous month due to receipt of capital PDC funding, which temporarily improves the cash balance pending payment to the suppliers for the PDC funded capital schemes.

Agency Expenditure
Agency spend in month 11 is £1.1m, like last month and £0.4m higher than February last year. Year-to-date, agency expenditure is £4.0m higher than this time last financial year (2022/23 £12.2m; 2021/22 £8.2m).

Cost Improvement Programme (CIP)
In month 11, £1.6m CIP was transacted, which was £0.4m adverse to plan. This is split £0.4m Divisional CIP and £1.2m Corporate CIP. Year to date, £22.2m has been transacted which is £0.3m ahead of plan. This includes £10.5m of Corporate CIP which is non-recurrent in nature. Corporate CIP is on track to deliver the planned value of £13.0m in year.

Better Payment Practice Code (BPPC)
BPPC year to date is 90.2% by volume and 93.9% by value. Performance by volume has improved slightly from the previous month (90.1%).

Appendix 1

The Trust maintained its exceptional performance against 104-week National Referral to Treatment (RTT) target and remains on track to eliminate non patient choice 78 week waits by the end of March 2023. National planning guidance for budget year 23/24 requires elimination of 65-week waiters by the end of March 2024, plans are already in place to achieve this with an internal stretch target to reduce the number of people waiting beyond 52 weeks to achieve future expectations.

Performance against Cancer waiting times continues to improve, with 65 patients waiting over 62 days for treatment as at the end of February, compared to over 100 in December. Significant improvement has been seen in the breast service, following investment into increasing one stop provision, a business case benefits realisation is scheduled for review in September Finance and Performance investment Committee. The Trust continues to work with Wigan Planned Delivery Board and Greater Manchester Cancer to increase primary care compliance with referral guidelines to reduce waiting times for patients in Lower GI services.

The Trust is currently delivering 92% of the 19/20 baseline activity levels and 92% of the income value and has not achieved the elective activity plan submitted to NHSE. Confirmation has been received that financial penalty will not be applied this year. There is clear indication that the level of complexity of patients within some areas is increasing, this along with winter pressures and strike action has heavily impacted delivery of the plan, 73% of elective activity was carried out in January compared to over 90% across all other months.

The overall waiting list continues to increase due to the ongoing impact of winter pressures, critical incidents, and industrial action. Whilst it is not possible to forecast the impact of further potential industrial action, focus continues treating the most urgent and longest waiting patients.
It should also be noted that the operational reality is still not in line with NHSI/e key planning assumptions to support delivery of the elective recovery plan - significant pressures are still seen in urgent care demand, cancer referral rates and bed occupancy levels. The Trust continues to work with system partners through the Wigan System Planned Care Board, Integrated Care Board and Greater Manchester Elective Recovery and Reform Board to safely manage both urgent and planned care.

WWL continues to rank number 1 Trust within Greater Manchester for A & E performance against the 4-hour standard for February 2023 and continues to be the top performing Trust for the financial year 2022-23 within Greater Manchester. Although still behind the England average, performance against the 4-hour standard slightly improve and ambulance hand over delays over 60 minutes reduced in January 2023 compared to December 2022.

The Trust continues to be faced with two, interdependent challenges, which impact on performance improvement and delivery of urgent and emergency care. Those two challenges are:

- Demand: In February, we continued to see increase in demand with greater number of high acuity patients (The proportion of particularly sick patients' attendances compared to the total A&E attendances) presenting to the A&E.
- Flow and Discharge: February saw an average of 144 patients on the no right to reside (NRTR) list an increase of further 4% from December 2022.

This combined with several days of industrial action has continued to place increasing demand on urgent and emergency care services and in turn impacts on delivery of core objectives.

Flow and Discharge is a key priority programme identified by the Healthier Wigan Partnership System Board and underpins delivery of the Trust's 23/24 operational plan which includes meeting the NHSi/E mandated targets. The Chief Executive of Wigan Council is the named Executive Lead for the programme whose focus is *"working together to support people to stay independent at home and safely go home from hospital"* based on five themes:

- Operationalising the Transfer of Care Hub, moving towards development of the "Independence Team" to get people home.
- Mental Health urgent access, bed capacity and discharge.
- New model of care for community beds to increase independence prior to returning home.
- Integrated neighbourhood working – primary care, third sector, community services, social care, and mental health – living well.
- Population health approach to broader health improvement and admission avoidance.

It is worth noting that previous efforts to deliver significant transformation across the system have proved challenging which is why it is key to success that the right conditions with partners are in place to deliver the programme. A proposal has been shared with Partner leads and Healthy Wigan Partnership System Board recommending dedicated Programme management to support delivery of a large and complex programme linked directly to quality, safety, delivery of NHS constitution standards and improved finances. Central to this is the development of a Programme Board and the Wigan wide Urgent Emergency Care Board remains paused until system leaders agree the governance framework which provides confidence to the IDB, and all partner organisations that the right things are being addressed and plans are in place to deliver solutions. Underpinning delivery of the programme is organisational development led by the interim Chief People's officer.

Agenda item: [20]

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Monthly Trust Financial Report – Month 11 (February 2023)
Presented to:	Board of Directors
On:	5th April 2023
Presented by:	Tabitha Gardner [Chief Finance Officer]
Prepared by:	Senior Finance Team
Contact details:	E: Kelly.Knowles@wwl.nhs.uk

Executive summary

Description	Performance Target	Performance	Explanation
Revenue financial plan	Achieve the financial plan for 2022/23.	Amber	Year to date, the Trust is reporting an actual deficit of £7.0m against the planned deficit of £7.6m, creating a favourable variance of £0.6m. The adjusted financial performance (used to measure system performance) is a deficit of £2.8m year to date, which is £4.6m favourable to plan. The Greater Manchester Integrated Care System (GM ICS) has agreed a series of mitigations and actions which are expected to deliver a break-even position for the 2022/23 year end across the system. This revised forecast outturn is collectively reported within the forecast to NHSE for all providers. The Trust is reporting a final revised deficit of £1.4m which would be £7.0m favourable to plan. The Trust will receive additional income of £9.0m from GM to support delivery of this position, which will improve the year end cash position. The final revised deficit of £1.4m assumes that the Trust will deliver the most likely scenario from the Financial Recovery Plan (FRP) of £10.4m, with an additional stretch applied of £0.5m. The additional stretch was calculated on a 'fair shares' basis.
Activity	Achieve the elective activity plan for 2022/23.	Red	The month 11 activity data highlights that the Trust has not achieved the elective activity plan that was submitted to NHSE. GM ICB have advised the Trust not to make a provision for a penalty as there is no intention to claw back any of the funding in year.
Cash & liquidity	Effective cash management ensuring financial obligations can be met as they become due.	Green	Cash is £42.7m at the end of month 11 which is £4.7m above the plan. This has improved by £11.2m from the previous month and deviated from current forecasts due to receipt of capital PDC cash £12.6m and timing in settlement of debts from customers, payments to suppliers.

Capital expenditure (CDEL)	Achieve CDEL for 2022/23.	Amber	Expenditure against total CDEL is £0.5m above plan in month 11 and £4.0m below plan year to date. A revised programme has been developed to mitigate risks to ensure delivery of the plan. To reduce the GM ICS over commitment to capital, the Trust has agreed to forecast £1.0m underspend on CDEL from slippage.
Cost Improvement Programme (CIP)	Deliver a 5% efficiency in 2022/23 as per the mandate from the GM ICS.	Amber	The year to date variance is favourable by £0.3m to the CIP target. The proportion of CIP delivered recurrently remains low (0.9%) which will impact the exit run rate for 2022/23.
Agency expenditure	To remain within the agency ceiling set by NHSE.	Red	Agency expenditure was £0.9m in month 11 and £12.2m year to date. The Trust is currently £4.5m above the ceiling year to date. Agency expenditure is £3.9m (49%) higher year to date than for the same time last financial year.
COVID-19 expenditure	To reduce COVID-19 expenditure by 57% in line with the reduction in system funding.	Amber	The COVID-19 expenditure in month was £0.2m which is similar to prior months. COVID expenditure is £3.8m year to date, which is £2.2m favourable to plan, however, the plan doesn't reflect the full reduction in COVID funding.
Business conduct	Comply with the Better Payments Practices Code (BPPC) of paying 95% of invoices within 30 days.	Amber	BPPC year to date is 90.2% by volume and 93.9% by value. Performance by volume has improved slightly from the previous month (90.1%). Work is ongoing with SBS, financial services and procurement teams to address the root causes.
Financial Risk	Report the financial risks through the Board Assurance Framework.	Amber	Whilst the Trust is now anticipating delivering the revenue financial plan for 2022/23 there are a range of risks which are driving an underlying deficit. These include high volumes of no right to reside patients, length of stay, temporary spend, delivery of CIP and inflationary pressures. The financial environment for 2023/24 for both revenue and capital will be highly constrained and may impact on the ability of the Trust to deliver its strategic objectives.

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 are risks associated with delivery of the year end forecast deficit of £1.4m, primarily around mitigating the increase in the expenditure run-rate that the Trust has seen since month 7. The use of NHSP incentive payments were restricted from February which has seen a reduction in the associated cost. However, significant escalation, including staffing unfunded areas which often rely on temporary staff and premiums, as well as the need for enhanced care are still present. The volume of no right to reside (medically fit for discharge) patients, length of stay, and delays in discharging people home or into social care settings continues to be a pressure on the Trust. The Trust is working with system and locality partners to support a multi-agency approach to discharges and negotiate additional funding support.

Capital expenditure is £4.0m below plan at month 11, and with the plan backloaded in quarter 4, significant spend is expected in the final month. All PDC schemes have now been formally approved and the funding drawn down. An operational task and finish group has been established weekly until the year end to monitor all schemes, resolve any issues promptly and trigger elements of the contingency plan as required.

The cash balance has reduced by £11.4m since 31st March 2022 (from £54.1m to £42.7m at the end of February 2023). As it stands, the Trust has sufficient cash to service this planned deficit and the planned capital programme. The contract adjustments for the year end will be cash backed, which will see an injection of cash of £9.3m. There will need to be a stronger focus on cash management in 2023/24 as the Trust expects to submit a deficit plan.

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

The Trust has reported an actual surplus of £8.1m in month, £8.9m favourable to plan. The adjusted financial performance is a surplus of £8.2m in month, which is £9.0m favourable to plan.

Year to date, the Trust has reported an actual deficit of £7.0m which is £0.6m favourable to plan. The adjusted financial performance is a deficit of £2.8m which is £4.6m favourable to plan.

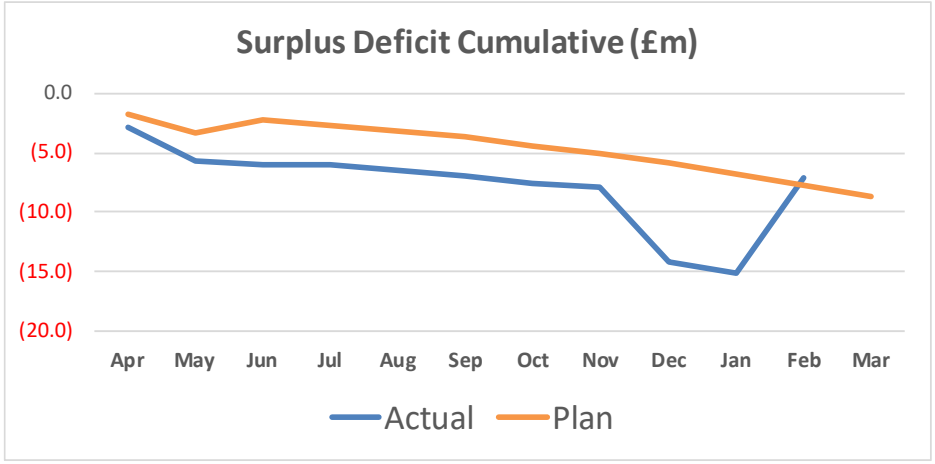
The Trust updated its forecast in month 10 to a full year deficit of £1.4m (adjusted financial performance), as agreed by the GM ICS. This would be £7.0m favourable to plan.

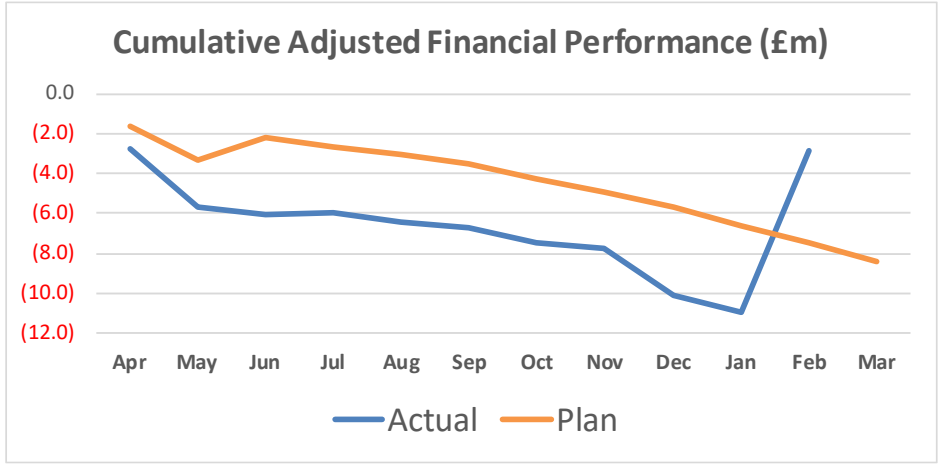
The Trust reported an actual surplus of £8.1m in month 11 (February 2023), favourable to plan. The year to date position is an actual deficit of £7.0m, which is £0.6m favourable to the planned deficit of £7.6m.

The adjusted financial performance is a deficit of £2.8m year to date, which is £4.6m favourable to plan. The year to date position has significantly improved due to additional funding agreed by GM wide system transacted in month. The actual income reported in month was £49.8m which is £11.7m favourable to plan. This includes the additional funding of £9.0m received from the GM wide system.

The year to date position includes a technical impairment of £4.0m for a capital scheme associated with cycle lanes (part of the Community Health Investment Partnership in last financial year). The impairment is excluded for the purposes of calculating the 'adjusted financial performance' which is how NHSE measure system performance.

The GM ICS reported a year to date deficit of £32.9m at the end of month 10, which was an adverse variance of £28.0m to the planned deficit of £4.9m. The GM ICS is forecasting to deliver a break even position.





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	49,801	38,113	11,688	450,055	419,102	30,953	457,223
Expenditure	(39,964)	(37,188)	(2,776)	(433,494)	(407,267)	(26,226)	(444,564)
Financing / Technical	(1,701)	(1,773)	72	(23,525)	(19,501)	(4,025)	(21,273)
Surplus / Deficit	8,137	(847)	8,984	(7,027)	(7,665)	639	(8,615)
Adjusted Financial Performance *	8,152	(831)	8,984	(2,833)	(7,488)	4,655	(8,426)
Other							
CIP	1,596	1,992	(395)	22,160	21,908	252	23,900
COVID-19 Expenditure	151	322	171	3,759	5,951	2,192	6,273
Agency Spend	1,093	311	(782)	12,163	3,420	(8,743)	3,731
Cash Balance	42,691	37,966	4,725	42,691	37,966	4,725	38,123
Capital Spend - CDEL	1,468	1,850	382	7,232	9,257	2,025	11,107
Capital Spend - PDC	3,423	2,446	(977)	4,920	6,863	1,943	11,843

* Surplus / Deficit less donated capital & grants & other technical adjustments

CIP

- £1.6m transacted in month 11 and £22.2m YTD.
- Split in month: Divisional £0.4m; Corporate CIP £1.2m.

COVID Expenditure

- £0.2m expenditure in month, in line with the spend in previous month followng the reclassification of expenditure within Medicine.

Agency

- Expenditure of £1.1m in month 11 and £12.2m YTD.
- Expenditure remains higher than last year.

Cash

- £42.7m cash balance, £4.7m above plan.
- Increase of £11.2m from month 10.

Capital

- £4.9m spend in month, £0.6m behind plan
- £12.2m YTD spend, £4.0m behind plan
- £2.0m of the variance is due to delays in approval of PDC schemes nationally, remaining £2.0m relates to delay in commencement of schemes.

Divisional Performance

Medicine

- (£1.2m) Adverse to plan in month, decrease of £0.5m from month 10
- (£0.5m) Nursing including 1:1
- (£0.5m) Escalation costs
- (£0.2m) Unacheived CIP
- (£0.1m) For the NHSP ED incentive

Surgery

- (£0.4m) Adverse to plan
- (£0.1m) CIP
- (£0.1m) Theatres pay
- (£0.1m) Paediatrics medical rota gaps, and cohorting
- (£0.1m) ACU non pay costs

Specialist Services

- £0.7m Favourable to plan in month
- £0.6m Favourable to plan T&O non pay and prosthesis
- £0.1m Over performance Rapid Diagnostic Centre (RDC) income

Community

- £0.1m Favourable to plan in month
- £0.1m Vodaphone credits and accrual reversal of GMMH SLA

Estates & Facilities

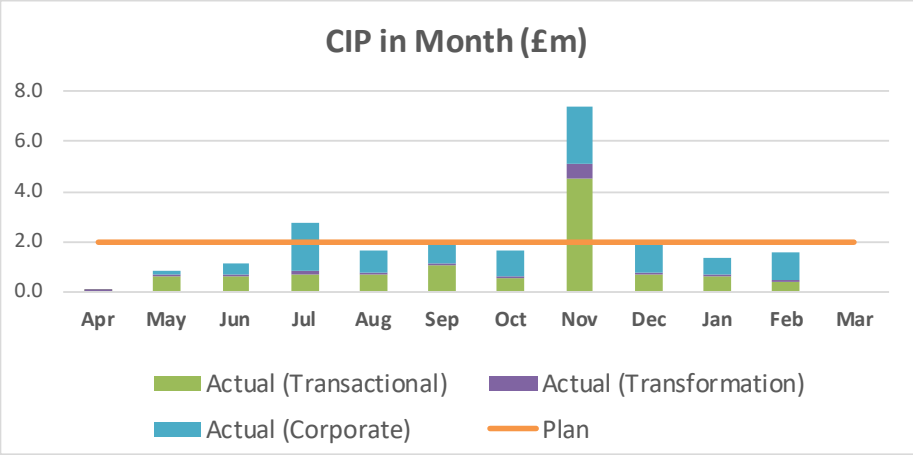
- £0.1m Favourable to plan in month
- £0.1m Small variances
- CIP on plan

Corporate Divisions

- (£0.2m) Adverse to plan
- (£0.3m) International nurse recruitment
- £0.1m Medical Director

All the clinical divisions have trigged the RAPID metrics in month 11. However, RAPID meetings for March will be converted to a budget check and challenge session for the 2023/24 plan. The meetings will have a structured agenda focused on reviewing base budgets and challenging cost pressures declared by the division. There will also be a significant focus on recurrent delivery of CIP for 2023/24. The divisions will be invited to discuss their service developments proposal and will be given an opportunity to discuss the resources requested to deliver the 2023/24 activity plan.

Cost Improvement Programme



In month 11, £1.6m CIP was transacted, which was £0.4m adverse to plan. This is split £0.4m Divisional CIP and £1.2m Corporate CIP.

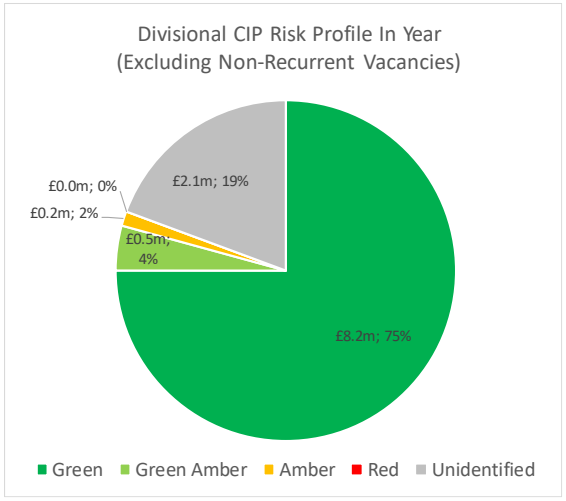
Year to date, £22.2m has been transacted which is £0.3m ahead of plan. This includes £10.5m of Corporate CIP which is non-recurrent in nature. Corporate CIP is on track to deliver the planned value of £13.0m in year.

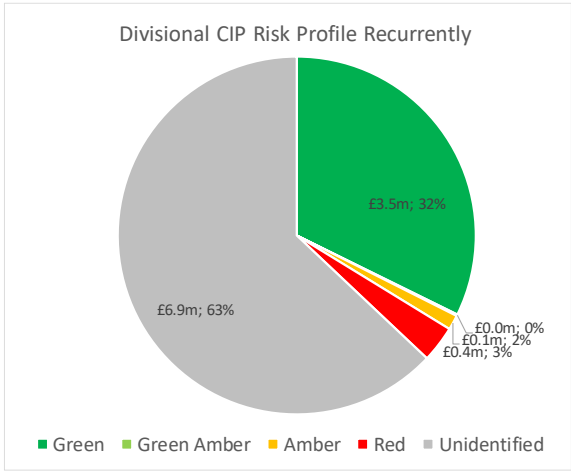
The remaining £11.6m is from divisional CIP. This is split between transactional savings of £10.4m and transformational savings of £1.2m.

The transformational CIP relates predominantly to the clinical services collaboration scheme, private patient income for Trauma and Orthopaedics and the financial delivery against the workforce efficiency programme.

The recurrent forecast delivery is £4.1m which is a further reduction of £0.8m from month 10. The recurrent forecast has deteriorated month on month since month 3, with schemes not progressing as originally planned.

As at month 11, there is a greater risk profile associated with the recurrent delivery with 63% currently unidentified. This is a key focus of the budget check and challenge meeting being held in place of the RAPID meetings during March.





Forward Look

The 2023/24 planning round is in progress with initial draft provider and ICS plans submitted in February. The financial environment for 2023/24 will be extremely challenging from both a revenue and capital perspective. The draft plan indicates a deficit of £56m, which includes a £12m efficiency target. This is driven by the reduction in contract income, inflationary pressures and the non-recurrent support utilised to support the financial position in 2022/23. The GM ICS draft plan deficit is £540m (including CIP) which is one of the highest in the country. Developing the 2023/24 plans will be an iterative process between submission of the draft and final plans. At the time of writing, 'confirm and challenge' meetings are taking place within the ICB and as a peer review process between providers. A full update on the 2023/24 plan will be provided to the Finance and Performance Committee on the 29th March 2023.

The GM ICS have been moved from segment 2 to segment 3 of the System Oversight Framework (SOF). The framework goes from segment 1 to 4. A diagnostic stocktake has been initiated to identify key drivers of the concerns that need to be resolved, with a view to implementing improvement actions. If the ICS is moved to segment 4, then it will enter the recovery support programme (formally known as special measures). The movement is a culmination of events, not an immediate reaction to the draft plan submission.

The GM ICS has commissioned Price Waterhouse Cooper to undertake a diagnostic review to identify the reasons for the financial, efficiency and productivity challenges within the GM ICS. As this immediate task is to support the NHS operational planning for 2023/24, this is focused on the NHS organisations; however, the financial, productivity and efficiency challenges across the wider system will need to be understood and acknowledged.

A draft 3 to 5 year capital plan has been developed and discussed at a workshop with the executive team, divisional triumvirates, and corporate leads on 28th February. The Trust has been advised of a draft CDEL limit of £12.5m for 2023/24, which is restrictive and creates a tension between maintenance of the estate and the ability to fund transformational large scale schemes. The Capital Strategy Group is advocating a change in approach for 2023/24 which considers how best the Trust sets itself up to respond to opportunities to bid for additional national capital.

Title of report:	Safe Staffing – 22/23 Q3 Update Report
Presented to:	Board of Directors
On:	5 April 2023
Presented by:	Rabina Tindale, Chief Nurse & DIPC
Prepared by:	Allison Luxon, Deputy Chief Nurse
Contact details:	Allison.luxon@wwl.nhs.uk

Executive summary

The purpose of this report is to provide an update and assurance with regards to actions taken to maintain safe nursing and midwifery staffing levels across Wrightington Wigan and Leigh Teaching NHS Foundation Trust (WWL) within Q3 of 2022/23. The report will also describe staffing risks and mitigating actions being taken to address these risks.

This report provides assurance that workforce challenges relating to staffing are a key focus and are being managed appropriately by the Trust. There are robust mechanisms in place to support the planning and management of staffing by Trust matrons which ensure a trust wide approach to the mitigation of risk are being actioned. Senior leadership support is provided during the staff huddles and in extremis, providing additional weekend support.

The overall vacancy position of the Trust continues to reduce assisted by ongoing domestic and international recruitment, turnover on average of Nursing and Midwifery posts is currently 8.2 %. The investment in international nursing and the domestic pipeline of recruitment is assisting in closing the vacancy gap. B2 vacancies remain high and appear static across the Divisions. Within the Divisions, there needs to be a key focus upon this staffing discipline within our workforce plans to ensure patient safety and delivery of quality care.

The Trust Strategic Retention group have been meeting and are using the NHSE self-assessment toolkit to develop WWL's retention strategy. The Community Division commenced their divisional last August, with the other Divisions increasingly following suit. This ongoing work will be monitored by the People Committee.

Within the Community Division, there remain challenges within DNS associated with increasing demand, a high number of vacancies and turnover of staff; it is recognised that caseload numbers and staff turnover are inter-related. The community division, having completed the data cleanse of the patients on the DNS caseload as planned, have been successful in completing the programme of work to ensure patients are aligned to the most appropriate service.

Following a successful recruitment drive in November the predicted shortfall in international nurses recruited has reduced to 2. Additionally, to support during the critical incident and winter pressures, 30 of the 59 pre OSCE international nurses travelled from Crewe each day to work in their allocated clinical areas for 24 hours per week.

Link to strategy

Patients: To be widely recognised for delivering safe, personalised, and compassionate care, leading to excellent outcomes and patient experience.

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

Performance: To consistently deliver efficient, effective, and equitable patient care.

Risks associated with this report and proposed mitigations

Risks associated with the delivery of corporate objectives relating to staff well-being, education, and training. This is being mitigated with ongoing recruitment including international recruitment, and involvement of the well-being team within specific services.
Potential risk relating to the ability of the Trust to ensure that all the international nurses identified within the business case will not be in the Trust by the end of December; further modelling is required to determine the scale of this risk.

Financial implications

There is a risk to achieving the corporate objective of financial balance due to overspend on temporary staffing. This risk will be mitigated by planned recruitment.

Legal implications

There is a potential for an increase in litigation associated with harms that occur to patients whilst in our care.

People implications

There is a potential for negative impact on staff well-being and opportunities for personal and professional development due to the inability to release staff for training. This is being mitigated by the use of temporary staff, paying additional hours and ongoing recruitment plans.

Wider implications

There is a potential for increased scrutiny from Commissioners and Regulators with regards to harms to patients and staffing levels.

Recommendation(s)

The Board of Directors are requested to receive this report and accept the priorities identified for Quarter 4 2022/23.

Q3 Safe Staffing Report

1. Introduction

1.1 The following report provides information relating to actions being taken to maintain safe staffing levels across Nursing and Maternity Services within WWL. The report is structured to provide assurance across 4 principal domains and is written to guide board members through workforce challenges including risks and assurance of actions being taken to mitigate these risks.

1.2 The content of the report has been informed by the monthly reports provided to the senior nursing teams which contain operational details relating to specific services.

1.3 The format of the report supports best practice assurance reporting as detailed by the National Quality Board (2016)[1] and NHS Improvement (2018)[2].

1.4 The full Q3 report has been received and scrutinised by the Quality and Safety Committee, and therefore this report to Board is an abridged version detailing salient points for escalation and assurance, with mitigation where appropriate.

2. Workforce

2.1 Overall nursing and midwifery vacancies across the Trust are reducing with notable reductions in the Medicine and Community Divisions since Q2 (Appendix 1, Chart 1).

2.2 Due to challenges with the international nursing recruitment process and a high number of withdrawals the Trust did not reach the target of 180 staff in the country by the end of December 2022. However, a further recruitment drive in November enabled the Trust to recruit to the posts where staff had withdrawn leaving the Trust with only a shortfall of 2 out of the 180 anticipated recruits highlighted in the Q2 report. In recognition of the numbers of staff still to commence in post the 12 WTE clinical educators on fixed term contracts to support the international nurses have had their contracts extended by 2 months.

2.3 Band 2 vacancies are high in numbers and needs to be a key focus within our future workforce plans.

2.4 50% of the vacancies at Band 5 are within the Community Division, particularly within District Nursing Services (DNS). Deep dive of the issue has identified that the issue is with retention of staff and therefore the division is considering how best to support staff who join. Furthermore, the division has completed work on the data cleanse of caseloads and realignment of patients to the correct service which is expected to reduce caseloads within DNS.

2.5 Vacancies at B6 level are largely attributable to Maternity Services who currently have 13 WTE vacancies. A full Birthrateplus® review has been undertaken and findings are being reviewed and analysed. Considering the vacancies, the service currently is offering 2 Midwifery Enhanced community teams within the Borough which are focused on women who are identified as having additional vulnerabilities or from at Risk groups. A full continuity service is not currently being provided and the current model is focussing on antenatal and post-natal periods of the woman's care. Ockenden recommends that MCoC services are only recommenced when there is sufficient staffing to safely deliver the service and therefore the remainder of the services remain suspended as staff are still required to support the high-risk areas of the maternity service.

2.6 Trust matrons continue to undertake a minimum of twice daily Staffing Huddles to collectively review staffing shortfalls and the acuity of patients to proactively address staffing shortfalls and mitigate risk of harm to patients. In extremis these meetings are undertaken 3 times daily. Supported by the senior nurse leadership team, these were also conducted during Christmas Eve and New Year's Eve weekends due to the

[1] National Quality Board (2016) 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time. Safe, sustainable and productive staffing.
[2] NHS Improvement (2018) Developing Workforce Safeguards. Supporting providers to deliver high quality care through safe and effective staffing. NHS Improvement, London.

operational pressures; calling of a Critical incident and the need to provide additional capacity through escalation of a further ward area at Wrightington.
2.7 Temporary staffing is still required to augment the shortfall of staffing at the point of roster creation and in response to short notice absence. Work to review NHSP rates has been undertaken in collaboration with senior nurse leaders, and targeted work continues to review the booking of staff for enhanced observations within inpatient areas (Appendix 1, chart 3).

2.8 There has been an improvement in the KPI creation of rosters 6weeks in advance to 94% in December in comparison to the end of Q2 in September when this was 50% (Appendix 1, chart 4).

2.9 To support our NHSP fill rates during the festive period, the retention of the workforce, and boost staff morale, an NHSP incentive scheme of an additional £5 per hour was offered across all staff groups. This was put into place from December 23rd and has been well received by our teams. This incentive is in line with other Trusts in GM and has ensured our staff and services are not disadvantaged.

2.10 For the month of October, 73% of ward leaders were supernumerary in practice and is unchanged from the Q2 report. However, during the month of December this performance reduced to 58% as the ward leaders were required to be clinically based to support staffing deficits and staff were released to support the escalated area of Ward 6 at Wrightington and to continue to maintain a substantive workforce on the escalated AAA (Appendix 1, chart 5).

2.11 Improvements in the workforce shortfalls across our theatres have been made on the acute site RAEI enabling the reduction of this workforce risk within the Surgical Division for scrub practitioners.

3. Quality and Safety

3.1 There have been no midwifery red flags raised within the reporting period.

3.2 The largest number of nursing red flags relate to a 25% reduction in the registered nursing time. 31 red flags were raised relating to having less than 2 registered staff on duty, this is an increase by 11 from Q2, however this risk was mitigated by the temporary deployment of staff from other areas. These 2 metrics are inter-related as the movement of staff to another area depletes roster staffing numbers. No areas had less than 2 registered nurses on duty because of the actions taken (Appendix1, chart 7).

3.3 Nurse sensitive indicators (NSI's) are used to determine the potential impact of staffing on the quality of nursing care delivered. Indicator metrics are provided in Appendix 1, chart 6.

3.4 There have been 23 CDTs reported within the quarter, an increase of 4 from the previous quarter, 7 of which have been subject to divisional review. These CDTs are all awaiting executive review at the time of writing the report and therefore lapses in care have not been verified.

3.5 There were 7 falls reported resulting in moderate or above harm to patients, 2 of which have been escalated to StEIS. One occurred in October 2022 on Pemberton Ward, resulting in a Head Injury. The second occurred on JHRU where a patient sustained a fractured NOF. Both incidents were also reported to RIDDOR.

3.6 In Quarter 3 The total number of Category 3,4 and unstageable PUs (moderate and severe harm) reported by staff and verified as HAPUs in Q3 was 3, a 40% decrease from 5 in Q2.
The total number of Category 3,4 and unstageable PUs (moderate and severe harm) reported by staff and verified as CAPU in Q3 was 17, an 11% decrease from 19 in Q2. There was 1 CAPU case reviewed at the Q3 Moderate and Severe Harm Pressure Ulcer Review Panel in November 2022 that met StEIS reportable criteria. There were 2 HAPU cases presented by Winstanley ward and Shevington ward, reviewed at the Q3 Moderate and Severe Harm Pressure Ulcer Review Panel in December 2022, both met StEIS reportable criteria and therefore are subject to further investigation. There was a further HAPU case (Occurred in the Community Assessment Unit, CAU) which met StEIS reportable criteria which occurred in Q2 (September 2022), however, was only heard in the moderate and severe harm review panel in Q3 (December 2022) and was reported to StEIS in Q3.

4. Benchmarking

4.1 CHPPD data demonstrates a median value of 9.4 hours in comparison to Q2 which was 9.7 however this metric cannot be reviewed in isolation. Registered nurses and midwives provide a median value of 4.8 hours of care. Unregistered hours of care provided is 4.6 hours. This variation in hours of time can be triangulated with the Trust approved skill mix of registered to unregistered staff (55:45), and with the measures instigated to mitigate the risk of harm for patient from falls, and for oversight and care to wander some patients who lack capacity. The high utilisation of unregistered staff is also reflected in Trust temporary spend.

4.2 There is currently no available data on the Model Hospital System to support comparison of acuity and dependency score, however the Trust is aware of the high levels of patients with no right to reside occupying acute beds, and these patients, increasingly, have greater levels of dependency and can be cared for by unregistered staff.

5. Staffing Risks

5.1 The Community Division has 3 staffing risks on the risk register for Q3. These range from scores of 6-12 and include 'Reduced staffing in the Continence Service (8) and Vacancies within Dietetics Paediatrics / Diabetes adults and paediatrics (9). The overriding staffing risk for the whole District Nursing Services has been closed and a new risk assessment completed for one specific team (SWAN/Wigan North and Central DN) where ongoing pressures remain. Specific actions and mitigations have been put in place to manage that teams' risk around vacancies and short-term sickness which is increasing individual visits for staff members. The sustained clinical pressures are impacting upon team morale and individual stress levels. The SWAN team and caseload have moved out into Ashton clinic to reduce pressure on the Wigan teams. These current mitigations have reduced the risk score currently to 8.

5.2 Vacancies within the Maternity service have also impacted on service delivery, and the CoC model remains suspended until these vacancies are filled.

5.3 Theatre staffing has improved markedly, with the risk score reduced to 10, with the likelihood of further reduction. Plans from a collaboration between Surgery and Specialist Services Divisions have evolved, with a recruitment event in March occurring and longer-term plans for the potential of a grow your own strategy being sourced. There have been no cancellations of procedures due to a lack of availability of theatre nursing/ODP staff.

5.4 The Medicine Division currently have 2 risks on their divisional risk register 3455. There is a risk that the Division are not able to recruit to all registered nurse vacancies due to a national shortage of nurses and poor retention leading to potential patient safety issues, loss of stakeholder confidence and potential breach of CQC conditions or registration (12) and 3453- There is a risk that a high percentage of our staff could retire imminently due to 18% of our staff within the division being over 55 leading to an impact on retention, skill mix linked to loss of expertise (12). Mitigations include the completion of a workforce plan to reflect the service delivery priorities and business cases development taking into consideration the opportunities afforded by alternative workforce models.

5.5 The Trust remains unable to release all ward leader time due to ongoing staffing and escalation pressures requiring ward leaders to be supervisory to practice for their substantive hours.

5.6 High vacancy and turnover rates within some services have the potential to negatively impact on our ambitions to achieve the people strategy objectives, especially with regards to staff well-being and retention.

5.7 Despite the challenges identified in Q2 regarding the international recruitment process, there was great success during Q3 following a further recruitment drive in November, leaving only a shortfall of 2 of the 180 targets.

6. Q3 Plan for Workforce

6.1 Review of the B2 pipeline and planning for a further B2 recruitment event for the Trust targeted at new to care staff.

6.2 A paper will be submitted a paper to NMALT on 2nd February to explore the opportunities of further HEE monies available for continue international recruitment. The paper will take into consideration current and predicted vacancies, including the domestic pipeline and the 'grow our own' strategy. This will allow us to make an informed decision as to how WWL should proceed with B5 recruitment.

6.3 Focus on increasing representation at B5 and above for FAME staff.

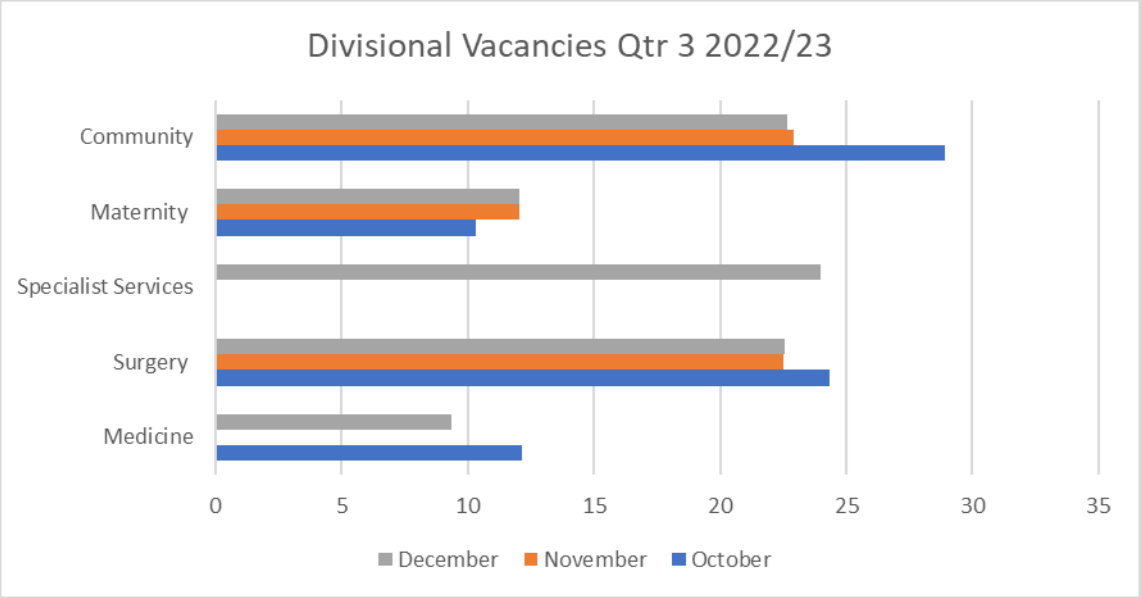
6.4 Surgery and Specialist Services continue to work in collaboration with the aim to develop a rotational programme for theatres staff at B5 level to support multi-site working as part of a recruitment and retention strategy.

6.5 Financial benefits of the roster efficiency and NHSP rates review to be finalised.

7. Conclusion

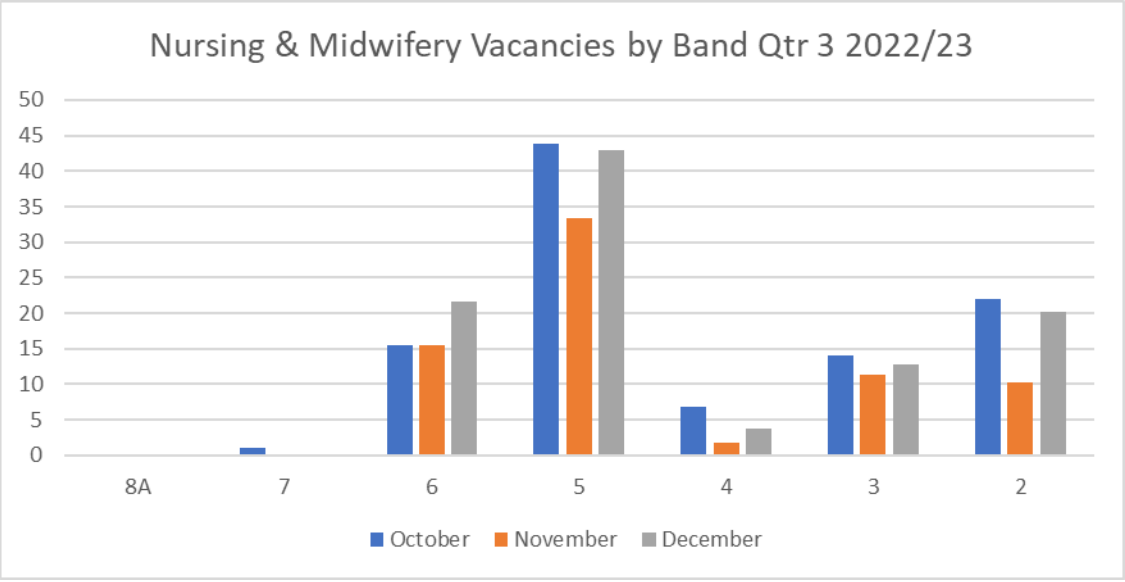
7.1 Trust Board are requested to receive this report noting the assurance provided relating to the maintenance of safe staffing and the ongoing mitigating actions with regards to workforce.

Appendix 1



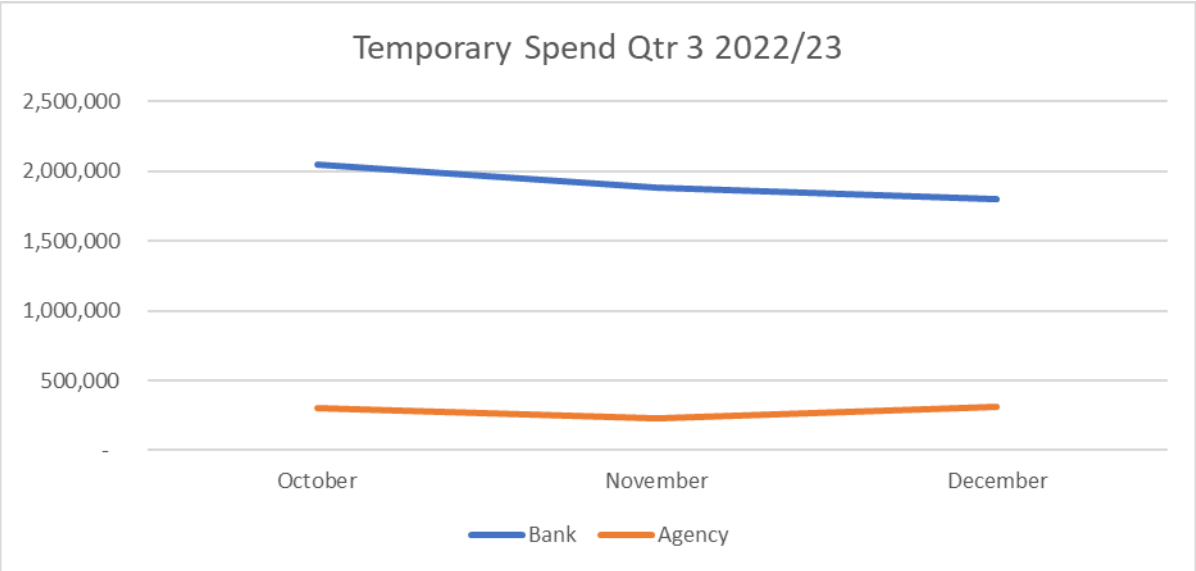
Divsional Vacancies	October	November	December
Medicine	12.13	0	9.37
Surgery	24.32	22.52	22.55
Specialist Services	0	0	24
Maternity	10.33	12.05	12.04
Community	28.9	22.92	22.67

Chart 1 Trust vacancies by Division Q3



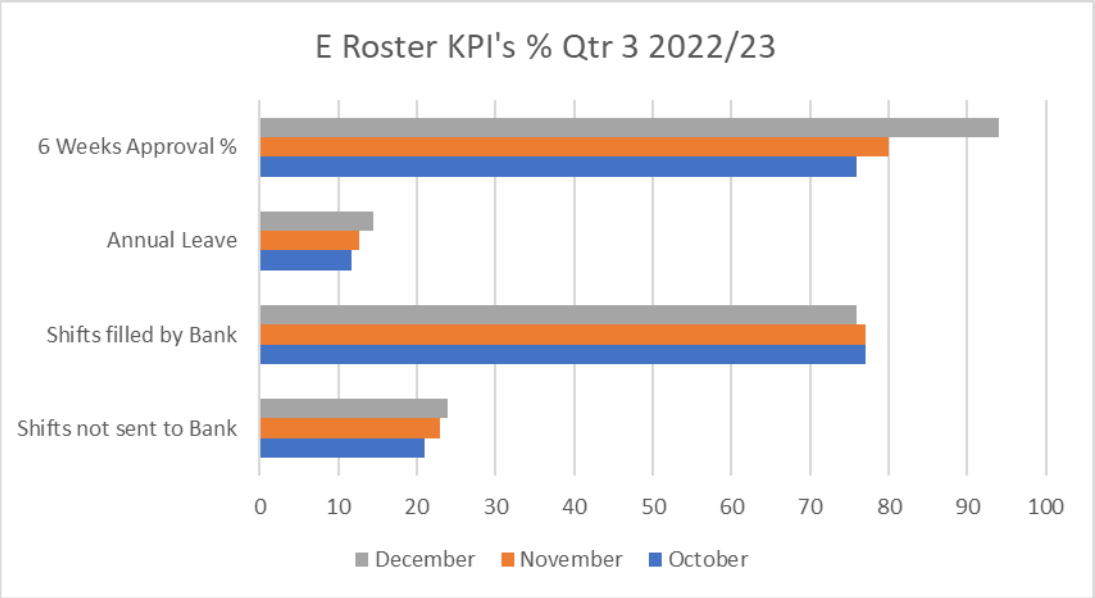
	October	November	December
8A	0	0	0
7	1	0	0
6	15.45	15.45	21.57
5	43.82	33.4	42.95
4	6.76	1.8	3.8
3	14	11.37	12.82
2	21.9	10.27	20.1

Chart 2 Trust N&M vacancies by Banding Q3



	October	November	December
Bank	2,051,213	1,884,933	1,801,889
Agency	302,366	233,458	308,191

Chart 3 Temporary Spend Q3

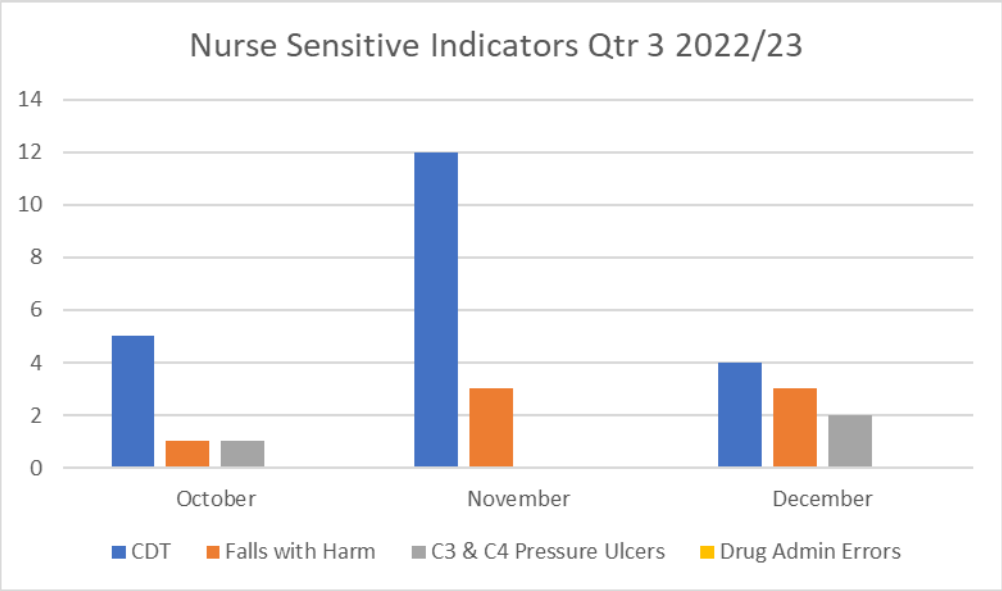


Roster KPI's %	October	November	December
Shifts not sent to Bank	21	23	24
Shifts filled by Bank	77	77	76
Annual Leave	11.7	12.7	14.5
6 Weeks Approval %	76	80	94

Chart 4 E Roster KPI's Q3

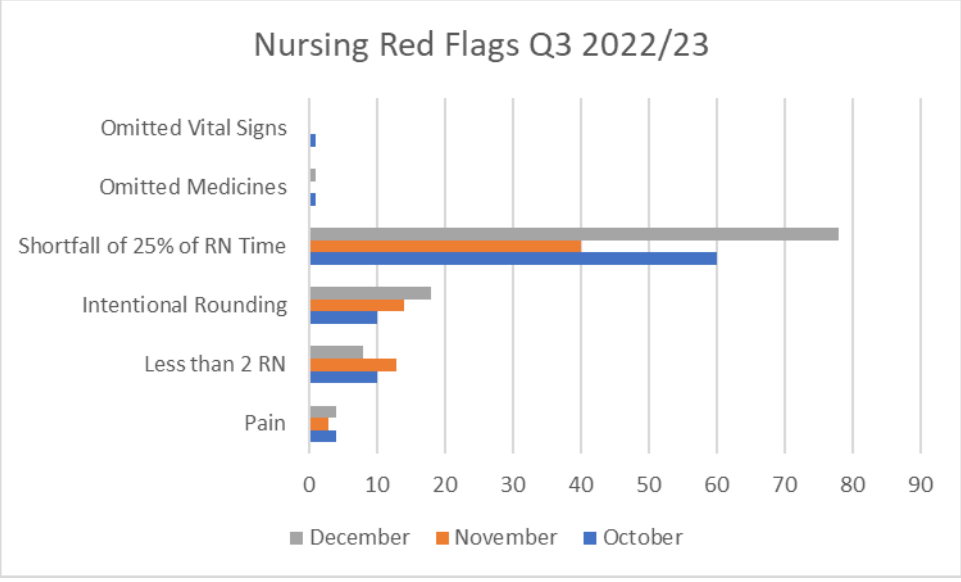
Division	Clinical Area	Supernumerary Status October 2022 (%)	Supernumerary Status December 2022 (%)
Specialist Services	B Ward /IDA	53	40
	JCW (PP)	72	77
	D and OAU	73	25
	Ward 1	49	-
	A Ward	16	85
	Aspull	81	58
Medicine			
	Astley	96	82
	Bryn	100	56
	Lowton	93	78
	Winstanley	70	79
	ASU	-	34
	Shevington	69	55
	Pemberton	79	59
	Standish	73	82
	Ince	98	65
	CCU	100	79
	MAU	81	61
Surgery	Rainbow	86	67
	Orrell	72	20
	Swinley	100	23
	Langtree	89	39
Community	CAU	75	77
	JHRU	55	95

Chart 5 Ward Leader Supernumerary Status Q3



	October	November	December
CDT	5	12	4
Falls with Harm	1	3	3
C3 & C4 Pressure Ulcers	1	0	2
Drug Admin Errors	0	0	0

Chart 6 Nurse Sensitive Indicators



	October	November	December
Pain	4	3	4
Less than 2 RN	10	13	8
Intentional Rounding	10	14	18
Shortfall of 25% of RN Time	60	40	78
Omitted Medicines	1	0	1
Omitted Vital Signs	1	0	0

Chart 7 Nursing Red Flags

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Seven Day Hospital Services Audit 2022/2023
Presented to:	Board of Directors
On:	5th April 2023
Presented by:	Dr S Arya, Medical Director
Prepared by:	Alison Unsworth Clinical Audit and Effectiveness Manager
Contact details:	Alison.Unsworth@wwl.nhs.uk

Executive summary

This audit compares WWL to the Seven Day Hospital Services (7DS) Clinical Standards set by NHS Services, Seven Days A Week forum. The audit was completed for a full seven-day period in September 2022 (Sat 3rd to Fri 9th September 2022). It indicates a relatively high level of achievement of the standards. 134 patient records were analysed. The next audit is due to be repeated in June 2023.

Standard	Percentage Achieved
Clinical standard 2 states that all emergency admissions should be seen as soon as possible by a consultant and within 14 hours of admission. For high volume specialties such as acute medicine consultant presence on site into the evening is likely to be needed every day.	**92% patients seen within 14 hours of admission to the ward**
Clinical standard 5 states that emergency and urgent access to appropriate consultant-led diagnostic tests (and reported results) should be available every day. Relevant diagnostic tests include CT, MRI and ultrasound imaging, endoscopy and echocardiography.	**100% available**
Clinical standard 6 states that emergency and urgent access to appropriate consultant-led interventions should be available every day. This covers many interventions, and typically should include emergency theatre, intensive care, interventional radiology, interventional endoscopy, PCI for acute myocardial infarction, emergency cardiac pacing, and thrombolysis and thrombectomy for stroke.	**100% available**
Clinical standard 8 states that patients admitted in an emergency should be reviewed by a consultant once daily (twice daily in high-dependency and critical care) unless the consultant has delegated this review to another competent member of the multidisciplinary team on the basis that this would not affect the patient's care pathway.	**Day 2: 98%** **Day 3: 93%** **Day 4: 84%** **Day 5: 88%** **Day 6: 92%** **Day 7: 96%** **(average 93%)**

The WWL Way

It is evident from the Audit that patients routinely get a review by a Consultant within the first 24 hours of their stay, wherever that might be.

Beyond the first day, the audit looks at whether there is a Senior Review and shows this is normally provided, with 98% reviewed on Day 2 / 93% reviewed on Day 3 / 84% reviewed on Day 4 / 88% Day 5 / 92% Day 6 / 96% Day 7. These are high levels of daily review.

Further standards (Standards 5 and 6) are about the availability of Consultant led investigation (such as CT / MRI with results) and Consultant Led Services (such as emergency theatre, PCI, ICU etc). These services were found to be fully available and meet the standards with 100% compliance.

Despite the current pressures suffered by WWL the audit provides a high level of assurance that patients are seen within 24 hours by a Consultant and are typically seen daily thereafter. Most patients will be reviewed on a daily basis over the weekend and there will be appropriate services available to them 7 days a week.

Risks associated with this report and proposed mitigations

None known

Financial implications

None known

Legal implications

None known

People implications

None known

Wider implications

The Audit provides a high level of assurance about Consultant delivered care within WWL and the 7 day standards set.

Recommendation(s)

The Board of Directors are asked to review the report and note the contents. The report provides evidence that 92% of patients achieve Clinical Standard 2 (Review by a consultant within 14 hours of admission), the average daily review is 93% for Clinical Standard 8 (Daily review by Consultant or Delegate). Clinical standards 5 and 6 (availability of certain investigations/interventions) both achieve 100%.

Seven Day Hospital Services
Main Report

Background

The Seven Day Hospital Services (7DS) Clinical Standards were developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

Ten 7DS clinical standards were originally developed by the NHS Services, Seven Days a Week Forum in 2013. Providers have been working to achieve all these standards, with a focus on four priority standards identified in 2015 with the support of the Academy of Medical Royal Colleges.

The four priority standards were selected to ensure that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and ongoing review (Clinical Standard 8) every day of the week.

Further information is available here: https://www.england.nhs.uk/wp-content/uploads/2022/02/B1231-board-assurance-framework-for-seven-day-hospital-services-08-feb-2022.pdf.

The purpose of this report is to provide evidence of compliance to the four priority standards.

Clinical standard 2 states that all emergency admissions should be seen as soon as possible by a consultant and within 14 hours of admission. For high volume specialties such as acute medicine consultant presence on site into the evening is likely to be needed every day.

Clinical standard 5 states that emergency and urgent access to appropriate consultant-led diagnostic tests (and reported results) should be available every day. Relevant diagnostic tests include CT, MRI, ultrasound imaging, endoscopy and echocardiography.

Clinical standard 6 states that emergency and urgent access to appropriate consultant-led interventions should be available every day. This covers many interventions, and typically should include emergency theatre, intensive care, interventional radiology, interventional endoscopy, PCI for acute myocardial infarction, emergency cardiac pacing, and thrombolysis and thrombectomy for stroke.

Clinical standard 8 states that patients admitted in an emergency should be reviewed by a consultant once daily (twice daily in high-dependency and critical care) unless the consultant has delegated this review to another competent member of the multidisciplinary team on the basis that this would not affect the patient's care pathway.

Methodology

The Board Assurance Framework suggest a snapshot or sampling approach should be used to identify the patients.

Patients were identified for **Standard 2 and 8** using Hospital Episode Statistics data for patients admitted via the Emergency Department for a seven-day period from: **Saturday 3rd September 22 until Friday 9th September 22.**

291 patients were identified, and 134 selected at random for further review.
Patients who stayed less than 14 hours were excluded from analysis.
HIS was used to analyse the patient details.

A proforma was created on AMaT (Audit Management and Tracking – the Trusts electronic management system) and data was collected and analysed by members of the clinical audit and effectiveness team.

Information for **standards 5 and 6** was provided by the subject experts

Findings

Clinical Standard 2

Clinical standard 2 states that all emergency admissions should be seen as soon as possible by a consultant and within 14 hours of admission. For high volume specialties such as acute medicine consultant presence on site into the evening is likely to be needed every day.

Summary of Standard 2:

- 123/134 patients **(92%)** seen within 14 hours of admission to the ward
- 11/134 patients **(8%)** seen by a consultant over 14 hours after admission to the ward

Breakdown of Standard 2 data:

Chart 2.1a shows the number of patients who were seen within 14 hours of admission to the ward per speciality:

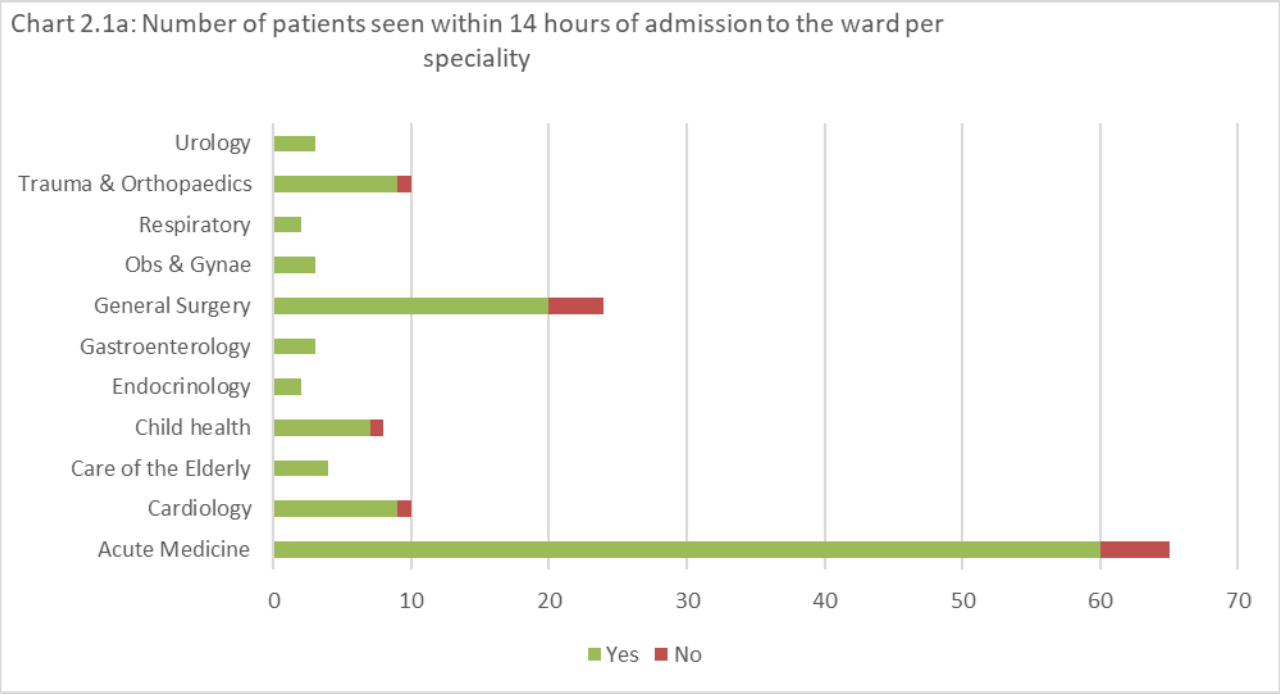


Chart S2.1b shows percentage and breakdown of individual figures per speciality:

Chart S2.1b	Seen within 14 Hours	Seen within 14 Hours: Number Patients	Not Seen within 14 Hours	Not seen within 14 Hours: Number of Patients	Grand Total
Acute Medicine	92.31%	60	7.69%	5	65
Cardiology	90.00%	9	10.00%	1	10
Care of the Elderly	100.00%	4	0.00%		4
Child health	87.50%	7	12.50%	1	8
Endocrinology	100.00%	2	0.00%		2
Gastroenterology	100.00%	3	0.00%		3
General Surgery	87.50%	21	12.50%	3	24
Obs & Gynae	100.00%	3	0.00%		3
Respiratory	100.00%	2	0.00%		2
Trauma & Orthopaedics	90.00%	9	10.00%	1	10
Urology	100.00%	3	0.00%	0	3

Clinical Standard 8:

Clinical standard 8 states that patients admitted in an emergency should be reviewed by a consultant once daily (twice daily in high-dependency and critical care) unless the consultant has delegated this review to another competent member of the multidisciplinary team on the basis that this would not affect the patient's care pathway.

This has been determined by analysing the notes of each of the 134 patients and determining if they had been reviewed by a consultant or a delegate on each day of their admission, up to 7 days after admission.

Chart S8a shows the number of patients admitted on day 1 (first day of admission) and the number of admissions per subsequent day. By day 7, 53 (40%) out of the 134 patients were still admitted.

S8a	Number of Patients still admitted	
	Number of in patients	% of patients still admitted
Day 1	134	100%
Day 2	131	98%
Day 3	116	87%
Day 4	89	66%
Day 5	84	63%
Day 6	68	51%
Day 7	53	40%

Summary of Standard 8

Chart S8b shows the cumulative number of patients and percentage that were seen by a consultant or delegate and the day of admission.

For example, 23 patients had their second day stay on a Monday and all 23 patients received a review. 17 patients had their 4th day stay on Saturday and 59% (10/17) had a review. Where the compliance is less than 100%, the denominator is also included in the figures.

S8b		MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Day 2	% achieved	100%	100%	100%	100%	100%	92%	92%
	Number of patients	23	13	18	23	19	11/12	24/26
Day 3	% achieved	100%	100%	100%	100%	100%	59%	78%
	Number of patients	22	17	11	16	21	10/17	7/9
Day 4	% achieved	100%	100%	100%	100%	100%	59%	50%
	Number of patients	8	19	14	10	12	10/17	8/16
Day 5	% achieved	100%	100%	100%	100%	100%	67%	73%
	Number of patients	18	7	15	10	8	10/14	11/15
Day 6	% achieved	100%	100%	100%	100%	100%	100%	50%
	Number of patients	14	11	6	12	8	3	5/10
Day 7	% achieved	100%	92%	100%	100%	100%	100%	75%
	Number of patients	8	12/13	10	3	8	3	3/4
Total	**% Achieved**	**100% 93/93**	**99% 79/80**	**100% 74/74**	**100% 74/74**	**100% 55/55**	**71% 47/66**	**82% 58/71**

Chart S83 shows the percentage of patients reviewed by day by day of admission:

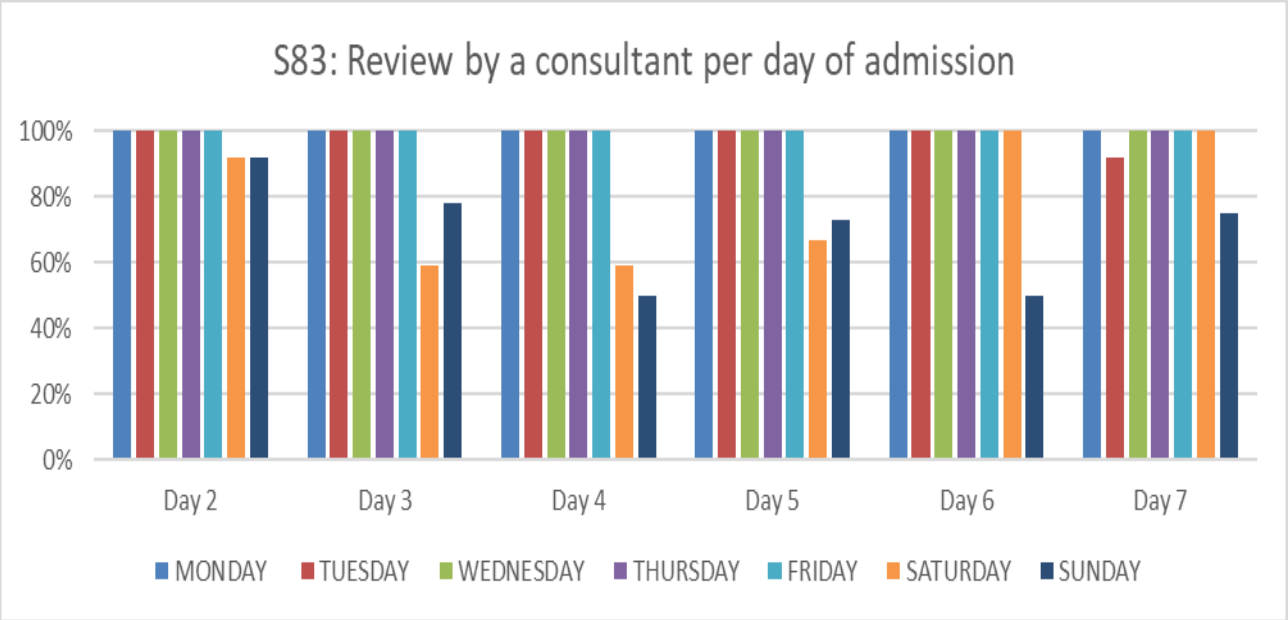
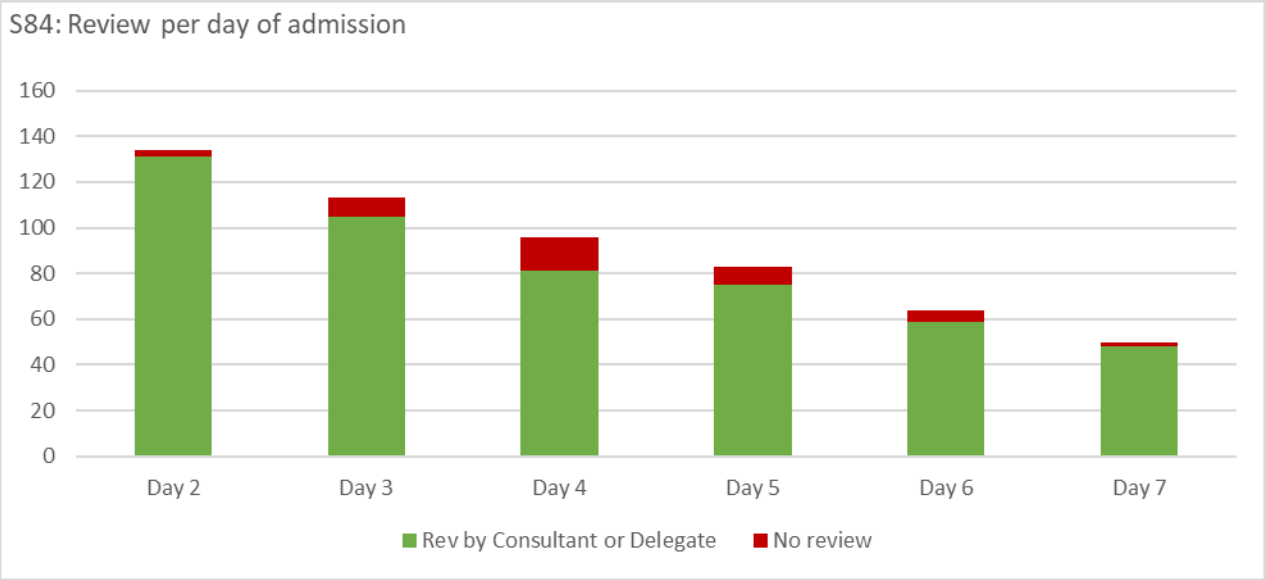


Chart S84 shows the number of reviews that did and did not take place per day of admission. For example, on day 2 of admission, 131/134 patients were reviewed by a consultant or delegate and 3 were not. On day 7, 50/134 patients were still in hospital and 48 were reviewed, 2 were not.



Clinical Standard 5

Clinical standard 5 states that emergency and urgent access to appropriate consultant-led diagnostic tests (and reported results) should be available every day. Relevant diagnostic tests include CT, MRI and ultrasound imaging, endoscopy and echocardiography.

Information has been sought from the relevant departments regarding availability of the tests.
Chart S5.1 shows the diagnostic tests and availability. All are available:

S5.1 Emergency Diagnostic Test	Available on Site at weekends	Available via network at weekends	Not available
USS	Yes		
CT	Yes		
MRI	Yes		
Endoscopy	Yes		
Echocardiography	Yes		
Microbiology	No	Yes	

Additional narrative:
USS: Available 9am – 8pm with consultant discussion. Typically converted to CT scanning or deferred until the next working day
Echocardiogram: Available by the on-call consultants
MRI: Limited to spinal cord compression/cauda equina syndrome
Microbiology: On call service by microbiology consultants, done remotely

Clinical Standard 6

Clinical standard 6 states that emergency and urgent access to appropriate consultant-led interventions should be available every day. This covers many interventions, and typically should include emergency theatre, intensive care, interventional radiology, interventional endoscopy, PCI for acute myocardial infarction, emergency cardiac pacing, and thrombolysis and thrombectomy for stroke.

Information has been sought from the relevant departments regarding availability of the interventions. Chart S6.2 shows the intervention availability. All are available:

S6.2 Emergency Intervention	Available on Site at weekends	Available via network at weekends	Not available
Intensive Care	Yes		
Interventional radiology		Yes	
Interventional endoscopy	Yes	Yes	
Surgery	Yes		

Additional narrative:
Interventional endoscopy for gastrointestinal bleeding/foreign body removal/oesophageal stenting/polypectomy is available on site. Other interventions, such as ERCP are available via network at weekends.

Interventional radiology: Available via network at weekends, case by case referral with usually consultant to consultant discussion

Conclusion

Standard	Percentage Achieved
Clinical standard 2 states that all emergency admissions should be seen as soon as possible by a consultant and within 14 hours of admission. For high volume specialties such as acute medicine consultant presence on site into the evening is likely to be needed every day.	**92% patients seen within 14 hours of admission to the ward**
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Clinical standard 8 states that patients admitted in an emergency should be reviewed by a consultant once daily (twice daily in high-dependency and critical care) unless the consultant has delegated this review to another competent member of the multidisciplinary team on the basis that this would not affect the patient's care pathway.	**Day 2: 98%** **Day 3: 93%** **Day 4: 84%** **Day 5: 88%** **Day 6: 92%** **Day 7: 96%** **(average 93%)**

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	2022/23 Annual Sustainability Report
Presented to:	Board of Directors
On:	05 April 2023
Item purpose:	Information
Presented by:	Director of Strategy and Planning
Prepared by:	Environmental and Sustainability Manager
Contact details:	Josh.balmer@wwl.nhs.uk

Executive summary

Link to strategy and corporate objectives

Green Plan, Net Zero Strategy, 2030 Strategy

Risks associated with this report and proposed mitigations

None

Financial implications

None

Legal implications

None

People implications

None

Wider implications

None

Recommendation(s)

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

Report

Introduction

The 2022/23 financial year has been a transition phase for the Trust in relation to sustainability. The scope of the work required has increased exponentially and focus has moved from the built estate on to all of the Trust's operations. The past year has been spent forging new relationships inside and outside of the Trust, collating data and plotting our route to Net Zero. The Trust has acknowledged the impact it is having on the Climate Emergency and the scale of the task it faces in reaching Net Zero and has started to resource the following areas in order to better understand and mitigate its impact.

Governance, Monitoring and Policy

The Trust has appointed Richard Mundon, Director of Strategy and Planning as the Net Zero board level lead. Richard also chairs the Greener WWL Steering Group, whose main function is to oversee and facilitate the Trusts sustainability objectives and to report progress through the below governance structure.

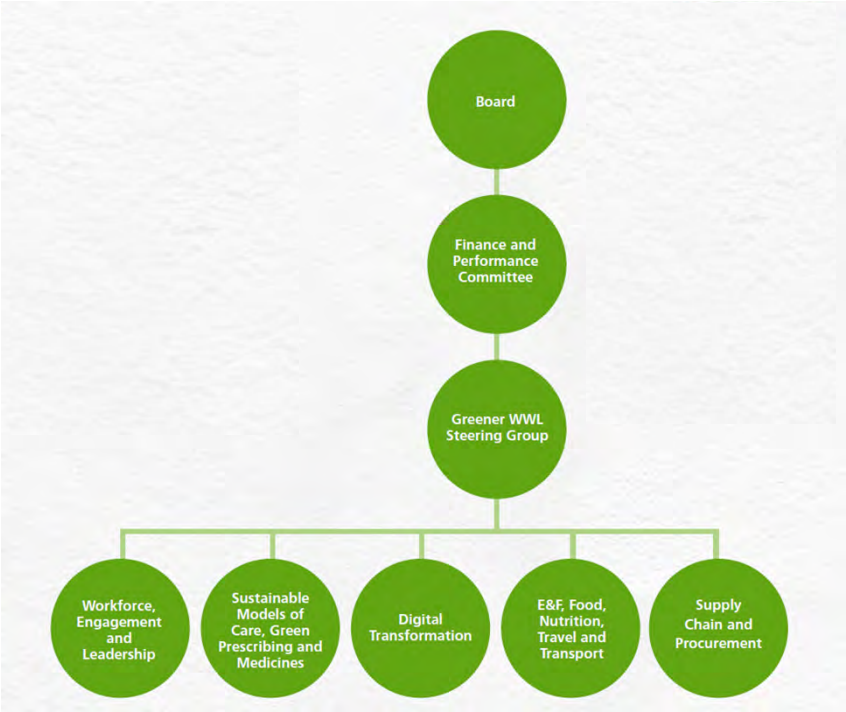

Figure 1 - WWL sustainability governance structure

There are now 5 different sub-groups dealing with different areas of Trust operations. Each of these sub-groups have working groups dealing with departmental and service specific issues. Work is ongoing to start setting stricter targets for these groups in line with Net Zero, Standard Contract and Long Term Plan targets.

The Sustainability team has expanded slightly to 2 members of staff, with Paula Gardner accepting a position as Environmental and Sustainability Officer. This has allowed for a renewed focus on communications and better data gathering ability.

Josh Balmer continues to co-ordinate the Trust response to sustainability, environment, energy and Net Zero. Josh also sits on local and regional sustainability leaders' groups and co-chairs the Wigan

Climate Coalition, a collaborative of the public, private and charity sectors aiming to tackle the climate crisis in the Wigan Borough.

Green Plan

The Trust has a board approved Green Plan that outlines our targets for 2022-2025. The Green Plan is currently under review and will be revised in early 2023/24 with new targets and updates on progress.

Net Zero

The Trust has been working closely with Ricardo AEA, a specialist energy, environmental and engineering consultancy to produce its Net Zero strategy. We now have draft copies of our Trust level and site level Net Zero strategies, and these will be presented to executives for sign off in early 2023/24. The next step is to identify funding for our Heat Decarbonisation Plan and begin to develop a robust bid for Public Sector Decarbonisation Funding, which will allow us to make improvements to the built estate in line with the findings outlined in the Net Zero Strategy.

2022/23 Carbon Footprint

The Sustainability Team have taken the unfortunate decision not to report on Trust level carbon emissions within this year's sustainability report. The following factors have led to this.

Utility suppliers

Our utility suppliers provide consumption figures for gas, electricity, and water generally on a monthly basis. In the 22/23 financial year the only consistent invoice we have received is for gas. Invoices for water and electricity have either not been issued or have been issued in error and credited since Q1 2022. This means there are large gaps in the data sets they provide and as such we would have to rely on our own metering systems to confirm consumption. This presents additional problems as the sub-metering suite does not cover all areas of site so data would again be patchy.

Our utility suppliers have indicated failure to issue invoices is tied to delays in Government tariff setting and the knock-on effects of the war in Ukraine. Attempts to remedy this through our brokers have not been successful.

Meter failures

The Trusts electricity sub-metering system is approximately 12 years old and has failed. Data will no longer pass through the Trust firewall. There have been numerous attempts by Estates, IT, the sub-metering contractor, and our back-office software supplier to address this, but these have been unsuccessful. We therefore require a full suite upgrade and a new metering strategy in order to produce an accurate report beyond site level consumption.

The Trusts water sub-metering system did not work at install and costs were recovered from the contractor that installed it. This was due to the supplier (WaterPlus) being unwilling to work with the sub-metering contractor. A decision has been made to delay the install of new water sub-meters and to tie their performance into the main supply contract rather than bring in another 3rd party to install.

Attempts have been made to calculate our carbon footprint based on extrapolating existing data, however we felt this had an unacceptable error margin and wasn't reflective of the true position and the progress we have made in year. We are now starting to receive invoices through in small

batches but need to confirm they are correct. Once we have received the invoices covering 22/23 financial year, we will build the updated footprint into the revised Green Plan in early 2023/24.

Funding

The Trust has calculated its Scope 3 (procurement and 3rd party related) emissions using a 3rd party in for the past 2 financial years. We were early adopters of this approach and were one of the only Trusts in the world to calculate our footprint to this level. A lack of funding in year has meant that this work could not be repeated and as such, a large portion (approximately 90%) of our emissions could not be calculated. Discussions are underway regarding a budget being identified for the Sustainability team, which would allow work such as this to continue.

Procurement

A 10% weighting for Net Zero and Social value is now applied to all tenders. Carbon Reduction Plans are now required for all new contracts over £5m.

Estates and Facilities

2022/23 has not been a year of reductions in term of our energy and water consumption. The Trust is still feeling the impact of COVID-19. Increased hand washing, increased PPE, and changed to ventilation requirements have resulted in increased electricity, gas and water consumption and waste production. This will inevitably result in increases to our carbon footprint, making our transition to Net Zero all the more important.

In better news April 2022 saw the commissioning of the final Combined Heat and Power Unit after lengthy planning and operational delays. The unit consists of a gas fired engine that is used to generate electricity for consumption on site. The heat generated by the engine is captured and used to heat water for the site. The unit has generated approximately 2,900,000kWh of electricity and delivers annual savings of approximately 1500 tCO_2e per annum.

2022 also so the commissioning of the Enlighted LED system across approximately 55% of RAEI and small areas of Leigh and Wrightington. The system uses sensors to monitor light levels and occupation levels in order to adjust the amount of light delivered. This allows the system to take advantage of natural light and non-occupation in order to reduce power consumption. In 22/23 the fixtures delivered 409,100kWh reduction in electricity consumption and a 272 tCO_2e carbon saving. The final drafts of the Net Zero strategy have outlined an approximate cost of £120,000,000 to achieve Net Zero across the owned estate. This eye-watering amount reflects the challenge we face in achieving our mandatory targets and the need to adopt alternative funding models, secure grant funding such as PSDS and work collaboratively with our local partners to maximise available opportunities.

The Estates team have engaged with Wigan Council on their Galleries masterplan, with a view to securing a supply from their planned heat network for Thomas Linacre Centre and Eventually RAEI. This will provide us with a N+1 source of low carbon heating, which would tackle the biggest issue facing our built estate in regard to decarbonisation – gas consumption. It is hoped that the heat network will be sized appropriately to allow expansion across all of our central Wigan sites.

Travel

The Trust carried out its annual travel survey on site at Leigh, Wrightington and RAEI and surveys went out to all staff via the intranet. The results are below.

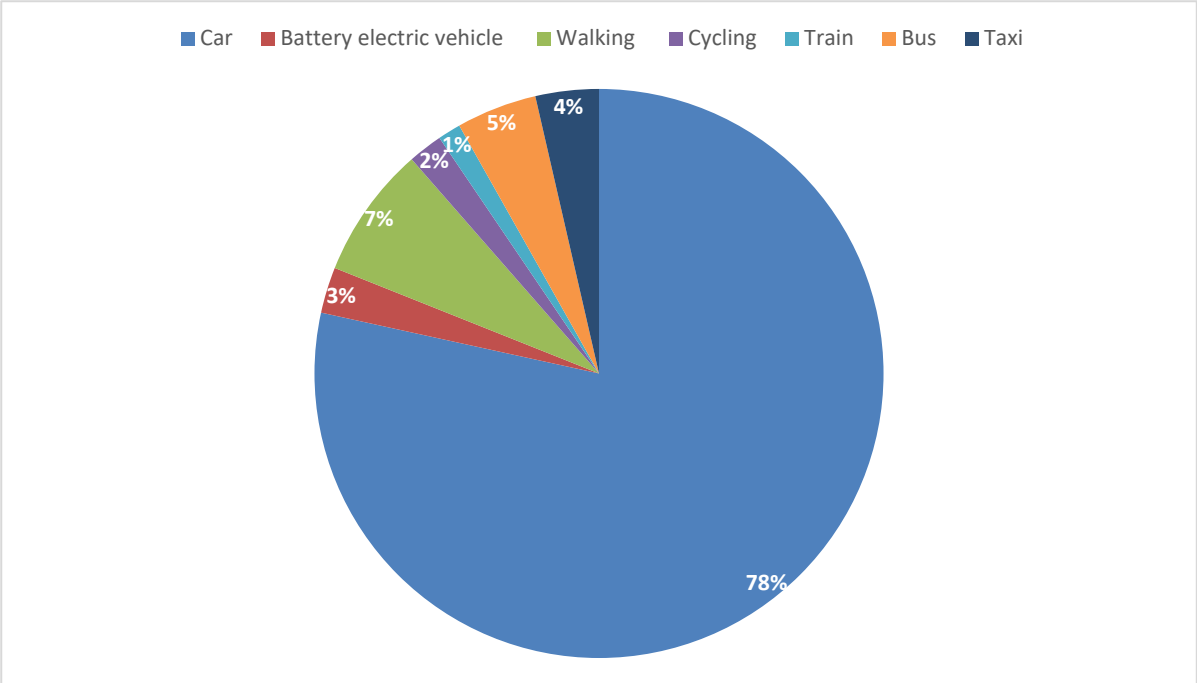

Figure 2 - Annual Travel Survey Results

Car is still the primary method of transport into site by a significant margin. Surveys indicated that this is down to reliability of public transport and lack of infrastructure to support more sustainable forms of travel. The sustainability team were successful in securing significant funding from Transport for Greater Manchester and in addition to considerable support from Capital, the Trust was able to install state of the art cycle hubs and lockers at RAEI, Leigh, Wrightington, TLC and Buckingham Row. The Trust now has capacity for over 100 cyclists across its sites but is lacking in shower facilities across all sites apart from RAEI. This will be a barrier to encouraging increased uptake in sustainable modes of travel.

Over 50% of all leased cars are now EV and the Estates team are continuing to review options to increase/replace the current aging infrastructure. The lack of charging facilities on site does not appear to be a barrier to increasing uptake and we do not plan to dramatically increase the number of chargers.

Food and Nutrition

The catering team is currently reviewing options for a switch away from disposable plastic cutlery. This would require dishwashers on wards or at a central point. Currently, dishwashers on wards are not feasible due to electrical capacity. It is likely the Trust will switch over to compostable cutlery in the short term with a medium term plan being a centralised dish wash facility.

The catering team have also run successful vegan/vegetarian menus to coincide will NHS Sustainability day and have introduced Digital Meal Ordering systems with a view to reducing food waste.

Models of Care and Medicines

The anaesthetics team have led the charge in terms of sustainability. They have reviewed Nitrous Oxide use and identified a 97% wastage on piped nitrous. This has led to the planned decommissioning of Nitrous manifolds and a switch to bottled supply.

Funding has been secured for a purchase of CoolSticks which will enable a switch away from Ethyl Chloride spray and an environmentally damaging product with a high Global Warming Potential used to text regional blocks. CoolSticks are a mechanical product used to test the effectiveness of epidural/spinal blocks.

The team have also reviewed their Desflurane use which is one of the gases with the highest Global Warming Potential. The Trust is one of the best performers in the region and will phase out use of Desflurane by March 2023 in line with national targets.

The RAEI Theatres team are also completing a review of theatre sets with a view to reducing the number of items in sets. The aim is to reduce the number of items being processed through SSDU, which will free up space and allow a switch away from disposable items towards reusables.

Appendices

[Set out any supporting data as appendices, **maximum 20 pages**. Each appendix should be clearly numbered, i.e. Appendix 1, Appendix 2 etc. Do not embed documents into the report as they do not work with the meeting software and cannot be read]

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Statement of responsibilities within the foundation trust
Presented to:	Board of Directors
On:	5 April 2023
Presented by:	Director of Corporate Affairs
Prepared by:	Director of Corporate Affairs,
Contact details:	E: paul.howard@wwl.nhs.uk

Executive summary

Best practice in corporate governance suggests that a written statement of responsibilities should be in place. A statement was previously approved by the board in 2020, and an updated version is now attached for routine review by the board. No significant changes have been made, although the document has been updated in line with the newly published Code of Governance for NHS Provider Trusts.

Link to strategy

There is no direct link to the foundation trust's strategy.

Risks associated with this report and proposed mitigations

There are no risks associated with the content of this report.

Financial implications

There are no financial implications arising from this report.

Legal implications

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

People implications

There are no people implications arising from this report.

The WWL Way

Wider implications

There are no wider implications arising from this report.

Recommendation(s)

The Board of Directors is recommended to approve the statement as presented.

Statement of responsibilities within the foundation trust

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

One of the principles within the *Code of Governance for NHS Provider Trusts 2023* ("the NHS Code") is that responsibilities should be clearly divided between the leadership of the board and the executive leadership of the trust's operations. The NHS Code notes that, as part of this, no individual should have unfettered powers of decision.

The *UK Corporate Governance Code 2018* ("the UK Code") published by the Financial Reporting Council sets out wider corporate governance best practice. The UK Code recommends that the responsibilities of the Senior Independent Director, Board and Committees should also be set out in writing, agreed by the Board of Directors and made publicly available. In light of this best practice and in an effort to further improve transparency, these additional responsibilities have also been set out in this statement.

Responsibilities of the Board of Directors and its Committees

The Board of Directors is responsible for setting the overall strategic direction of the foundation trust. The business of the foundation trust is managed by the Board of Directors and all the powers of the foundation trust are exercisable by the Board of Directors on its behalf. The matters that the Board has reserved to itself and those which have been delegated to individual directors or committees are clearly documented within a Scheme of Delegation. The Board operates in accordance with Standing Orders and the organisation operates in accordance with financial rules agreed by the Board in Standing Financial Instructions.

The Board has established a number of committees in order to have oversight and to seek assurance in specified areas. Each of these committees has clear terms of reference which set out the scope of the committee's responsibilities and any delegated powers given to it by the Board. They report back to the Board after each meeting, providing assurance or escalating risks as appropriate.

Responsibilities of the Council of Governors

The Council of Governors is comprised of governors who have either been elected from amongst the various constituencies within the foundation trust's membership or appointed by one of our partner organisations. The Council of Governors has two general duties:

1. To hold the non-executive directors to account, individually and collectively, for the performance of the Board of Directors; and

2. To represent the interests of the foundation trust's members as a whole and the interests of the public.

Additionally, the Council of Governors also has a number of specific responsibilities as set out below:

- To appoint and, where necessary, remove the Chair and the other non-executive directors;
- To approve the appointment of a Chief Executive by the non-executive directors;
- To decide the remuneration and allowances, and the other terms and conditions of office, of the non-executive directors;
- To appoint or remove the external auditor;
- To appoint or remove any other external auditor appointed to review and publish a report on any other aspect of the foundation trust's affairs;
- To be presented with the annual accounts, any report of the external auditor and the annual report;
- To approve significant transactions as defined within the constitution;
- To approve an application by the foundation trust to enter into a merger, acquisition, separation or dissolution;
- To decide whether the foundation trust's non-NHS work would significantly interfere with the fulfilment of its principal purpose (which is the provision of goods and services for the purposes of the health service in England) or the performance of its other functions;
- To approve amendments to the constitution;
- To provide their views to the Board of Directors when the Board is preparing the foundation trust's forward plan;
- To prepare, and from time-to-time review, the membership strategy and the policy for the composition of the Council of Governors, and
- Where appropriate, to act collectively and through individual governors to communicate with members about developments in the foundation trust and the work of the Council of Governors.

Responsibilities of the Chair and Chief Executive

The respective responsibilities of the Chair and Chief Executive are set out in the table below:

Chair	Chief Executive
Reports to the Board of Directors.	Reports to the Chair and to the Board of Directors.
Other than the Chief Executive, no executive reports to the Chair.	All members of the management structure report, either directly or indirectly, to the Chief Executive.
Ensures effective operation of the Board of Directors and Council of Governors.	Runs the foundation trust's operation and day-to-day business.
Ensures that the Board of Directors as a whole play a full part in the development and determination of the foundation trust's strategy and overall objectives.	Responsible for proposing and developing the foundation trust's strategy and overall objectives.

Chair	Chief Executive
The guardian of the Board of Directors' decision-making processes.	Implements the decisions of the Board of Directors and its committees.
Leads the Board of Directors and the Council of Governors.	Ensures the provision of information and support to the Board of Directors and Council of Governors.
Ensures the Board of Directors and Council of Governors work together effectively.	Facilitates and supports effective joint working between the Board of Directors and Council of Governors.
Oversees the operation of the Board of Directors and sets its agenda.	Provides input to the board of director's agenda on behalf of the executive team.
Ensures the agendas of the Board of Directors and Council of Governors take full account of the important issues facing the foundation trust.	Ensures the Chair is aware of the important issues facing the foundation trust and proposes agenda items accordingly.
Ensures the Board of Directors and Council of Governors receive accurate, timely and clear information.	Ensures the provision of reports to the Board of Directors which contain accurate, timely and clear information.
Ensures compliance with the Board of Directors' approved procedures.	Ensures the compliance of the executive team with the Board of Directors' approved procedures.
Arranges informal meetings of the directors to ensure that sufficient time and consideration is given to complex, contentious or sensitive issues.	Ensures that the Chair is alerted to forthcoming complex, contentious or sensitive issues affecting the foundation trust.
Proposes a schedule of matters reserved to the Board of Directors; proposes terms of reference for each Board of Directors committee and proposes other board policies and procedures.	Provides input as appropriate on changes to the schedule of matters reserved to the Board of Directors and committee terms of reference.
Facilitates the effective contribution and the provisions of effective challenge by all members of the Board of Directors.	Supports the Chair in facilitating effective contributions by executive directors including effective challenge.
Facilitates constructive relationships between executive and non-executive members of the Board of Directors.	Supports the Chair in sustaining constructive relations between executive and non-executive members of the board.

Responsibilities of the Senior Independent Director

The Senior Independent Director is appointed by the Board of Directors, in consultation with the Council of Governors. The role of the Senior Independent Director is to:

- act as a sounding board for the Chair and to serve as an intermediary for the other directors when necessary;
- lead the performance evaluation of the Chair, within a framework agreed by the Council of Governors, taking into account the views of directors and governors;
- lead meetings of the non-executive directors without the Chair present at least annually to appraise the Chair's performance and on such other occasions as are deemed appropriate;
- report the outcomes of the Chair's appraisal to the Council of Governors;
- be available to governors if they have concerns that contact through the normal channels of Chair, Chief Executive, Chief Finance Officer or Company Secretary has failed to resolve or where such contact is inappropriate; and
- attend sufficient meetings with governors to listen to their views in order to help develop a balanced understanding of their views, issues and concerns.

This statement was approved by the Board of Directors at its meeting on 29 March 2023.

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Mark Jones
Chair
For and on behalf of the Board of Directors

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	Committee terms of reference
Presented to:	Board of Directors
On:	5 April 2023
Presented by:	Consent agenda
Prepared by:	Director of Corporate Affairs and Deputy Company Secretary
Contact details:	E: paul.howard@wwl.nhs.uk

Executive summary

In accordance with best practice, each board committee is invited to consider its terms of reference each year and to recommend any changes to the Board of Directors for approval.

Most committees approved only minor changes to their terms of reference, as highlighted through the 'track changes' facility in Microsoft Word and marked in red within the series of documents which are attached to this report.

The Quality and Safety Committee is yet to meet to discuss changes in respect of its terms of reference, these will therefore be brought to the next board meeting for approval.

The Audit Committee required several slightly more significant changes and the rationales for these are set out in the table below for ease of reference:

Paragraph	Rationale for change to Audit Committee terms of reference
1.1 and 10.1	The original requirement to consult with the Council of Governors around the committee's terms of reference was set out in provision C.3.2 of the NHS Foundation Trust Code of Governance. The Code of Governance for NHS Provider Trusts supersedes this guidance with effect from 1 April 2023 and contains no such requirement. The proposal to remove the requirement to consult with the Council of Governors therefore accords with the most recent best practice guidance issued by NHS England.

Paragraph	Rationale for change to Audit Committee terms of reference
3.1	The proposal to reduce the number of independent non-executive directors on the committee to three is in line with both the current and new Codes, which both state that the minimum number should be three. The new Code also allows for a minimum of two in smaller trusts. As the Chair is not permitted to be a member of the committee, there are seven remaining non-executive directors. Selecting four from this cohort is a significant proportion of the remaining NEDs and is likely to lead to committee chairs being members of the committee, which is not ideal given its oversight role.
3.3	The proposal to reduce the quorum to two is a result of the proposal at para. 3.1
6.2	This paragraph has been reworded to clarify that the committee shall meet with both the internal auditors and the external auditors at least once a year without any management representatives being present. The original wording omitted the internal auditors and only excluded executive directors.
7.3	The word 'provider' has been inserted to clarify the reference to the foundation trust's provider licence.
7.6	Clarification has been provided that it is for the board to approve any proposed changes to the Scheme of Reservation and Delegation.
8.4	A number of minor amendments have been made to ensure that this paragraph accords with paragraph D.2.4 of the new Code of Governance for NHS Provider Trusts.
8.5	Confirmation has been included that the committee shall receive the minutes of the other board committees, with the exception of the Remuneration Committee.

Link to strategy

There is no direct link 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 to bring to the board's attention.

Legal implications

There are no legal implications.

People implications

There are no people implications to highlight.

Wider implications

There are no wider implications to highlight.

Recommendation(s)

The Board is recommended to approve the proposed amendments to its committees' terms of reference.

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

AUDIT COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

1.1. The Audit Committee ("the Committee") is constituted as a standing committee of the Foundation Trust's Board of Directors ("the Board"). Its constitution and terms of reference shall be as set out below, subject to ~~consultation with the Council of Governors and~~ amendment at a future Board meeting.

1.2. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

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

2. MAIN PURPOSE

2.1. The Committee has primary responsibility for monitoring the integrity of the financial statements, assisting the Board in its oversight of risk management and the effectiveness of internal control, oversight of compliance with corporate governance standards and matters relating to the external and internal functions.

2.2. The Committee shall provide the Board with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Foundation Trust's activities both generally and in support of the annual governance statement.

2.3. The Board is responsible for ensuring effective financial decision-making, management and internal control including:

(a) Management of the Foundation Trust's activities in accordance with statute and regulations; and

(b) The establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought.

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

3. MEMBERSHIP

3.1. The Committee shall be composed of ~~four (4)~~ three (3) independent Non-Executive Directors and the Committee shall ensure that it has sufficient skills to discharge its responsibilities. At least one (1) member should have recent and relevant financial experience.

3.2. The Chair of the Foundation Trust shall not chair nor be a member of the Committee.

3.3. A quorum shall be formed on the attendance of ~~three (3)~~ two (2) Non-Executive Directors.

4. SECRETARY

4.1. The Company Secretary or his/her nominated deputy shall be secretary to the Committee.

5. ATTENDANCE

5.1. Only members of the Committee have the right to attend meetings of the Committee but the Chief Finance Officer, the Medical Director, the Counter-Fraud Specialist and the Director of Corporate Affairs, and the Trust's appointed internal and external auditors shall generally be invited to attend routine meetings of the Committee.

5.2. Other executive directors and staff shall be invited by the Committee Chair, to attend those meetings in which the Committee will consider areas of risk or operation that are their responsibility.

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

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

6. FREQUENCY OF MEETINGS

6.1. Meetings shall be held at least four (4) times per year, with additional meetings being convened as necessary.

6.2. ~~The external auditor shall be afforded the opportunity at least once per year to meet with the Committee without executive directors present.~~ At least once a year, the Committee shall meet with the internal and external auditors without management present.

7. DUTIES

7.1. With respect to the financial statements and the annual report:

(a) Monitor the integrity of the financial statements of the Foundation Trust, any other formal announcements relating to the Foundation Trust's financial performance and reviewing the significant financial reporting judgments contained in them;

(b) Review the annual statutory accounts before they are presented to the Board, in order determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

(i) the meaning and significance of the figures, notes and significant changes;

(ii) areas where judgment has been exercised;

(iii) adherence to accounting policies and practices;

(iv) explanation of estimates or provisions having material effect;

(v) the schedule of losses and special payments;

(vi) any unadjusted statements; and

(vii) any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

(c) Review the annual report and annual governance statement before they are submitted to the Board to determine completeness, objectivity, integrity and accuracy;

(d) Review each year the accounting policies of the Foundation Trust and make appropriate recommendations to the Board; and

(e) Review all accounting and reporting systems for reporting to the Board, including in respect of budgetary control.

7.2. With respect to internal control and risk management:

(a) Review the Foundation Trust's internal financial controls to ensure the provision and maintenance of an effective system of risk identification and associated controls, reporting and governance;

(b) Review and maintain an oversight of the Foundation Trust's general internal controls and risk management systems, liaising with the Risk Management Group where necessary;

(c) Review processes to ensure appropriate information flows to the Committee from executive management and other committees in relation to the Foundation Trust's overall internal control and risk management position;

(d) Review the Trust's risk management strategy prior to its presentation to Board for approval;

(e) Review the adequacy of the policies and procedures in respect of all counter-fraud work;

(f) Review the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks; and

(g) Review the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements.

7.3. With regard to corporate governance:

(a) Monitor corporate governance compliance (e.g. compliance with the terms of the provider licence, constitution, codes of conduct, Standing Orders, Standing Financial Instructions and maintenance of registers of interests).

7.4. With regard to internal audit:

(a) Monitor and review the effectiveness of the Foundation Trust's internal audit function, taking into consideration relevant UK professional and regulatory requirements;

(b) Review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation;

(c) Oversee on an ongoing basis the effective operation of internal audit in respect of:

(i) adequate resourcing;

(ii) its coordination with external audit;

(iii) meeting relevant internal audit standards;

(iv) providing adequate independence assurances; and

(v) it having appropriate standing within the Foundation Trust.

(d) Consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations; and

(e) Consider the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal of internal audit staff; and

7.5. With regard to external audit:

(a) Review and monitor the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements;

(b) The Council of Governors should take the lead in agreeing with the Committee the criteria for appointing, reappointing and removing external auditors. To support them in this task, the Committee should:

(i) provide information on the external auditor's performance, including details such as the quality and value of the work, the timeliness of reporting and fees;

(ii) make recommendations to the Council of Governors in respect of the appointment, reappointment and removal of an external auditor and related fees as applicable. To the extent that a recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

(c) Discuss with the external auditor, before the audit commences, the nature and scope of the audit;

(d) Assess the external auditor's work and fees each year and, based on this assessment, make the recommendation to the Council of Governors with respect to the reappointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards;

(e) Oversee the conduct of a market testing for the appointment of an auditor at least once every five (5) years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the auditor;

(f) Review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations; and

(g) Develop and implement a policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance.

7.6. With regard to Standing Financial Instructions:

(a) Review on behalf of the Board the operation of, and proposed changes to, the Standing Financial Instructions;

(b) Examine the circumstances of any significant departure from the requirements of Standing Financial Instructions; and

(c) Review the Scheme of Reservation and Delegation and recommend any changes to the Board for approval.

7.7. With regard to other matters:

(a) Review performance indicators relevant to the remit of the Committee;

(b) Examine any other matter referred to the Committee by the Board and initiate investigation as determined by the Committee;

(c) Develop and use an effective assurance framework to guide the Committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as to fulfil its functions in connection with these terms of reference;

(d) Review the work of all other foundation trust committees in connection with the Committee's assurance function; and

(e) Consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health sector and professional bodies with responsibilities that relate to staff performance and functions.

8. MINUTES AND REPORTING

8.1. Formal minutes shall be taken of all Committee meetings.

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

8.3. The Committee will report to the Board after each meeting. The report shall include details of any matters in respect of which actions or improvements are needed.

8.4. The foundation trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities. The report shall include:

(a) the significant issues relating to the financial statements that the Committee considered ~~in relation to financial statements, operations and compliance~~ and how these were addressed;

(b) an explanation of how the Committee has assessed the independence and effectiveness of the external audit process and the approach taken to the appointment or reappointment of the external auditor, ~~the value of external audit services and~~ information on the length of tenure of the current audit firm, ~~and~~ when a tender was last conducted and advance notice of any retendering plans; and

(c) if the external auditor provides non-audit services, ~~the value of the non-audit services provided and~~ an explanation of how auditor objectivity and independence are safeguarded.

8.5. The Committee shall routinely receive the minutes of the following committees:

(a) Finance and Performance Committee;

(b) People Committee;

(c) Quality and Safety Committee; and

(d) Research Committee

8.6. The following sub-groups shall also report to the Audit Committee:

(a) Caldicott Group

(b) Risk Management Group

(c) Senior Information Risk Officer Meeting

9. PERFORMANCE EVALUATION

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

10. REVIEW

10.1. These terms of reference of the Committee shall, ~~in consultation with the Council of Governors~~, be reviewed by the Board at least annually.

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST
RESEARCH COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

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

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

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

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

2. MAIN PURPOSE

2.1. The Committee will give strategic direction and enable the Board to obtain assurance around the development and delivery of the Research Strategic Plan. This will include receiving assurances that the research department has a plan in place and is delivering against this to meet the membership criteria for the University Hospital Association, a prerequisite of becoming a University Hospital Trust.

2.2. Its key duties are as follows:

(a) To develop, review and update the strategic direction and business plan for research and innovation through:

(i) Approving the Research Strategic plan

(II) Receiving assurances around the implementation of the Research Strategic Plan

(b) Promoting and establishing highly effective collaborative relationships with universities, other organisations (including NHS), research and innovation networks and other key stakeholders.

(c) ~~Receiving updates on and reviewing changes in research-related legislation and national research and / or innovation policy and guidance~~. Receiving assurance that any changes in research-related legislation and national research and/or innovation policy and guidance have been appropriately embedded.

(d) Supporting research and innovation being embedded at every level of the organisation through establishing the conditions for increasing participation in clinical trials.

(e) Overseeing establishment of the conditions for, and promoting, a patient-focused and ambitious culture for research and innovation.

(f) To oversee and direct the activities which support the development of a research into action culture, bringing research and clinical application closer.

(g) To promote and see innovation and clinical research working seamlessly together.

(h) To assure high robust management and governance of research and innovation.

(i) To monitor research and development finances, including grant income.

(j) To assure the Board that where there is a research risk that may jeopardise the Trust's ability to deliver its strategic objectives or which have significant reputational, patient or cost impact, that these are being managed in a controlled and timely manner to mitigate the risks.

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

3. MEMBERSHIP

3.1. The membership of the Committee shall consist of:

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

(b) Director of Strategy and Planning;

(c) Medical Director;

(d) Chief Nurse

(e) Director of Communications and Stakeholder Engagement

3.2. The Committee will be deemed quorate on the attendance of two Non-Executive Directors and two Executive Directors.

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

4. SECRETARY

4.1. The Director of Corporate Assurance or his/her nominee shall be secretary to the Committee.

5. ATTENDANCE

5.1. The following participants are required to attend meetings of the Committee:

(a) Clinical Director for Research and Development

(b) Head of Research and Development

(c) Divisional Research Champion (on 1 in 4 rotational basis)

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

6. FREQUENCY OF MEETINGS

6.1. Four meetings per year will be scheduled.

7. MINUTES AND REPORTING

7.1. Formal minutes shall be taken of all Committee meetings.

7.2. Once approved by the Committee, the minutes will be presented to the Board for information.

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

7.4. The following group shall report to the Committee:

~~(a) Research and Development Committee~~

(a) Institutional Review Group;

(b) Research Action Group

8. PERFORMANCE EVALUATION

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

9. REVIEW

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

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

CHARITABLE TRUST COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

1.1. Wrightington, Wigan And Leigh Teaching Hospitals NHS Foundation Trust ("the Foundation Trust") is the sole trustee of the Wrightington, Wigan and Leigh Health Services Charity, registered charity number 1048659, ("the Charity").

1.2. The Charity has powers under section 11 of the Trustee Act 2000 to appoint and delegate to agents. This power includes appointing a committee, membership of which is not necessarily restricted to its directors.

1.3. The Charity also has powers of advancement, as set out under section 32 of the Trustee Act 1925, as amended by section 9 of the Inheritance and Trustees' Powers Act 2014.

1.4. The Committee is authorised by the Board to act within its terms of reference. Members of the Charitable Trust Committee act as agents of the Foundation Trust. All members of staff are directed to co-operate with any request made by the Committee.

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

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

2. MAIN PURPOSE

2.1. The Committee will enable the Board to obtain assurance around the appropriate administration of charitable funds.

2.2. Its key duties are as follows:

(a) Set the purpose and strategy of the Charity, including any relevant associated policies;

(b) Determine the Charity's investment strategy, where such a strategy is required, in line with the Trust's strategic direction and priorities;

(c) Approve the set up of any new sub funds;

(d) Set budgets; spending priorities and criteria for individual spending decisions, in respect of each fund;

Commented [NG1]: WWL do not currently have an investment strategy, since we do not currently invest our charitable funds. However, should the funds balances increase to a material amount that would warrant investment, then such a strategy would be required.

(e) Agree business case expenditure from each fund, as per the Foundation Trust's Standing Financial Instructions, in line with the Committee's own strategy and overall affordability;

(f) Agree all material fund raising initiatives;

(g) Produce an annual report, in line with Charity Commission guidance, outlining all the Charity's key achievements and areas of specific patient/public interest

2.3. The Committee will provide its annual accounts to the Audit Committee.

3. MEMBERSHIP

3.1. The membership of the Committee shall consist of:

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

(b) Chief Finance Officer;

(c) Chief Nurse;

(d) Deputy Chief Executive;

(e) Director of Communications and Stakeholder Engagement; and

(f) Director of Strategy and Planning

3.2. The Committee will be deemed quorate on the attendance of two Non-Executive Directors and two Executive Directors.

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

4. SECRETARY

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

5. ATTENDANCE

5.1. The Associate Director of Financial Services and Payroll is required to attend meetings of the Committee.

5.2. A Governor representative will be appointed and entitled to attend meetings of the Committee.

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

5.4. Representatives of the Charity's Independent Reviewer shall be entitled to attend all meetings, if desired.

6. FREQUENCY OF MEETINGS

6.1. Four meetings per year will be scheduled.

6.2. If there is limited business to transact, the Chair will take the decision on whether the meeting should proceed, provided that there are a minimum of two meetings per year.

7. MINUTES AND REPORTING

7.1. Formal minutes shall be taken of all Committee meetings.

7.2. Once approved by the Committee, the minutes will be presented to the Board for information.

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

7.4. The following groups shall report to the Committee:

(a) Divisional charitable fund groups;

(b) Sub funds

8. PERFORMANCE EVALUATION

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

9. REVIEW

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

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

PEOPLE COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

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

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

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

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

2. MAIN PURPOSE

2.1. The main purpose of the Committee is to be responsible for:

(a) Approval and oversight of the implementation of the WWL People Strategy and Our Family, Our Future, Our Focus engagement programme;

(b) Approval of prioritised annual People objectives;

(c) Assuring the Board of compliance against key national and statutory workforce requirements, including the National People Plan and People Promise

(d) Developing strategic workforce recommendations for approval by the Board

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

3. SCOPE OF RESPONSIBILITIES

(a) To monitor the implementation and relevance of the WWL People Strategy and WWL People Promise;

(b) To ensure that WWL has thorough and robust implementation plans to deliver against the WWL People Promise Pledges;

- Employment Essentials

- Steps for Wellness
- Your Voice Matters
- Learn and Grow

(c) To provide assurance of improvements and compliance against key statutory and NHS specific workforce equality, diversity and inclusion requirements;

(d) To ensure that a culture of psychological safety, civility and learning is embedded throughout the Trust

(e) To provide assurance to the Board of Directors on workforce issues; taking account of local and national agendas;

(f) To monitor and provide assurance to the Board of the specific workforce risks identified within the Board Assurance Framework or Corporate Risk Register and people related corporate objectives;

(g) To monitor delivery progress of the People Strategy and mandated standards;

(h) To ensure strategic alignment of the WWL People agenda with the NHS Long Term Plan, National People Plan, People Promise, HR / OD Futures report and NHSE/I mandated standards;

(i) To grow the recruitment brand and retention strategies;

(j) Talent management and the expansion of management and leadership opportunities;

(k) Innovation and the development of new clinical and non-clinical roles to meet the needs of our patients and innovation in service delivery models

4. MEMBERSHIP

4.1. The membership of the Committee shall consist of:

(a) Non-Executive Director Chair;

(b) A minimum of 2 Non-Executive Directors;

(c) Chief People Officer

(d) Chief Nurse;

(e) Medical Director;

4.2. A representative of the Council of Governors shall be entitled to attend to observe the meeting.

4.3. The Committee will be deemed quorate to the extent that two Non-Executive Directors and two Executive Directors, one being the Director of Workforce or their nominated

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

5. SECRETARY

5.1. The Company Secretary or their nominated deputy shall be secretary to the Committee.

6. ATTENDANCE

6.1. The following participants are expected to attend meetings of the Committee;

(a) Deputy Director of HR;

(b) Deputy Director of Staff Engagement & Organisational Development;

(c) Staff Side Chair

6.2. In addition, a representative from the divisional leadership team and subject matter experts relevant to agenda items may be invited by the Chair to attend for their agenda item(s) only.

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

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

6.5. Any member or non-member, including the secretary to the Committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

7. FREQUENCY OF MEETINGS

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

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

8. MINUTES AND REPORTING

8.1. Formal minutes shall be taken of all Committee meetings.

8.2. Once approved by the Committee, the minutes should be circulated to the Board for information.

8.3. The following sub-groups shall report to the People Committee:

(a) Local Negotiating Group;

(b) Educational Governance Group;

(c) Partnership Group;

(d) Workforce Divisional Quality Executive Group

(e) Equality Diversity and Inclusion Strategy Group (People)

9. PERFORMANCE EVALUATION

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

10. REVIEW

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

WRIGHTINGTON, WIGAN AND LEIGH TEACHING HOSPITALS NHS FOUNDATION TRUST

FINANCE AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

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

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

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

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

2. MAIN PURPOSE

2.1. The Committee will enable the Board to obtain assurance around the financial and performance elements of the foundation trust's business.

2.2. Its key duties are as follows:

Finance

(a) Reviewing and endorsing the foundation trust's annual financial plan prior to presentation to the Board for approval;

(b) Monitoring the foundation trust's in-year performance against the agreed financial plan at divisional and organisational level;

(c) Reviewing and monitoring the strategic five-year capital programme~~; and the~~ annual capital budgets and the long term financial plan and recommend these to the Board for approval;

(d) Reviewing the cash position of the foundation trust and the related treasury management policies;

(e) To consider and recommend the borrowing strategy for consideration by the Board, where such a strategy is required;

(f) To identify and review external financing arrangements or vehicles, e.g. borrowing, joint ventures or PFI;

(g) Monitoring delivery of the Cost Improvement Programme;

(h) Monitoring the detailed monthly income and expenditure position of the foundation trust, and reviewing the robustness of the risk assessments underpinning financial forecasts; and

(i) Assessment of the working capital position of the foundation trust, including reviewing the 12-month rolling cash flow forecast and investment portfolio of the foundation trust.

(j) Receiving updates on estates and facilities key performance indicators and other matters relevant to the Trust's performance

(k) Receiving updates on procurement key performance indicators and other matters relevant to the Trust's performance;

Performance

(l) To review the performance quadrant of the overall balanced scorecard performance report and to seek assurances around deliverability of key performance standards;

(m) To receive performance data disaggregated by ethnicity and deprivation where relevant and seek assurances that data is used to reduce health care inequalities;

~~(m)~~(n) To consider the adequacy of forecasting models used in relation to operational performance;

~~(n)~~(o) To consider investment or divestment in services;

~~(o)~~(p) To monitor delivery against the IT investment plan;

~~(p)~~(q) To review and monitor progress of the digital strategy;

~~(q)~~(r) To monitor delivery against the green plan;

~~(r)~~(s) To monitor the foundation trust's operational performance against planned trajectories and seek assurances around any necessary corrective planning and action; and

~~(s)~~(t) To seek assurance that the underpinning systems and processes for data collection and management are robust and provide relevant, timely and accurate information to support the operational management of the organisation.

Risk

~~(t)~~(u) Consideration of all relevant risks within the Board Assurance Framework as they relate to the remit of the Committee and escalate any issues to Board as required.

Business cases

~~(u)~~(v) On the recommendation of the Trust Management Committee, the Committee shall consider:

(i) For approval, any business case over £500,000, up to a value of £999,999;

(ii) For recommendation to the Board of Directors, any business case of £1m or more.

(iii) Gain assurance on the effectiveness of such investments through post investment appraisals

The Committee should consider business cases in line with the Trust's strategic direction, priorities and affordability.

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

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

3. MEMBERSHIP

3.1. The membership of the Committee shall consist of:

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

(b) Chief Finance Officer;

(c) Chief Operating Officer; and

(d) Director of Strategy and Planning.

3.2. A representative of the Council of Governors shall be entitled to attend to observe the meeting.

3.3. The Committee will be deemed quorate on the attendance of two Non-Executive Directors and one Executive Director.

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

4. SECRETARY

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

5. ATTENDANCE

5.1. Representative from the divisional leadership team and subject matter experts will be invited to attend meetings on an agenda driven basis by the Committee Chair and should be present only for the duration of the items in respect of which they have been invited.

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

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

6. FREQUENCY OF MEETINGS

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

6.2. Additional meetings may be held on an exceptional basis at the request of the chairperson or any three members of the Committee.

7. MINUTES AND REPORTING

7.1. Formal minutes shall be taken of all Committee meetings.

7.2. Once approved by the Committee, the minutes will be presented to the Board for information.

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

7.4. The following groups shall report to the Committee:

(a) Digital Strategy Oversight Group;

(b) Global Training Education Steering Group;

(c) Greener WWL Steering Group

8. PERFORMANCE EVALUATION

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

9. REVIEW

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

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

Title of report:	IPC Board Assurance Framework update. Version 1.11
Presented to:	Board of Directors
On:	5 April 2023
Presented by:	Rabina Tindale, Chief Nurse, DIPC
Prepared by:	Julie O'Malley, Deputy Director IPC Cheryl Osborne, Lead Nurse IPC
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Executive summary

In line with guidance the IPC BAF is updated on a regular basis and required for presentation at Trust Board.

This report provides an update by exception of the NHSE IPC BAF version 1.11, with any noted changes in compliance measures/ evidence, any gaps in assurance and any mitigating actions in place at 22.3.2023. See Appendix 1 for the IPC BAF update as completed at 22.3.2023.

Gaps in Assurance and Mitigating Actions

- **Lack of an Infection Control Doctor:** 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 vacancies, long term sickness, the emergence of seasonal respiratory viruses. Support has been requested to secure funding for investment in the IPC Service. Risk assessments and business case have been submitted for review.

The WWL Way

- **The IPC Audit Programme** continues to be modified in response to the COVID-19 virus and other seasonal respiratory viruses. The identification of other positive respiratory cases (Influenza and Respiratory syncytial virus (RSV) within the Trust continues to impact on bed capacity and the response required by the IPC Team to deliver a full IPC audit programme.
  CDT cases are currently 66 against a threshold of 53 for the year. This is a significant increase compared to this time last year. There is currently a backlog of Executive reviews for CDT cases for Q2, Q3 and Q4. A plan in place to reduce this backlog.
- **Within the Trust there is limited side room capacity** to consistently enable isolation as required for patients with confirmed or suspected infections, not limited to COVID-19. All identified COVID-19 positive and Flu in-patients are transferred to designated Flu/COVID-19 positive areas or isolation rooms. 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.
- **Limited capacity to segregate patients within Emergency Department (ED) without adaption of the environment.** Rapid PCR and Point of care (POC)/ LFD testing for COVID-19 is available within ED. In December 2022, new 4 virus, point of care testing equipment was installed in ED to support the placement of patients with seasonal respiratory viruses. Training for the 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.
- **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.
- **Mandatory IPC e-learning modules:** Trust compliance rates for February 2023 were 94% for Level 1 IPC (increased since December 88%), and 83% for Level 2 IPC (Decrease from December 2022 92%). Staff who are non-compliant, receive an email which is escalated to their managers to action the completion of the training. IPC are planning to reinstate face to face training in Q1, 2023.
- **Hand hygiene compliance** has increased across the organisation, Trust compliance was 82% for February 2023 compared to 70% in December 2022, and 79% in January 2023. There were several non-submissions in December which affected the overall compliance score.
- **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. This has impacted on IPC mitigation measures in terms of our ability to segregate respiratory and non-respiratory viruses. Whilst Covid positive cases continue to be identified, the rate of other seasonal respiratory viruses such as Influenza/ RSV have decreased since the peak in December 2022. 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.

- **Review of Face Mask wearing.** A proposed review of Face Mask wearing by ETM planned for March 2023, with a recommendation to rationalise to specific clinical areas only. To await the outcome decision.

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, new cleaning standards and isolation capacity.

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

People implications
Additional resource will be required in some areas e.g., to address the current challenges associated with COVID-19 and other 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: 22 March 2023:***

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
A respiratory plan incorporating respiratory seasonal viruses that includes: ▪ Point of care testing (POCT) methods for infectious patients known or suspected to have a respiratory infection to support patient triage/placement according to local needs, prevalence, and care services	POCT testing for COVID-19 is available in the emergency dept using the IDNOW machine. Patients displaying respiratory symptoms are tested to aid clinical diagnosis and patient management.	POCT testing for other seasonal respiratory viruses is not currently in place in the emergency dept. Training for the new POC testing equipment (Cepheid) has not commenced due to operational pressures within the ED, delaying the introduction of the new equipment.	Patients displaying symptoms of respiratory viruses are isolated where possible Testing protocols for Flu and other seasonal respiratory viruses is carried out via the existing laboratory protocols. The plan is to introduce 4 viruses testing once training has taken place.
▪ Segregation of patients depending on the infectious agent considering those most vulnerable to infection e.g., clinically immunocompromised.	Patients known to be clinically immunocompromised are prioritised for side room allocation. Dedicated COVID-19 areas continue to be operational. The Trust continues to experience an increased demand on bed capacity and isolation capacity.	Limited options for segregation within the current configuration within the ED. Lack of isolation rooms across the Trust.	Risk assessment in place. Review of side room occupancy performed by IPCT as required. Ownership of side room reviews by ward area encouraged.
▪ A surge/ escalation plan to manage increasing patient/ staff infections	Surge/escalation plans for increasing patient/staff		

	infections continue to be discussed as required.		
▪ A multidisciplinary team approach is adopted with hospital leadership, operational teams**,** estates and facilities, IPC teams and clinical and non-clinical staff to assess and plan for creation of adequate isolation rooms/cohort units as part of the plan	Safe patient care, placement and isolation capacity continue to be explored by the multi-disciplinary team, for all patients receiving care from point of entry into the ED department to placement within the Trust with a continued focus on segregation of any patient who requires isolation.	High volume of patients requiring admission. The inability to create cohort areas in periods of high prevalence or new emerging infections.	Patient placement/ isolation priority managed in collaboration with Operations Team, IPC Team, and Estates/ Facilities. Cohort areas are identified when required for patients positive with the same pathogen.
Organisational /employers risk assessments in the context of managing infectious agents are: ▪ Based on the measures as prioritised in the hierarchy of controls ▪ Applied in order and include elimination. substitution, engineering, administration and PPE/RPE ▪ Communicated to staff ▪ Further reassessed where there is a change or new risk identified e.g., changes to local prevalence	Wearing of face masks currently continues in all clinical/ patient facing areas. A proposed review of Mask wearing by ETM planned for 23 March 2023, with a recommendation to rationalise to specific clinical areas only.	None	N/A
▪ The completion of risk assessments has been approved through local governance procedures, for example Integrated Care Systems.	No changes to note at 22.03.2023.	None	N/A
▪ Risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with the infectious agents	No changes to note at 22.03.2023.	None	N/A
▪ Ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons.	No changes to note at 22.03.2023. Gaps and Mitigating measures continue.	Limited Isolation capacity. High volume of patients requiring admission. The inability to create cohort areas in periods of high prevalence or	Transfers of infectious patients between care areas are carried out based on clinical need and the requirement for Specialist care.

		new emerging infections	
▪ Resources are in place to monitor and measure adherence to the NIPCM. This must include all care areas and all staff (permanent, flexible, agency and external contractors)	Ward and Service area visits, Walk Abouts and ASPIRE accreditation visits completed by the Senior Leadership Team, including DIPC and DDIPC, Senior Nurses and Governance to provide challenge and learning opportunities to support staff, compliance, and patient safety. The visits extend to include multiple areas of care, leadership, management, learning, staff wellbeing and development. IPC Team provide supportive visits to clinical/ practice areas in both hospital and community settings. Audits of practice include all staff members, including external contractors and staff who may be working from an agency or Bank. Feedback is given to individuals as required.	Limited IPC team capacity to maintain a robust audit programme and visibility to clinical areas.	Increasing resources and capacity within the IPCT. IPC business case resubmitted, awaiting outcome. Additional funding agreed for an IPC Nurse secondment post, Band 6.
▪ The application of IPC practices within the NIPCM is monitored e.g., 10 elements of SICPs.	No changes to note at 22.03.2023. Gaps and Mitigating measures continue.	Limited IPC team capacity due to long term sickness, vacant posts, and role demands have limited the annual audit schedule staff visibility within clinical areas.	Increasing resources and capacity within the IPCT. IPC business case resubmitted, awaiting outcome. Additional funding has been agreed for an IPC Nurse secondment post, Band 6.

▪ The IPC Board Assurance Framework (BAF) is reviewed, and evidence of assessments are made available and discussed at Trust board level.	No changes to note at 22.03.2023.	None	N/A
▪ The Trust Board has oversight of incidents/outbreaks and associated action plans.	No changes to note at 22.03.2023.	None	N/A
▪ The Trust is not reliant on a single respirator mask type and ensures that a range of predominantly UK made FFP3 masks are available to users as required.	Mask fit Testing programme continues, with access available to staff to attend. There are currently 5 makes and model of mask used by the Trust. 1. Drager 1730+ 2. Kolmi (Small & Medium) 3. GVS31000. 4. 3M1863+ / 3M9330+ 5. Handanny The country of manufacture is indicated below. 1. UK Made 2. UK Made 3. UK Sourced 4. UK Sourced 5. UK Sourced	The make and model of mask used by individual staff is reliant on the mask fit test result, and whilst there are various FFP3 masks available not all are compatible for wearing by all staff. The Department of Health and Social Care (DHSC) PPE Portal continues to supply the Trust with FFP3 masks however, this is anticipated to cease in March 2024. All models of masks have been procured through the National NHS Buyers; however, the location of manufacture, whilst believed to be the UK in most cases, is to be	The Health and Safety Team are discussing any potential consequences of the DHSC PPE Portal withdrawal with Procurement and a plan is being drafted to ensure supplies of the masks staff are tested to remain available. Full Support, a former supplier of FFP3 masks to the Trust, with great mask fit test results pre-pandemic, also being approached to re-establish supply chain. Despite several requests, a response from the National NHS Buyers is outstanding regarding the specific manufacturing location of each mask.

		confirmed by the buyers.	
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: ▪ The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level	No changes to note at 22.03.2023.	None	N/A
▪ The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/room	No changes to note at 22.03.2023.	None	N/A
▪ Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment	No changes to note at 22.03.2023. Gaps and Mitigating measures continue.	Non-clinical areas are not currently monitored in all areas. Priority is given to clinical areas.	Where an area consistently fails an audit on 3 occasions an efficacy training mechanism is put in place. Compliance issues relating to Nurse cleaning and Estates issues are escalated to the appropriate teams. The second 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 pressures.
▪ Enhanced/increased frequency of cleaning should be incorporated into environmental decontamination protocols for patients with suspected/known infections as per the NIPCM (Section 2.3) or local policy and staff are appropriately trained	No changes to note at 22.03.2023.	None	N/A
▪ Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products	No changes to note at 22.03.2023.	None	N/A
▪ For patients with a suspected/known infectious agent the frequency of cleaning should be increased particularly in: ➢ Patient isolation rooms	No changes to note at 22.03.2023.	None	N/A

➢ Cohort areas ➢ Donning & doffing areas – if applicable ➢ 'Frequently touched' surfaces e.g., door/toilet handles, chair handles, patient call bells, over bed tables and bed/ trolley rails ➢ Where there may be higher environmental contamination rates, including: ➢ Toilets/commodes particularly if patients have diarrhoea and/or vomiting			
▪ The responsibility of staff groups for cleaning/decontamination are clearly defined and all staff are aware of these as outlined in the National Standards of Healthcare Cleanliness	No changes to note at 22.03.2023.	None	N/A
▪ **A terminal clean of inpatient rooms is carried out:** ➢ When the patient is no longer considered Infectious ➢ When vacated following discharge or transfer (This includes removal and disposal/or laundering of all curtains and bed screens) ➢ Following an AGP if clinical area/room is vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room)	No changes to note at 22.03.2023.	None	N/A
▪ **Reusable non-invasive care equipment is decontaminated:** ➢ Between each use ➢ After blood and/or body fluid contamination ➢ At regular predefined intervals as part of an equipment cleaning protocol ➢ Before inspection, servicing, or repair equipment	All patient equipment requires decontamination, by clinical staff following Trust processes and SOP.	There has been concerns due to inconsistency of standards of cleanliness. The variance in standards appear to be linked with lack of resources and Education.	The cleaning scores are displayed on the entrance of each clinical area. The scores are reported to the Ward Manager the Matron, Heads of Nursing and Deputy Chief Nurse posts. How to address the inconsistent standards will be discussed and actioned at the Trust Cleaning Standards Forum.
▪ Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	The Trust has designated auditors who monitor the standard of cleanliness of the clinical environment in line with the NSHC. IPCT also audit cleanliness as part of the scheduled audit process.	Limited IPC team capacity due to long term sickness, vacant posts, and role demands have limited the annual audit schedule staff visibility within clinical areas.	Increasing resources and capacity within the IPCT. IPC business case resubmitted, awaiting outcome. Additional funding agreed for a secondment post, Band 6.

▪ Ventilation systems should comply with HBN 03:01 and meet national recommendations for minimum are changes https://www.england.nhs.uk/publication/specialised-ventilationforhealthcare-buildings/ ▪ Ventilation assessment is carried out in conjunction with organisational estates teams and or specialist advice from the ventilation group and/ or the organisations, authorised engineer and plans are in place to improve/ mitigate inadequate ventilation systems wherever possible ▪ Where possible air is diluted by natural ventilation by opening windows and doors where appropriate	No changes to note at 22.03.2023. Gaps and Mitigating measures continue.	There are some areas that have no mechanical ventilation and little or no natural ventilation – these are generally not patient areas and are small, such as storage or transit areas etc. RAEI Planned Investigation Unit (PIU) has neither mechanical ventilation or opening windows technical options have been investigated but can only be implemented pending major maintenance funding (with associated major disruption to the unit). E&F Estates in conjunction with Microbiology and IP&C undertook an assessment of ventilation across WWL's acute sites during 2021. The ventilation Working Group	Many patient areas are not directly mechanically ventilated (especially RAEI Phase 2, RAEI Maternity and Outpatient Depts across many sites) and therefore accurate air changes cannot be dynamically measured. These areas were designed to be ventilated by natural ventilation (opening windows) – the NHS had subsequently introduced a 100mm maximum opening (falls from windows mitigation) – this obviously reduced the effectiveness of natural ventilation. Most in-patient areas have had their window openings increased to 200mm (with window bar safety mitigation in place) – most windows across RAEI now have 200mm opening windows.

		and IP&C Committee were updated with the findings and actions.	

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: ▪ Arrangements for antimicrobial stewardship (AMS) are maintained and a formal lead for AMS is nominated	No changes to note at 22.03.2023. Gaps and Mitigating measures continue.	There is currently no designated Microbiologist/ Infection Control Doctor in post to support AMS.	Risk assessments are in place.
▪ NICE Guideline NG15 https://www.nice.org.uk/guidance/ng15 is implemented - Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use	No changes to note at 22.03.2023.	None	N/A
▪ 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 https://www.gov.uk/government/publications/antimicrobialstewardship-start-smart-then-focus are followed	No changes to note at 22.03.2023. Gaps and Mitigating measures continue.	Limited resources currently to provide regular scheduled teaching sessions and opportunities	Risk assessment in place due to the lack of an Infection control Doctor/ Microbiology support.
▪ Contractual reporting requirements are adhered to, and boards continue to maintain oversight of key performance indicators for prescribing including: ➢ Total antimicrobial prescribing. ➢ Broad-spectrum prescribing. ➢ Intravenous route prescribing. ➢ Adherence to AMS clinical and organisational audit standards set by NICE: https://www.nice.org.uk/guidance/ng15/resources	No changes to note at 22.03.2023.	None	N/A
▪ 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).	Limited resources currently to provide regular scheduled teaching sessions and opportunities, however, it is intended that at least one ward round occur each	There is currently no designated Microbiologist/ Infection Control Doctor in post to support the IPC	Two IPC Risk Assessments currently subject to the review process: *Lack of Microbiology support to IPC Nursing Service* and *IPC Service unable to deliver*

	week that must address antimicrobials classified as 'reserve' on the WHO AWaRe classification.	Nursing Service and lead on specific IPC Doctor role, i.e., IPC Group (formerly Committee, Policy, Decontamination, Ventilation, antimicrobial stewardship role.	*service due to lack of specialist staff*.

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: ▪ IPC advice/resources/information is available to support visitors, carers, escorts, and patients with good practices e.g., hand hygiene, respiratory etiquette, appropriate PPE use ▪ Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff, and visitors	No changes to note at 22.03.2023.	None	N/A
▪ National principles on inpatient visiting and maternity/neonatal services will remain in place as an absolute minimum standard. National guidance on visiting patients in a care setting is implemented.	No changes to note at 22.03.2023.	None	N/A
▪ Patients being accompanied in urgent and emergency care (UEC), outpatients or primary care services, should not be alone during their episode of care or treatment unless this is their choice	No changes to note at 22.03.2023.	None	N/A
▪ Restrictive visiting may be considered by the incident management team during outbreaks within inpatient areas This is an organisational decision following a risk assessment and should be communicated to patients and relatives	No changes to note at 22.03.2023.	None	N/A
▪ There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, respiratory hygiene, and cough etiquette. The use of facemasks/face coverings should be determined following a local risk assessment.	Wearing of face masks currently continues in all clinical/ patient facing areas. A proposed review of Mask wearing by ETM planned for	None	N/A

	23 March 2023, with a recommendation to rationalise to specific clinical areas only.		
▪ If visitors are attending a care area to visit an infectious patient, they should be made aware of any infection risks and offered appropriate PPE	A proposed review of Mask wearing by ETM planned for 23 March 2023, with a recommendation to rationalise to specific clinical areas only.	None	N/A
▪ Visitors, carers, escorts who are feeling unwell and/or who have symptoms of an infectious illness should not visit. Where the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting	No changes to note at 22.03.2023.	None	N/A
▪ Visitors, carers, escorts should not be present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian	No changes to note at 22.03.2023.	None	N/A
▪ Implementation of the supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted where required C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	No changes to note at 22.03.2023.	None	N/A
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: ▪ All patients are risk assessed, if possible, for signs and symptoms of infection prior to treatment or as soon as possible after admission, to ensure appropriate placement and actions are taken to mitigate identified infection risks (to staff and other patients)	No changes to note at 22.03.2023.	Limited capacity to segregate within ED. IPCT, Estates, Operations and ED Teams continue to collaborate to identify options to enable safe	Risk assessment in place due to lack of isolation facilities, for further reassessment.

		patient placement where isolation is required. Lack of isolation facilities at RAEI.	
▪ Signage is displayed prior to and on entry to all health and care settings instructing patients with symptoms of infection to inform receiving reception staff, immediately on their arrival (see NIPCM)	No changes to note at 22.03.2023.	None	N/A
▪ The infection status of the patient is communicated prior to transfer to the receiving organisation, department or transferring services ensuring correct management /placement	No changes to note at 22.03.2023.	None	N/A
▪ Triaging of patients for infectious illnesses is undertaken by clinical staff based on the patients' symptoms/clinical assessment and previous contact with infectious individuals, the patient is placed /isolated or cohorted accordingly whilst awaiting test results. This should be carried out as soon as possible following admission and a facemask worn by the patient where appropriate and tolerated.	No changes to note at 22.03.2023.		
▪ Patients in multiple occupancy rooms with suspected or confirmed respiratory infections are provided with a surgical facemask (Type II or Type IIR) if this can be tolerated.	No changes to note at 22.03.2023.	None	N/A
▪ Patients with a suspected respiratory infection are assessed in a separate area, ideally a single room, and away from other patients pending their test result and a facemask worn by the patient where appropriate and tolerated (unless in a single room/isolation suite) ▪ Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting test results and a facemask worn by the patient where appropriate and tolerated only required if single room accommodation is not available.	No changes to note at 22.03.2023. Gaps and Mitigating measures continue.	Lack of isolation capacity in the Trust with competing priorities for isolation.	**See section 7**
▪ Patients at risk of severe outcomes of infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room protective isolation.	No changes to note at 22.03.2023.	As above	**See section 7**

▪ If a patient presents with signs of infection where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes	No changes to note at 22.03.2023.	None	N/A
▪ The use of facemasks/face covering should be determined following a local risk assessment	A proposed review of Mask wearing by ETM planned for 23 March 2023, with a recommendation to rationalise to specific clinical areas only.	None	N/A
▪ Patients that attend for routine appointments who display symptoms of infection are managed appropriately, sensitively, and according to local policy.	No changes to note at 22.03.2023.	None	N/A
▪ Staff and patients are encouraged to take up appropriate vaccinations to prevent developing infection.	No changes to note at 22.03.2023. Gaps and Mitigating measures continue.	Low compliance with Staff Vaccination programme.	**Vaccination rates:** Sept 2022 – Feb 2023: Total Trust Employees = 7065 COVID Vaccines = 2506 (35%) Flu Vaccines = 2288 (32%)
▪ Two or more infection cases linked in time, place and person trigger an incident/outbreak investigation and are reported via reporting structures.	No changes to note at 22.03.2023.	None	N/A

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: ▪ IPC education is provided in line with national guidance/recommendations for all staff commensurate with their duties ▪ Training in IPC measures is provided to all staff, including: the correct use of PPE.	IPC Level 1: Compliance reporting: Feb 2023: 94% IPC Level 2: Compliance reporting: Feb 2023: 83% IPC Team target support to ward areas during outbreaks and periods of increased incidence of COVID-19/Flu.	None	N/A
▪ All staff providing patient care and working within the clinical environment are trained in hand hygiene technique as per the NIPCM and the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it (NIPCM)	No changes to note at 22.03.2023. Gaps and Mitigating measures continue.	Limited capacity of the IPC Team due to long term sickness and staff vacancies.	Communication and reminders to staff for training completion. Discussion with Finance/ Budget Lead to progress recruitment to

			Band 6 (within budget limits) to enable succession planning for the IPC Team. Review of IPC Structure and work programme.
▪ Adherence to NIPCM, on the use of PPE is regularly monitored with actions in place to mitigate any identified risk ▪ Gloves and aprons are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's ▪ Hand hygiene is performed: ➢ Before touching a patient ➢ Before clean or aseptic procedures ➢ After body fluid exposure risk ➢ After touching a patient; and ➢ After touching a patient's immediate surroundings	No changes to note at 22.03.2023. Gaps and Mitigating measures continue.	Hand Hygiene compliance is below expected standard in some areas. Overall, Trust compliance: January 2023 was 79% February 2023 was 82%.	A refocus on IPC Compliance with "Back to Basics" approach will be adopted to support improved compliance and ownership. Steering Group for the Gloves Off Campaign has paused due to IPC Team capacity. Plan to resume in April 2023, if team capacity allows. Baseline data gathering in progress in preparation for improvement initiative.
▪ The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination (NIPCM).	No changes to note at 22.03.2023.	None	N/A
▪ Staff understand the requirements for uniform laundering where this is not provided for onsite.	No changes to note at 22.03.2023.	None	N/A

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: ▪ That clear advice is provided; and the compliance of facemask wearing for patients with respiratory viruses is monitored (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs	No changes to note at 22.03.2023.	None	N/A

▪ Patients who are known or suspected to be positive with an infectious agent where their treatment cannot be deferred, care is provided following the NIPCM	No changes to note at 22.03.2023.	None	N/A
▪ Patients are appropriately placed i.e.; infectious patients are ideally placed in a single isolation room. If a single/isolation room is not available, cohort patients with confirmed respiratory infection with other patients confirmed to have the same infectious agent	No changes to note at 22.03.2023. Gaps and Mitigating measures continue.	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.
▪ Standard infection control precautions (SIPC's) are applied for all, patients, at all times in all care settings ▪ Transmission Based Precautions (TBP) may be required when caring for patients with known / suspected infection or colonization	No changes to note at 22.03.2023. Gaps and Mitigating measures continue.	Compliance with Hand hygiene is below standard in some areas.	**See section 6**

8. Secure adequate access to laboratory support as appropriate: *No changes within this Criterion*			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: ▪ Laboratory testing for infectious illnesses is undertaken by competent and trained individuals ▪ Patient testing for infectious agents is undertaken promptly and in line with national guidance	No changes to note at 22.03.2023.	None	N/A
▪ Staff testing protocols are in place for the required health checks, immunisations, and clearance	No changes to note at 22.03.2023.	None	N/A
▪ There is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available.	No changes to note at 22.03.2023.	None	N/A
▪ Inpatients who go on to develop symptoms of infection after admission are tested/retested at the point symptoms arise	No changes to note at 22.03.2023.	None	N/A

COVID-19 Specific ▪ Patients discharged to a care home are tested for SARS-CoV-2, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge. Coronavirus (COVID-19) testing for adult social care services - GOV.UK (www.gov.uk) ▪ For testing protocols please refer to: COVID-19: testing during periods of low prevalence - GOV.UK (www.gov.uk) C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	No changes to note at 22.03.2023.	None	N/A

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: ▪ Resources are in place to implement, measure and monitor adherence to good IPC and AMS practice. This must include all care areas and all staff (permanent, flexible, agency and external contractors) ▪ Staff are supported in adhering to all IPC and AMS policies	No changes to note at 22.03.2023.	Compliance with SICP's is below standard in some areas.	**See section 6**
▪ Policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	No changes to note at 22.03.2023.	None	N/A
▪ All clinical waste and infectious linen/ laundry used in the care of known or suspected infectious patients is handled, stored, and managed in accordance with current national guidance as per NIPCM.	No changes to note at 22.03.2023.	None	N/A
▪ PPE stock is appropriately stored and accessible to staff when required as per NIPCM.	No changes to note at 22.03.2023.	None	N/A

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure that: ▪ Staff seek advice when required from their occupational health department/ IPCT/ GP or employer as per their local policy ▪ Bank, flexible, agency, and locum staff follow the same deployment advice as permanent staff	No changes to note at 22.03.2023.	None	N/A
▪ Staff understand and are adequately trained in safe systems of working commensurate with their duties	No changes to note at 22.03.2023.	None	N/A
▪ A fit testing programme is in place for those who may need to wear respiratory protection.	The Trust has invested in a central Mask Fitting Service (Mon-Fri) which is available to all staff, including students and bank/agency staff working for WWL. Outside of core hours a register of local fit testers is available.	None	N/A
▪ Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: ➢ Lead on the implementation of systems to monitor for illness and absence ➢ Facilitate access of staff to treatment where necessary and implement a vaccination programme for the healthcare workforce as per public health advice ➢ Lead on the implementation of systems to monitor staff illness, absence, and vaccination ➢ Encourage staff vaccine uptake	No change to note at 22.03.2023.	None	N/A
▪ Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in NIPCM	No changes to note at 22.03.2023.	None	N/A
▪ A risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza or severe illness from COVID-19. ➢ A discussion is had with employees who are in the at -risk groups, including those who are pregnant and specific ethnic minority groups ➢ That advice is available to all health and social care staff, including specific advice to those at risk from complications	No changes to note at 22.03.2023.	None	N/A

➢ Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff ➢ A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff			
▪ Testing policies are in place locally as advised by occupational health/public health	No changes to note at 22.03.2023.	None	N/A
▪ NHS staff should follow current guidance for testing protocols: C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	No changes to note at 22.03.2023.	None	N/A
▪ Staff required to wear fit tested FFP3 respirators undergo training that is compliant with HSE guidance, and a record of this training is maintained by the staff member and held centrally/ ESR records.	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. Initial upload of evidence onto ESR completed. Work ongoing to establish monthly update. 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.	None	N/A
▪ 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 2-years	None	N/A

▪ Fit testing is repeated each time a different FFP3 model is used	Trust offers a selection of 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 – repeated every 2 years or sooner if there is a change related to the wearer which may affect fit.	Ongoing work to ensure staff are fit tested to the make / model which they are wearing.	Ongoing promotion regarding the need to be fit tested to each model. Swiftqueue for easy access booking of a mask fit test.
▪ All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	Communication to all staff of requirement to be tested to multiple models. Use of porta count machine is facilitating two / three tests per appointment.	The make and model of mask used by individual staff is reliant on the mask fit test result, and whilst there are various FFP3 masks available not all are compatible for wearing by all staff.	Where necessary staff will be tested on each model available until a secure fit to 2 different mask models has been achieved. If a secure fit to a 1st or 2nd mask cannot be achieved, wards and departments will need to ensure a mechanical respirator and hood is available for use.
▪ Those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators or an alternative is offered such as a powered hood	Record sheet completed by mask fit tester – information duplicated onto register for upload onto central mask fit database. Wearer takes the record sheet with instruction to share with line manager and keep own copy. Invited for further appointment where possible to facilitate testing to alternative mask model(s). Training provided for alternative powered hood where need is identified.	None	N/A

▪ That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions	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. This information is also on the intranet and a copy kept with the equipment.		
▪ Members of staff who fail to be adequately fit tested: a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm ▪ Documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health	No changes to note at 22.03.2023.	None	N/A
▪ Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	A quarterly report on the status of mask fit testing compliance is presented to the Occupational Safety and Health Group, which is chaired by a member of the Board. The report is also shared with Divisions at their Divisional Health and Safety Group.	None	N/A

	Trust Respiratory Protective Equipment Policy in place.		
▪ Staff who have symptoms of infection or test positive for an infectious agent should have adequate information and support to aid their recovery and return to work.	No changes to note at 22.03.2023.	None	N/A

Reference: NHS England. Infection Prevention Board Assurance Framework. Version 1.11. Published January 2023

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of report:	Draft WWL and EHU Joint Clinical Academic Workforce Strategy
Presented to:	Board of Directors
On:	05 April 2023
Presented by:	Dr Sanjay Arya, Medical Director
Prepared by:	Professor Adam Watts, Clinical Director for Research Alison Robinson, Head of Research
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Executive summary

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

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

One of the criteria to achieve University Hospital status is to achieve 20 clinical academic appointments.

The recently approved Research Strategy *Research for All* is one of the key enabling strategies to achieving University Hospital status.

Aim 2 of the Research Strategy is "*to nurture a culture that embeds research as a core component of high-quality service delivery and develop a sustainable research active workforce*".

This paper presents a strategic plan to achieve 20 clinical academic EHU substantive appointments with honorary clinical status at WWL to meet the University Hospitals Association requirements.

Link to strategy

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

The Research Strategy *Research for All* is one of the key enabling strategies to achieving University Hospital status.

Risks associated with this report and proposed mitigations

None

Financial implications

Proposals may have a positive financial impact relating to current expenditure on Locums appointed in areas which are known as difficult to recruit to if permanent clinical academic staff are attracted into such consultant positions.

Legal implications

None

People implications

Proposals for staff to change substantive employment to EHU is discussed and concerns mitigated.

Wider implications

None

Recommendation(s)

The Board is asked to consider the proposals for ratification at Trust Board.

Report

Introduction

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

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

One of the criteria to achieve University Hospital status is to achieve 20 clinical academic appointments.

The recently approved Research Strategy *Research for All* is one of the key enabling strategies to achieving University Hospital status.

Aim 2 of this Strategy is "*to nurture a culture that embeds research as a core component of high-quality service delivery and develop a sustainable research active workforce".*

Objectives

- WWL and EHU are committed to a partnership developing health research for the benefit of patients, the community and workforce.
- WWL Trust Board has set an objective to achieve University Hospital Status.
- A strategy is required to achieve a minimum of 20 Consultants with substantive appointments at EHU and Honorary contracts at WWL to meet the University Hospital Association Requirements.

One of the key strategic aims of WWL Trust strategy "Research for All" is to "support and develop a sustainable workforce with the skills to deliver world class research across all our clinical areas and disciplines, thereby creating fulfilling roles and attracting the best people." One of the strategies to support this is an aim to achieve University Hospital status working collaboratively with Edge Hill University. The University Hospital Association (UHA) states that the research criteria to achieve this are:

1. Research
   a. The Trust shall have in place with the University a Memorandum of Understanding on Joint Working for Effective Research Governance; it will actively investigate joint Research Offices to foster more efficient working;
   b. The Trust shall demonstrate that it is working collaboratively with the University to develop an agreed joint research strategy;
   c. There shall be evidence of significant research activity within the Trust, much of which will involve collaboration with university staff. This will include:
      i. A core number of university principal investigators. There must be a minimum of twenty consultant staff with substantive contracts of employment with the university with a medical or dental school which provides a non-executive director to the Trust Board. These individuals must have an honorary contract with the Trust in question.
      ii. The research output to be REF returnable;
      iii. For Trusts in England, an average Research Capability Funding allocation of at least £200k average p.a. over the previous two years.

Source: https://www.universityhospitals.org.uk/wp-content/uploads/2021/09/University-Hospital-Status-2021.pdf accessed 20/01/2023

A clear strategy is required to develop a research workforce in accordance with the UHA criteria within the timeline of the Trust strategy. This workforce will enable delivery of other key UHA criteria.

Strategy

Aim

To deliver a minimum of 20 clinical academics at consultant grade with substantive appointments at EHU and honorary contracts at WWL to align with other key targets for delivery of university hospital status.

Timeline

The timeline for recruitment of 20 clinical academics is the end of 2026 in line with the projected target for achieving two years of RCF funding.

Recruitment options

1. Provide honorary contracts for existing EHU substantive employees

EHU employs two clinicians with substantive academic contracts, Dr Paola Dey and Dr Greg Irving. Discussion should be held with HR at WWL to provide Honorary consultant contracts for these two academic clinicians.

Enablers

- They are established clinicians with substantive contracts at EHU.
- Provision of honorary contracts will facilitate collaborative research between these clinical academics and WWL.

Barriers

- None foreseen.

2. Convert substantive consultant grade NHS employees to substantive EHU contracts

Active clinical researchers at WWL should be offered substantive contracts at EHU where any of the following criteria are met:

a) EHU has funding and is willing to appoint the clinical academic to such a role.
b) The clinical academic has sufficient funding from research grants for a minimum of two years to fund a minimum of 2 PA research sessions per week.
c) The Trust has agreed to fund a minimum of 2 PA research sessions per week to develop a clinical academic career.

Enablers

- Work has been done within WWL to identify levels of research income against individual consultants at WWL. A small number of clinicians currently meet the criteria outlined in 2b.
- Some clinicians are currently applying for research grants that would potentially place them in a position to meet these criteria.
- A grant support service has been established within WWL Research Team to support appropriate costing to meet this criterion.
- There is provision for people to hold EHU contract and still contribute to NHS Pension Scheme.

Barriers

- Current research income does not guarantee future research income. EHU would have to be satisfied that there is some risk to recruiting these individuals.
- Clinicians on an NHS contract may be wary of resigning from this secure employment to take up a substantive contract at EHU. This could be mitigated with a contractual agreement that if the Clinical Academic position at EHU is terminated for a non-disciplinary reason then a substantive NHS contract would be offered to the clinician.
- Clinical academics with a research interest may be wary of contractual obligations to provide levels of teaching that would interfere with research capacity and delivery. This could be mitigated with flexible contracts that permit agreement of levels of teaching required within the contract through negotiation on an individual basis.
- Clinicians on an NHS contract may be concerned about impact to their NHS Pensions. Advice to be provided on the options and impacts here.

3. Use areas of need to recruit new clinical academics

There are clinical areas within WWL that struggle to recruit to substantive appointments either due to workforce shortages, working conditions or other local factors. These areas may be relying on costly locum Consultant appointments to fulfil these roles and provide a service to the local population. This provides an opportunity to create attractive academic clinician positions in sectors of need to aid recruitment. Whilst WWL would have to fund the academic sessions for recruits to these roles, this is likely to result in a cost saving to the Trust when compared to employing a locum in the same role.

Enablers

- Making recruitment to clinical areas of need more attractive.
- Improved continuity of service and care for patients through permanent appointments.
- Reduce cost burden of locum services.
- Increase in research in these areas with potential positive impact on patients and staff.

Barriers

- Ensuring service provision whilst providing research sessions in job plan.
- Workforce shortages may remain barriers.
- Identifying suitably qualified clinicians for the clinical academic role may be challenging in some areas.

4. WWL strategic decision to fund clinical academic role.

WWL may take a strategic decision to support the development of an individual within a clinical academic role towards the Trusts strategic aims. WWL R&I is developing a research investment fund. A research investment strategy will be developed for approval by the Research Committee. One possible use of this investment fund would be the pump priming of time limited research PA's to support individual's with grant applications that are thought to have a good chance of success.

Enablers

- Creating a nurturing environment will aid workforce retention and recruitment.

- Supporting clinicians with a strong research idea in applying for research grants could translate into an increase in Research Capability Funding, which enables the Trust to grow the research infrastructure further.

Barriers
- Perceived impact on service delivery in a challenging clinical environment with long waiting lists and NHS financial stresses.

5. Non-medical Consultant Grades

The wording of the UHA criteria states "a minimum of 20 Consultant staff". WWL employs a number of nurses and allied health professionals in Consultant roles and EHU employs a number of AHPs in academic roles. Exploration is required whether these individuals can help to meet the UHA criteria. This may require a direct approach to UHA. If accepted, the same principles can be applied as outlined for Medical Consultants.

Enablers
- Large workforce with ambition to develop research potential.
- Enhanced career progression opportunities to aid recruitment and retention.
- Embracing the national NMAHPs strategy for increasing research capability.

Barriers
- UHA may provide clarification that prevents consideration of non-medical consultant grades.
- Potential short term negative impacts on service delivery if backfill arrangements are of concern.

Delivery plan

1. Approval of strategy by key stakeholders
2. Offers of Honorary contracts to be made to appropriate EHU employees
3. HR advice to be prepared for NHS employed candidates ref. contractual and NHS Pension arrangements.
4. Approaches to clinical researchers meeting criteria 2a and 2b to explore change of employment.
5. Identification of areas of need with high numbers of locum Consultant contracts and exploration of possible clinical academic roles in these areas
6. Broader strategic discussion about "pump priming" of key personnel with research pedigree to support transition to clinical academic role and to support specific grant applications.
7. Discussion with UHA regarding non-medical consultant grade eligibility.

Recommendations

The Research Committee is requested to consider the strategic plan and proposed Delivery Plan to support submission to the Trust Board for ratification.