# Board of Directors - Public Meeting

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

**Boardroom, Trust Headquarters**

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

## Agenda

**13:30 - 13:31**
1 min

### 12. Declarations of Interest

*Information* *Mark Jones*

Verbal item

**13:31 - 13:32**
1 min

### 13. Minutes of Previous Meeting

*Approval* *Mark Jones*

- 13. Minutes_Board of Directors Public Meeting_071222.pdf (5 pages)
- 13. Public Board Action Log - Dec 2022.pdf (1 pages)

**13:32 - 13:47**
15 min

### 14. Chair's Opening remarks

*Information* *Mark Jones*

Verbal Item

**13:47 - 14:07**
20 min

### 15. Chief Executive's report

*Information* *Silas Nicholls*

- 15. Board Report_CEO_February_2023_FINAL.pdf (3 pages)

**14:07 - 14:27**
20 min

### 16. Committee chairs' reports

*Information* *NEDs*

#### 16.1. Research

*Clare Austin*

- 16.1 AAA - Research - Dec 2022 1.pdf (2 pages)

#### 16.2. Finance and Performance

*Mick Guymer*

- 16.2 F&P Committee AAA summary report - Jan 2023.pdf (2 pages)

#### 16.3. People

*Lynne Lobley*

- 16.3 AAA _ People - 10 Jan 2023 - awaiting ETM approval.pdf (2 pages)

### 16.4. Quality and Safety

*Francine Thorpe*

- 16.4 AAA Q&S December 22.pdf (3 pages)

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**14:27 - 14:37**
10 min

## 17. Board assurance framework

*Decision* *Paul Howard*

- 17. BAF Report Board 1 Feb 2023 final version.pdf (30 pages)

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**14:37 - 14:52**
15 min

## 18. Integrated performance report

*Discussion* *Claire Wannell/Rabina Tindale/Tracy Boustead*

- 18. Performance Report - Community Division Performance Report - Jan 23.pdf (5 pages)
- 18. Performance Report - Elective Recovery Jan 23.pdf (6 pages)
- 18. Board of Directors M9 2223 Scorecard_v1.pdf (5 pages)
- 18. Performance Report - Urgent E Care Jan 23.pdf (7 pages)

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**14:52 - 15:07**
15 min

## 19. Finance Report

*Discussion* *Kelly Knowles*

- 19. Trust Financial Report 22-23 December month 9 Board.pdf (10 pages)

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**15:07 - 15:27**
20 min

## *Break*

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**15:27 - 15:37**
10 min

## 20. Maternity

*Decision* *Rabina Tindale*

### 20.1. CNST reports, including annual declaration

*Decision* *Rabina Tindale*

- 20.1 Trust Board – Maternity Incentive Scheme Update.pdf (18 pages)
- 20.1 MIS_SafetyAction_2023_V13 1.pdf (39 pages)
- 20.1 ATAIN ACTION PLAN UPDATED Jan 2023.pdf (5 pages)
- 20.1 Letter GMEC LMNS_CNST Sign off by ICB 20.12.22.pdf (2 pages)

### 20.2. Maternity Dashboard

*Information* *Rabina Tindale*

- 20.2 Maternity Dashboard report December 22.pdf (5 pages)
- 20.2a December 22 Maternity dashboard.pdf (3 pages)

### 20.3. Maternity Perinatal quality surveillance

*Information* *Rabina Tindale*

- 20.3 Maternity Perinatal Quality Surveillance Q3( For Board).pdf (22 pages)
- 20.3a December 2022 Perinatal Dashboard.pdf (2 pages)

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**15:37 - 15:52**
15 min

## 21. Risk appetite statement 2022/23

*Decision* *Paul Howard*

21. Risk Appetite - Board Final 1 Feb.pdf (17 pages)

**15:52 - 15:57**
5 min

## 22. Well-Led action plan

*Decision* *Paul Howard*

22. Well-led action plan - Feb 2023.pdf (15 pages)

**15:57 - 16:15**
18 min

## 23. Consent agenda

### 23.1. Infection prevention and control board assurance framework

*Information*

23.1 FINAL IPC BAF for Board 1.2.23.pdf (37 pages)

### 23.2. Standing Financial Instructions

*Approval*

23.2 SFI Changes Trust Board.pdf (11 pages)
23.2a SFIs Sept 2022 after changes.pdf (64 pages)

**16:15 - 16:15**
0 min

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

*Information* *Mark Jones*

05 April 2023, Boardroom, Trust Headquarters, 1:15pm - 4:15pm

# Board of Directors Public Meeting

*Wed 07 December 2022, 14:00 - 16:15*

Boardroom, Trust Headquarters

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

## Attendees

**Present:**

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|---|---|
| Mr M Jones | Chair (in the Chair) |
| Prof C Austin | Non-Executive Director |
| Mrs A Balson | Chief People Officer |
| Ms K Knowles | Acting Chief Finance Officer |
| Lady R Bradley | Non-Executive Director |
| Mr I Haythornthwaite | Non-Executive Director |
| Mr P Howard | Director of Corporate Affairs |
| Mrs L Lobley | Non-Executive Director |
| Ms R Tindale | Chief Nurse |
| 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 |

**In attendance:**

| | |
|---|---|
| Dr M Farrier | Associate Medical Director |
| Mrs N Guymer | Deputy Company Secretary (minutes) |
| Mr A Haworth | Member of the Public |
| Mrs H Hendricksen | Divisional Director of Operations for Specialist Services |

## Meeting minutes

### 162. Declarations of Interest

Information
Mark Jones

No declarations of interest were made.

### 163. Minutes of Previous Meeting

Approval
Mark Jones

It was noted that the Director of Strategy and Planning had been in attendance at the last meeting, despite this not being noted in the minutes. Subject to this amendment, the Board **APPROVED** the minutes as a true and accurate record.

The Board reviewed the action log.

***76/22(a) Staff story***
The Associate Medical Director advised that an Advanced Clinical Practice Forum now exists and reports to the Nursing Midwifery and Allied Health Professional Body. It was agreed that this action could be closed and any further concerns would be monitored by the People Committee.

***115/22 Board Assurance Framework***
The Board noted the update within the action log and agreed that the action could now be closed.

18. Minutes_Board of Directors - Public Meeting_051022 (1).pdf
18a. Public Board Action Log - October 2022.pdf

## 164. Chair's Opening remarks

Information
Mark Jones

The Chair noted that he had started in post around one year ago and remarked that the Trust still holds the same values and the qualities that attracted him to the role at that time.

He reported on the annual meeting, which had taken place on 10 November 2022, providing a summary of the agenda and advising that WWL had welcomed three new governors, with some longer standing governor colleagues being re-elected.

He explained that recently himself and the Chief Executive had met with the MP for Wigan, Lisa Nandy and various other external colleagues, in a bid to ensure a smooth transition to working as an Integrated Care Partnership and that positive relationships with partner organisations are nurtured.

He thanked Mr I Boyle who had recently departed as WWL's Chief Finance Officer as well as Mrs A Balson, who would be leaving the organisation later in the month, for the work done in her time as WWL's Chief People Officer. He went on to advise that Mrs A Tumilty, Non Executive (NED) Chair of WWL's Finance and Performance Committee (F&P) had also recently left to focus on challenges that she is facing, as Chair of another Board.

The Board received and noted the verbal update.

## 165. Chief Executive's report

Information
Silas Nicholls

The Chief Executive summarised the salient points of the report which had been circulated in advance of the meeting. He advised the Board that the risk rating in respect of the organisational risk around insufficient patient flow, has now been increased to the maximum risk score of 25 to reflect the increasingly concerning position.

He highlighted the importance of admission avoidance and how WWL's community teams play a key role here, something which has been highlighted in the local news recently by the Health Outreach and Inclusion Team's spot as finalists at the first ever Best of Wigan Awards. Members of the team were nominated in the Health Hero category, which highlights the extraordinary efforts of healthcare support workers who care for and empower vulnerable people. The Health Outreach and Inclusion Team tackle health inequalities within the most vulnerable communities in society, particularly those from disadvantaged groups who often have difficulties accessing services. He went on to note how WWL's pioneering virtual ward service continues to strengthen and is another great healthcare advancement assisting to reduce admissions.

The Board received and noted the report.

20. Board Report_CEO_December 2022_FINAL UPDATED .pdf

## 166. Committee chairs' reports

Information
NEDs

The Non Executive Committee Chairs each provided an update from their last meeting.

### 166.1. Audit

Ian Haythornthwaite

Mr I Haythornthwaite summarised the report which had been provided and supplemented this by explaining that many of the items discussed at the meeting provided assurance or evidence around actions taken in response to issues which had been highlighted previously. He congratulated the Trust on the audit results received in the recently completed internal audits.

21. AAA Audit - Nov 2022.pdf

### 166.2. Finance and Performance

Rhona Bradley

Lady R Bradley summarised the report which had been circulated following the meeting bundle, noting that late circulation would continue, due to the close proximity of the F&P and Board meetings.

The Acting Chief Finance Officer outlined the change made to the finance report following the realisation that WWL's Cost Improvement Programme (CIP) benchmark was very low, compared to other trusts. On closer review it transpired that other organisations have been counting as CIP savings, things which WWL have considered to be business as usual. Therefore, the revised approach will ensure that WWL are reporting in line with other trusts, so that WWL can benchmark accurately. It is likely therefore that CIP achievement will look to have improved, although this will not impact on the bottom line and therefore the overall financial position will remain as it is.

### 166.3. People

Lynne Lobley

Mrs L Lobley summarised the report which had been provided in advance of the meeting.

The Chair queried the position of the vacancy rate and asked if this is still the same as the report provided at the last meeting.

The Chief People Officer noted that the vacancy rate is improving and that WWL are now putting more work in to retention initiatives, which she emphasised is equally important. She listed several streams of work which would support this. She noted an increase in the staff survey completion rate from 29% to 36%. It was acknowledged that this is still below average but that the increase was a positive step forward. The outputs of the survey would be taken through the People Committee and included in relevant action planning.

Mrs F Thorpe noted the importance of considering Allied Health Professionals in extended and advanced roles and highlighted the opportunity for the Trust here, given the national need to reshape the workforce to deal with current staffing pressures.

Lady R Bradley asked whether the approach to filling vacancies in this way can be strengthened externally and applied when filling Trust roles, roles in social care and other external roles.

The Chair advised that the NEDs meet twice each month and discuss in particular, issues raised at Committee meetings which cross over multiple areas of service. The range of meetings which NEDs now sit across has also been revised to ensure that there is overlap between all areas and that matters are considered from multiple perspectives when they are raised.

21. AAA _ People - 18 Oct 2022 2.pdf

### 166.4. Quality and Safety

Francine Thorpe

Mrs F Thorpe advised that the paper circulated was the previous month's version and that the correct version had been shared that morning.

Prof C Austin queried the complaints response time noting that the percentage response rate has remained the same in comparison to the year end target.

Mrs F Thorpe noted progress within individual divisions and that action plans had been presented to the Committee. The Chief Nurse added that in particular support is being given to the medicine division, since they have been struggling with complaints responses more that others have.

21. AAA QS - Oct 22.pdf

### 166.5.

The Board received and noted the updates.

## 167. Board assurance framework

**Decision**
Paul Howard

The Director of Corporate Affairs introduced the report, noting that no risks have been added or escalated, although none have been deescalated. He invited the executive risk leads to take questions from the Board.

The Chief Nurse added that an ASPIRE Quality Standards Steering Group has now been set up, which will monitor compliance with the requirements of the Ward Accreditation Scheme and report up to the Quality and Safety Committee.

Mrs F Thorpe noted that the Quality and Safety Committee had recently noted less progress that they would have expected in respect of corporate objectives CO1 and CO2 but that she has a meeting scheduled with the Medical Director to discuss progress here.

Prof C Austin noted the risk statement for the ward accreditation program which, she highlighted, focusses on the supernumerary status of ward leaders and the risks of Covid 19 as key barriers to achieving accreditation. Given the current various operational pressures being faced, she asked whether the statement requires modifying, to reflect these broader issues.

The Chief Nurse agreed that the ability of ward leaders to act in a supernumerary capacity is being affected by the increase in operational pressures and agreed to consider an amendment to the wording to reflect this.

The Chief People Officer advised that many of the risk treatments in this version of the document have been since updated and that significant progress has been made in many areas from a learning & development perspective. However, a lack of additional capacity to fit in these types of activity, following the pressures of the pandemic, has resulted in slow progress.

The Chief People Officer advised that in respect of achievement of the net zero requirement and risk PR14, a paper would be taken to the upcoming Executive Team Meeting so that a decision could be made as to how WWL may take this forward with what is achievable within the financial regime available.

The Interim Chief Finance Officer advised that in respect of risks PR8 and 9, there is a risk treatment included within the financial recovery plan, which had been reviewed and approved for submission by the Board in the private part of the meeting and that the risk score is in line with this.

The Board noted the updates provided.

22. BAF Report December 2022 Board Meeting.pdf

## 168. Integrated performance report

**Discussion**
Alison Balson/Martin Farrier/Mary Fleming/Rabina Tindale

The Chief Nurse and Associate Medical Director; Chief People Officer; Deputy Chief Executive and Interim Chief Finance Officer summarised the sections of the report, as designated to them within the document provided.

The Board received and noted the the updated provided.

23. Board of Directors M7 2223 Scorecard_v1.pdf

## 169. Finance Report

**Discussion**
Kelly Knowles

The Interim Chief Finance Officer summarised the report provided in advance of the meeting.

The Board received and noted the content of the paper.

24. Trust Financial Report 22-23 October month 7 Board.pdf

## 170. Findings from East Kent investigaton

**Discussion**
Rabina Tindale

The Chief Nurse presented the report which had been shared in advance of the meeting. She explained that the recent report in to services at East Kent Hospitals University NHS FT has set out recommendations which were actually aimed at national bodies, royal colleges and education providers but that in any event, WWL had provided the report for the Board so that they would have the opportunity to review and scrutinise assurance mechanisms in place within the Trust's maternity service and request that any appropriate action be taken to strengthen these, should the same be required.

The Board took assurance from the report provided and did not consider that any associated actions would be required.

25. East Kent Paper for Dec Trust Board Final.pdf

## 171. Consent Agenda

Information

The papers having been circulated in advance and the directors having consented to them appearing on the consent agenda, the Board **RESOLVED** as follows:

### 171.1. IPC Board Assurance Framework

**THAT** the paper and updates provided therein be received and noted.

26.1. FINAL IPC BAF v1.11. November 2022.pdf

### 171.2. Guardian of Safe Working report

**THAT** the paper be received and noted and its recommendations for further reporting **AGREED**.

26.2. BoD cover report - guardian of safe working Dec 2022.pdf
26.2a. Quarter 1 Report GoSWH Sept 2022.pdf

### 171.3. Freedom to speak Up Guardian report

**THAT** the paper and updates provided therein be received and noted.

26.3.FTSU - December 2022.pdf

### 171.4. Review of well-led action plan

Approval

**THAT** the paper be received and noted and its proposal to close recommendation 11 of the action plan **AGREED**.

26.4. Well-led action plan - Dec 202.pdf

### 171.5. Emergency preparedness and resilience (EPRR) core standards report

**THAT** the paper be received and its findings noted.

26.5a. 2022 EPRR Core Standards Action Plan V2.pdf
26.5. EPRR Core Standards Board Report 2022 V2.pdf
26.5b. 2022 Core Standards V3 26-10-2022.pdf

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

Information
Mark Jones

1 February 2023, Boardroom, Trust Headquarters, 1:15pm - 4:15pm

# Action log

| Date of meeting | Minute ref. | Item | Action required | Assigned to | Target date | Update |
|---|---|---|---|---|---|---|
| | | | **NO ACTIONS DUE** | | | |

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

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|---|---|
| **Title of report:** | Chief Executive's Report |
| **Presented to:** | Board of Directors |
| **On:** | 01/02/23 |
| **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**

Since our last Board of Directors meeting in December 2022, the pressure on WWL's services has risen to unprecedented levels and the challenges met by our staff have been well-documented. A combination of factors, including annual winter pressures, increased Emergency Department attendances, staff sickness, delays with discharges resulted in the need for the Trust to declare a critical incident in the run up to the festive Bank Holiday period; this enacted further intense support from partner organisations to make sure urgent and emergency care could still be provided safely to the people of the Wigan Borough and surrounding areas. A phenomenal Trust-wide and system-wide effort was made before, during and after the four-day critical incident period, providing an excellent example of how our partnership working with primary care, social care and the local authority supported discharges and patient flow throughout WWL's services and helped to manage the significant challenges faced within the Emergency Department. Despite this, and the de-escalation of the critical incident, it is imperative that we continue to encourage the public to think very carefully about their healthcare choices and to only use our Emergency Department when it is deemed absolutely necessary, as this will significantly help WWL to manage the ongoing pressures. Maintaining the highest levels of patient safety possible will always be WWL's priority, but alongside this, particularly during moments and periods of intense pressure, we always also prioritise support for the physical, mental, and psychological safety of our staff. Through the Trust's nationally recognised Steps4Wellness service, we have supported all staff who have needed it and will continue to do so.

On Wednesday 18th January and Thursday 19th January 2023, nursing colleagues who are union members of the Royal College of Nursing took part in industrial action against the Government. We know that action of this type is not against WWL, and as a Trust we respect the rights of union members to take part in industrial action recommended by their trade union. During this time, WWL ensured that tried and tested plans were put in place to manage any disruption and to make sure patient safety remained our priority. Our focus was to protect essential life and limb services such as the Emergency Department, Maternity, Emergency Theatres and the Intensive Care Unit, as well as chemotherapy and dialysis. As a result of the change in staffing levels across our services, we did have to adjust the provision of some services, including temporary opening time changes for our Urgent Treatment Centres and postponing a number of out patient appointments and planned non-urgent elective care.

Despite experiencing a difficult few months, I am delighted to report back on some excellent progress and achievements happening across WWL, including the new developments at our Leigh Infirmary site. After receiving planning permission in November, work to build an additional theatre and Community Diagnostic Centre (CDC) began in December. The CDC will provide improvements to diagnostics for patients nearer to their homes in areas which are under-served, in as few visits as possible, and will supported joined-up care between secondary, community and primary care. The benefits will, in turn, free up capacity at Royal Albert Edward Infirmary for urgent diagnostic tests, resulting in shorter waiting times. We will be able to provide much faster access to diagnostics and quicker outcomes alongside an improved experience. Elsewhere in the Wigan Borough, building work at Aspull Health Centre has now finished, with a new community facility created for people living in the local area. This highly anticipated centre has been delivered through WWL's partnership with OneMedical Property, Aspull Surgery, NHS Greater Manchester Integrated Care Board and Wigan Council, and will provide a modern, fully integrated healthcare facility, offering access to a wide range of WWL services that are available in community clinics across the Wigan Borough.

A number of WWL services have recently experienced successful accreditations. The Finance Team have maintained their Level 3 Finance Skills Development accreditation for the excellent standard of development of finance colleagues and continued support offered to all areas of the organisations, whilst our Occupational Health Team's re-accreditation by the Safe Effective Quality Occupational Health Service was commended for providing a high quality of service, expert leadership, knowledge and visibility. WWL's Catering Team have also recently received an excellent report following a third-party assessment at the Central Production Unit at Leigh Infirmary, demonstrating food safety compliance for patients, staff and visitors, as well as the assurance required to enable WWL to be listed as a supplier on the NHS Shared Business Services supply chain framework, allowing the Trust to supply local NHS and Local Authority organisations. Elsewhere, we continue to strive for excellence within our Pulmonary Rehabilitation service, as WWL became one of the first 100 of its kind to register for accreditation from the Royal College of Physicians on the Pulmonary Rehabilitation Services Accreditation Scheme. All of these achievements provide examples of the continuous improvements we are making for our patients, as we aim to provide the best possible care and services.

I would also like to highlight excellence within our community services and congratulate Health Outreach and Inclusion Team members who were named Wigan Borough 'Health Heroes' at the first ever Best of Wigan Awards in December 2022. They received this award for their outstanding support to vulnerable people during the COVID-19 pandemic. Along with their colleagues in the Health Outreach and Inclusion Team, and the wider Community Division, they continue to improve access to a variety of healthcare services for vulnerable people in the Wigan Borough, in turn playing an important part in helping WWL to tackle capacity challenges experienced during the winter months.

Supporting the people of the Wigan Borough and surrounding areas is at the core of everything we do, and so it was very pleasing to see many WWL colleagues working together to support the Wigan Borough-wide Christmas appeal, alongside our partners at Wigan Council, Wigan and Leigh College, Greenmount Projects and Daffodils Dreams. Hundreds of presents, including a wide-range of practical items, were donated by staff to the appeal to be distributed to care leavers across the Borough.

Finally, I would like to officially welcome Tracy Boustead as WWL's Interim Chief People Officer. Tracy joined the Trust on 1st January 2023 and bring significant leadership experience operating at the highest levels across Health, Local Authority and Higher Education. Shortly after our last Board of Directors meeting, we also appointed a new Chief Finance Officer, Tabitha Gardner, who will join the Trust in March 2023, having held the role of Director of Finance at Rochdale Care Organisation, part of the Northern Care Alliance NHS Foundation Trust.

# Committee report

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| **Report from:** | Research Committee |
| **Date of meeting:** | 1 December 2022 |
| **Chair:** | Clare Austin |

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

**ALERT**

- The Committee had nothing to alerts the Board in respect of.

**ASSURE**

- All five of our clinical leader roles are now filled, the two most recent being the NMAP and community roles which also now spread across AHP and nursing as well as 4 doctors, Christina's report.
- The Committee received its first 'research story' and were assured by the quality of the cutting edge research that WWL undertake and that the team are able to mobilise quickly to facilitate participation in trials and research initiatives, with a Sponsorship Manager now in place and the Research Hub now being fully functioning. They heard stories on:
  - RHAPSODY
  - Capillary study
- The powerful nature of the stories complimented the discussion and will be a feature of future meetings.
- WWL are meeting all of the targets set out in the RAF, notably recruitment figures for both staffing and trials.
- WWL are on target to received RCF funding as required for university hospital by 2024/25.

**ADVISE**

- The Committee is considering invitations to Health Innovation Manchester and any other appropriate external organisations.
- Moving forwards, work will be done to better align to divisional research activity with the other divisional metrics considered through the divisional assurance meetings.
- Upcoming detailed work on mapping funding to projects and testing and recording the impact of research outputs
- The Ashton Research Hub will be due to hold a formal opening ceremony shortly, for which some Board attendance will be sought
- Better comms - WWL will set up a Twitter account for research moving forwards and share the Research Hub Prospectus.
- Also publications to be shared through regular comms and report what we have published.

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| ▪ Moving forwards we will ensure a better link between audit and research – Adam and Sanjay |
| **RISKS DISCUSSED AND NEW RISKS IDENTIFIED** |
| ▪ |

# Committee report

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| **Report from:** | Finance & Performance Committee |
| **Date of meeting:** | 25th January 2023 |
| **Chair:** | Mick Guymer |

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

| **ALERT** |
|---|
| • Finance outturn 2022/23 and planning/budget setting for 2023/24 is being carried out against an uncertain backdrop of the Greater Manchester Integrated Care Board (GM ICB). Whilst good internal work is progressing well, the broader GM footprint will need close oversight & monitoring. |
| **ASSURE** |
| • The Community Division presented a deep dive into their current performance, finances and service delivery and challenges. Solid progress is being made across all three aspects, so good levels of assurance were recorded.<br>• The performance reports expressly covered the community division, urgent/emergency care and the elective recovery performance and demonstrated good progress despite the many adversities being faced.<br>• Good levels of assurance were taken from the 2023/24 planning & budget setting coverage. The early work pre the national issuing of planning guidance and the engagement with Divisions is building a good platform for concluding this work over the coming weeks.<br>• The CIP Programme was reviewed and recognised good in-year progress. However, the recurrent elements of this caused some concern, but the meeting also noted that these lower recurrent levels were not untypical of system-wide delivery. |
| **ADVISE** |
| • The Committee received the finance report for month 9 to 31st December 2022. The distance from plan was acknowledged, along with the strategies being pursued to recovery to the planned outturn of £10.4m deficit.<br>• The review of the recovery action planning implementation & delivery (RAPID) updates was received, and actions noted. Good assurance was taken from the focus and actions through this initiative.<br>• The business case for MRI Scanner Upgrade was received and supported. It was noted that this may require a vesting certificate which would need to be noted in the external auditor's annual ISA260 declaration (but this was deemed as a potentially necessary outcome if the scheme benefits are to be achieved). |
| **RISKS DISCUSSED AND NEW RISKS IDENTIFIED** |

- After a full review of F&P related BAF items it was considered that the risk around Trust long term finances may need reviewing/increasing in the light of the Trust's exit run-rate from 2022/23 and the wider GM financial outlook.

# Committee report

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| **Report from:** | People Committee |
| **Date of meeting:** | 10 January 2023 |
| **Chair:** | Lynne Lobley |

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

**ALERT**

- The Committee expressed concern with the risks in respect of workforce digitisation, particularly the rolling back of the recently piloted Empactis absence management system. They noted the resulting importance of the upcoming business cases, requesting funding for implementation of ESR and digital rostering solutions, which will support workforce efficiency, allow us to comply with NHSEI standards, and meet the requirements needed for roll out of ESR's replacement. However, they noted that there will be many competing needs for funding and prioritisation will be stringent.
- The Committee heard that the role of the Equality, Diversity and Inclusion (ED&I) Lead has been a temporary one which will soon come to an end, with lack of recurrent funding identified for the post. They were concerned that this would result in the Trust only being able to meet its minimum statutory requirements for ED&I and being unable to progress significantly in this area.
- The Committee wished to alert the Board to the ongoing work around the strategic needs assessment and associated ongoing impact assessment. It wished to emphasise the importance of ensuring that all relevant actions required have been identified and that the route for taking forwards and implementing these actions must be clearly identified.

**ASSURE**

- The strategic needs assessment provided assurance in respect of the streams of work which have been identified around wellbeing offers for staff as well as the work which will align WWL with the requirements set out within the NHS People Plan and the People Strategy.
- The Committee noted the progress made on the vacancy trajectory and that this is now more accurate, still to be developed further to allow for a more focussed understanding of the position within each staff group (and possibly division) moving forwards.
- Assurance was noted through the staff story, which was provided by the Daisy Community Midwife, around the service that they provide at WWL. The staff story item continues to be a lynchpin of the Committee by providing a real time snapshot of how services are being run.
- The People Dashboard was well received and noted to be effectively addressing the Committee's requirements. Improvements were noted based on feedback at the last meeting and that this now better aligns to the metrics which are reviewed by the

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| Board.<br>▪ The national staff survey response rate has increased and WWL are now in the middle of the pack in terms of the rate across Greater Manchester for similar sized Trusts in respect of the National People Pledge metrics.<br>▪ The Freedom to Speak Up report continued to provide good assurance around the progress made with the service since it has been outsourced. |
| **ADVISE** |
| ▪ The Talent Management Program was noted to have made progress and to be on the workplan for discussion at the next meeting. It will mitigate some of the risk posed by the high numbers of staff due to retire in the coming years through the creation of succession planning opportunities.<br>▪ The medical workforce plan will be presented to the Committee at the March 2023 meeting.<br>▪ Recruitment processes have been improved through initiatives such as the electronic recruitment system and the shortened application forms and is monitored in terms of 'time to hire' by the Workforce Efficiencies Group.<br>▪ The Committee noted through the Guardian of Safe Working report that junior doctors are experiencing pressures as a result of demand, often resulting in them staying later than they should on shift.<br>▪ The Committee noted the usual workforce audit and risk report. |
| **RISKS DISCUSSED AND NEW RISKS IDENTIFIED** |
| ▪ The Committee noted the significant risks that the workforce directorate faces in respect of the challenge to ascertain funding through the upcoming business planning round, particularly in respect of digital rostering and medical temporary spend.<br>▪ There may be a limiting ability to ensure efficiency both from a workforce and financial perspective, posed by the limit to the resourcing.<br>▪ Risks were discussed in the context of the corporate objectives, as per those outlined through the Board Assurance Framework.<br>▪ The Committee received an update on the ongoing industrial action and the measures in place at WWL to ensure safe care during this period, which will centre around management by both individual Gold Command Groups which have been set up (for both nursing and the ambulance service) and the emergency preparedness and resilience team. WWL's good relationships with trade unions was positively noted. |

# Committee report

| | |
|---|---|
| **Report from:** | Quality and Safety Committee |
| **Date of meeting:** | 14th December 2022 |
| **Chair:** | Francine Thorpe |

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

**ALERT**

- Evidence provided within the reports to the Committee highlighted that the extreme pressures being managed across the Trust are adversely affecting achievement of our corporate objectives.
- Excessive demand within the A&E department resulting in delay in the recognition and treatment of sepsis which is likely to compromise objective C01
- Delay in progressing the necessary improvement work along with system-wide demands that result in End-of-Life patients being admitted will adversely affect achievement of objective C02.
- Staffing pressures within the Division of Medicine mean that the supernumery status of ward leaders is not being achieved, adversely affecting complaints response times which impact objective C05. This is further impacted by an increase in complaints.
- Executive leads for each objective agreed to review and update the associated risks using the BAF prior to the next committee meeting.
- A theme around patients "being lost to follow up" was highlighted within the Serious Incident Report. This is currently being investigated and further information will be provided at the next meeting.
- The Q2 complaints report highlighted a 20% increase in the number of complaints and a 30% increase in the number of concerns raised. The main themes are communication, clinical treatment, appointments, and patient care. Thematic analysis continues to inform improvement work. The Committee receives regular reports at each meeting and will continue to monitor closely.
- The Estates & Facilities divisional spotlight report highlighted delays associated with repair and maintenance of known areas of risk due to high bed occupancy. This is being closely monitored and work undertaken when possible.

**ASSURE**

- A written report provided assurance of mitigating actions being taken to manage results reporting whilst an electronic solution is being progressed. It is expected that this will be implemented in March 2023.

- This report also provided information on actions completed within Gastroenterology and Endoscopy following the deep dive into treatment delays which has resulted in a reduction in incidents being reported.
- Progress against the action plan as a result of the treatment delays deep dive was noted. This will continue to be monitored at Patient Safety Group with any issues being escalated to Q&S as necessary.
- Comparative data about the performance of breast two week wait services across GM was received which demonstrated WWL consistently achieving the required standard.
- The Committee continues to receive information on actions taken to maintain patient safety within the A&E department. It was pleasing to note that the use of Appreciative Enquiry and After-Action Reviews have been introduced to encourage staff to focus on the delivery of good patient care; promoting a positive learning culture.
- Visibility of the executive team within A&E and the ability for staff to escalate specific concerns was identified as a positive factor in maintaining the safety of patients.
- A detailed Harm Free Care (HFC) report was received providing assurance that pressure ulcers, falls and catheter acquired infections are being closely monitored, as well as thematic analysis that is used to inform improvement work. Evidence of an improving picture in relation to training compliance was included as well as promotion of best practice through national awarenss raising campaigns. Slight changes in the numbers of HFC measures were highlighted.
- The complaints report highlighted a number of actions taken following concerns being raised. The level of detail within the report provides assurance of improvements made in response to patient feedback.
- A range of papers relating to maternity services were received including an update on Ockenden actions and a report outlining themes identified within the recent investigation into maternity at East Kent. This was discussed by the Board at our last meeting.
- The Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries Perinatal Surveillance Report was received which provided assurance that the Trust is on track to meet the national ambition to reduce stillbirths by 2025.
- The Q2 Patient Experience report along with a summary of the findings from the national inpatient survey provided assurance that the Trust is seeking out the views of patients from a range of sources and developing actions to address any areas of concern.

**ADVISE**

- The Estates & Facilities Division provided a spotlight report on their key challenges and highlights in relation to quality and safety that included:
  - Good governance processes in place in relation to risk management, incident reporting and triangulation of information
  - Challenges associated with mandatory training for staff
  - Workforce challenges
  - Actions implemented to support the Trust in mitigating risk associated with the clinical waste management contract
- The Q2 Safe Staffing report highlighted a reduction in nursing vacancies (up to end September), however high levels of sickness in some areas which contributed to an increase in reported red flags. Delays in the international recruitment programme were highlighted with the expectation that all posts would be filled by April 2023. The supernumerary status of ward leaders is being monitored; some areas are managing to

maintain this capacity, redeployment of staff to address the current high levels of demand impact negatively on our ability to achieve consistency in this area.

- Both the Harm Free Care Report and the Safe Staffing Report presented were for Q2. The time lag between the data outlined and the situation across the Trust at the time of the meeting should be noted. It is anticipated that quality and safety indicators will continue to deteriorate unless the extreme pressures being managed ease.
- Despite these huge pressures the Trust continues to maintain a clear focus on monitoring a range of quality and safety indicators, identifying risk and mitigating actions where possible. This is evident through the reports received
- During this highly challenging period it is noted that the use of Appreciative Inquiry and After Action reviews being used to encourage staff to focus on and learn from what goes well is a positive move to maintain staff morale.

**RISKS DISCUSSED AND NEW RISKS IDENTIFIED**

- Risks relating to the BAF were discussed and it was acknowledged that there is an increased likelihood of non-acheivement of some of our corporate objectives. Executive leads will review for the next meeting
- No additional risks were highlighted

| | |
|---|---|
| **Title of report:** | Board Assurance Framework (BAF) Report |
| **Presented to:** | The Board |
| **On:** | 1 February 2023 |
| **Presented by:** | Director of Corporate Affairs |
| **Prepared by:** | Head of Risk<br>Director of Corporate Affairs |
| **Contact details:** | E: paul.howard@wwl.nhs.uk |

**Executive summary**

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

**Link to strategy**

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

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

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

**Financial implications**

There are no financial implications associated with this report.

**Legal implications**

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

**People implications**

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

**Wider implications**

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

**Recommendation(s)**

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

## 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 2022/23.

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 reviews the BAF on a bi-monthly basis.

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

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

## 2. BAF Review

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

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 14 December 2022.

2.3 Two new risks have been added since the last Board meeting in December 2022:
- ID 3647: Preferred Place of Death
- ID 3676: Complaint Response Rates

2.4 Control measures have been updated to reflect the following examples of what we've changed together:-

- Reduced the number of pressure ulcers identified as lapses in care by WWL
- Reduced the number of falls with avoidable serious harm
- Improved Acute Kidney Injury (AKI) pathways to ensure that there is no avoidable harm
- Introduced the ASPIRE ward accreditation programme and have already accredited 6 wards as SILVER status
- Introduced Human Factor Training with over 330 staff trained so far

2.5 **People:** The risk scores for *ID3279: Participation in preventative and restorative wellbeing activities* and *ID3283: Personal development* have increased from 12 to 15 since the last Board meeting in December 2022.

2.6 The risk score for *ID3532: Person centred people management* has increased from 9 to 12.

2.7 The increase in people risk scores and the reduction in associated assurance levels are due to the operational pressures and the impact that these pressures are having now and will continue to have for the next few months, meaning releasing staff for training is becoming increasingly more difficult.

2.8 **Performance:** Current risks were reviewed and updated in line with the 2022/23 corporate objectives prior to the F&P Committee meeting on 25 January 2023. There are no new risks to report.

2.9 *ID 3295 Estates Strategy - Capital Funding* has decreased from 12 to 8.

2.10 *ID 3290 Activity not in line with the funding* available has decreased from 16 to 8.

2.11 *ID 3533 Urgent and Emergency Care – Winter Pressures* has increased from 12 to 20.

2.12 **Partnership:** There are no new risks to report.

2.13 ID 3300 Partnership Working - CCG Changes has increased from 6 to 8.

2.14 ID 3299 University Teaching Hospital - Association Criteria has increased from 6 to 8.

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

3.1 *ID 3647: Preferred Place of Death* – risk score of 9.
3.2 ID 3676: Complaint Response Rates – risk score of 10.

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

4.1 No risks have de-escalated or accepted and closed from the BAF since December 2022.

**5. Review Date**

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

**6. Recommendations**

6.1 The Board are asked to:

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

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

# Board assurance framework

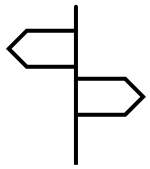
2022/23

The content of this report was last reviewed as follows:

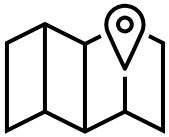
| | |
|---|---|
| Quality and Safety Committee: | December 2022 |
| Finance and Performance Committee: | January 2023 |
| People Committee: | January 2023 |
| Audit Committee: | November 2022 |
| Executive Team: | January 2023 |

> **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

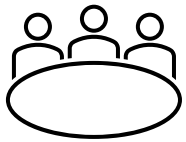


**Strategy:** Our strategy sets out our vision for the next decade, our future direction and what we want to achieve between now and the year 2030. It sets out at a high level how we will achieve our vision, including the areas we will focus our development and improvement, our strategic ambitions and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

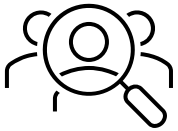


**Corporate objectives:** Each year the Board of Directors agrees a number of corporate objectives which set out in more detail what we plan to achieve. These are specific, measurable, achievable, realistic and timed to ensure that they are capable of being measured and delivered. The corporate objectives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

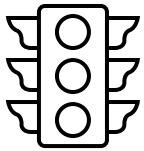
**Board Assurance Framework:** The board assurance framework provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains risks that are most likely to materialise and those that are likely to have 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.<br>1st Line functions that own and manage the risks, 2nd line functions that oversee or specialise in compliance or management of risk,<br>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.<br>Five T's - Terminate, Transfer, Tolerate, Treat, Take the Opportunity. |
| **Monitoring:** | The forum that will monitor completion of the required actions and progress with delivery of the allocated objectives |

# Our approach at a glance

**Our Strategy 2030**



| | |
|---|---|
| **Patients:** | To be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience |
| **People:** | To create an inclusive and people-centred experience at work that enables our WWL family to flourish |
| **Performance:** | To consistently deliver efficient, effective and equitable patient care |
| **Partnerships:** | To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester |

**FY022/23 Corporate Objectives**

## Patients

**We will…**

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

## People

**We will…**

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

## Performance

**We will…**

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

## Partnerships

**We will…**

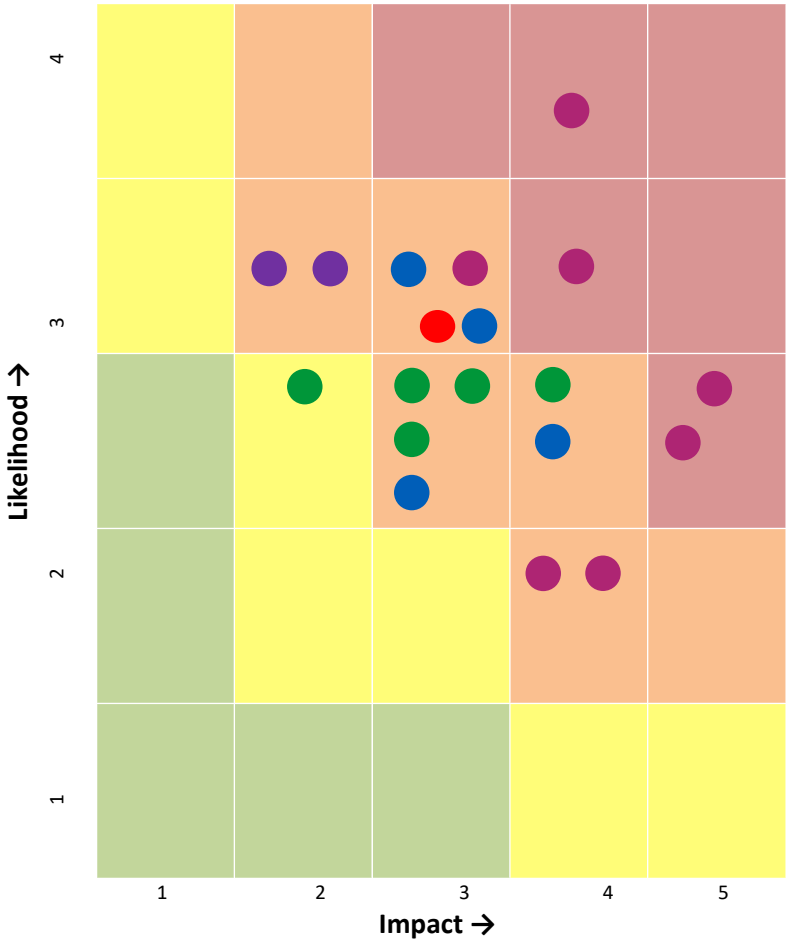
- Positively impact on the social and economic factors of our Borough
- Develop effective relationships within Wigan Borough and Greater Manchester for the benefit of our patients
- Make progress towards becoming a University Teaching Hospital

# Risk management

Our risk appetite position is summarised in the following table:

| Risk category 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 18 strategic risks based on their current scores:




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

# Patients

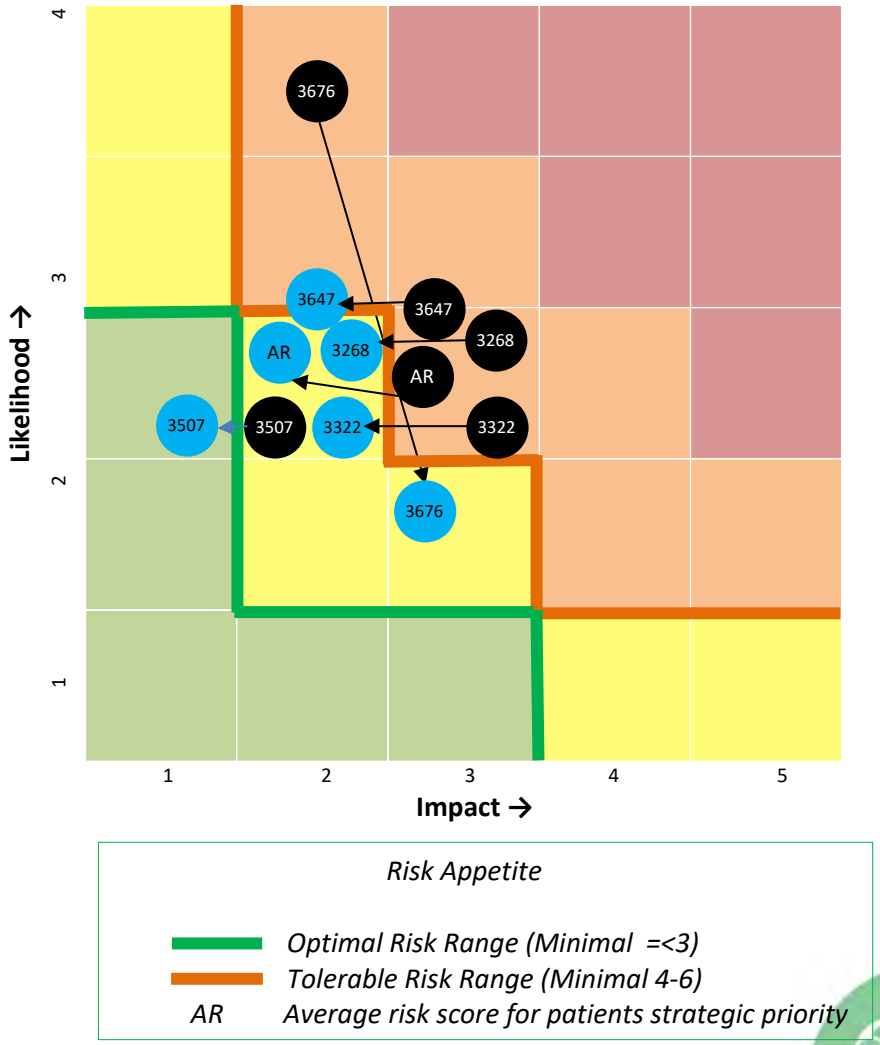
Our ambition is to be widely recognised for delivering safe, personalised and compassionate care, leading to excellent outcomes and patient experience

Monitoring: Quality and Safety Committee

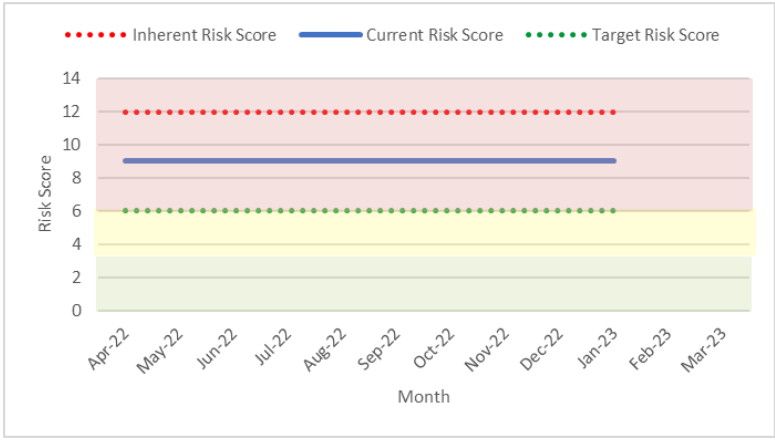
The following corporate objectives are aligned to the **patients** strategic priority:

| 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:

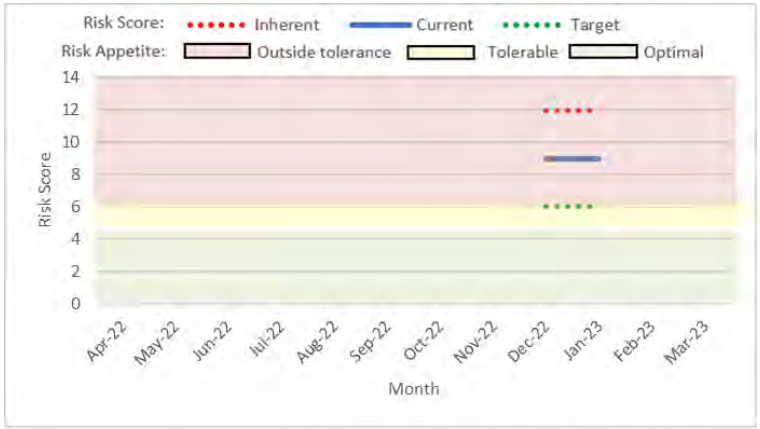


| **Corporate Objective**: **CO1** Improve the safety and quality of clinical services | | | | | | | **Overall Assurance level** | **Low** |
|---|---|---|---|---|---|---|---|---|
| **Principal risk** What could prevent us achieving our strategic objective | **Risk Title:** | **PR 1: Clinical Services - 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** | **23.01.23** | **Risk Rating** | 12. High | 9. High | 6. Moderate | **Risk treatment** | Treat | |



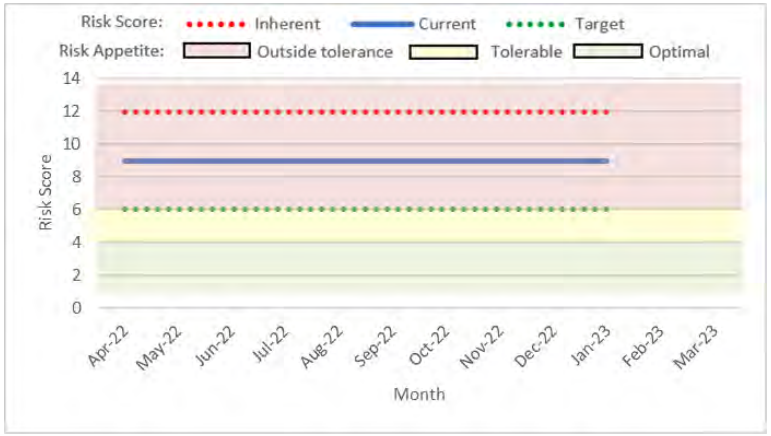

| **Strategic Opportunity / Threat Linked Risk** | **Existing controls** | **Gaps in existing controls** | **Assurances (and date last seen)** | **Gap in assurances** | **Risk Treatment** | **Due Date / By Whom** |
|---|---|---|---|---|---|---|
| **Threat:**<br>**(ID 3268)**<br>3270 – Consultant cross cover from SRFT for AKI service | • This is a dedicated corporate objective for FY2022/23.<br>• Rapid Improvement Group.<br>• Sepsis QI group.<br>• Sepsis Improvement Plan.<br>• Sepsis live in HIS.<br>• Visibility of AKI and Sepsis Nurse in clinical areas<br>• AKI and sepsis audits undertaken.<br>• Themed SIRI panel on sepsis focused on improvement work and highlighted achievements to date.<br>• Improved AKI pathways to ensure that there is no avoidable harm caused by WWL. | • Workload demands for AKI and Sepsis nurses.<br>• AKI Improvement Plan needs to be developed. | **2nd Line:**<br>• Quality & Safety Committee December 2022. | • 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** | **23.01.23** | **Risk Rating** | 12. High | 9. High | 6. Moderate | **Risk treatment** | Treat | | |



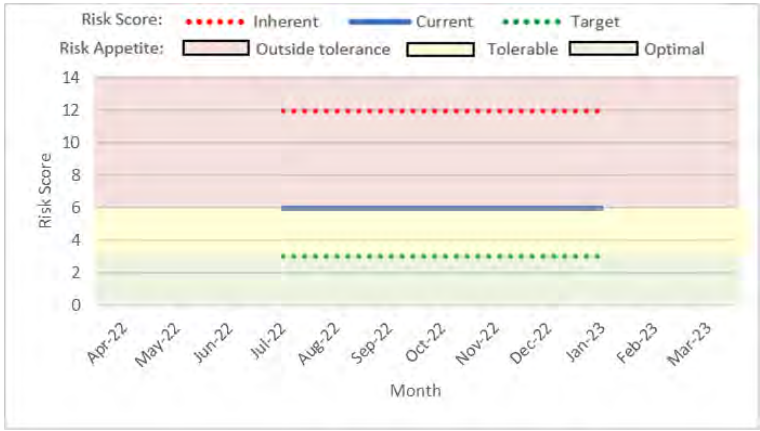

| Opportunity / Threat | Existing controls | Gaps in existing controls | Assurances (and date last seen) | Gap in assurances | Risk Treatment | Due Date / By Whom |
|---|---|---|---|---|---|---|
| **Threat:**<br>**ID 3647** | • Dedicated Palliative Care Hospital team, consisting of clinical and nursing staff and dedicated palliative care lead for community<br>• GM link now live on HIS identifying patients with an advance care directive<br>• Weekly deaths audits which will identify areas of concern<br>• Multi-professional mortality meetings which will address any immediate concerns/learning<br>• Working Group (Acute Trust, Community, Hospice and Primary Care) meeting.<br>• 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<br>• 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<br>• 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. Therefore, 88% patient died at home and 22% in hospital. | • Lack of community resources<br>• Night support for End-of-Life Patients dying at home<br>• Delays in commencing package of care for patients requesting dying at home (ongoing work to develop pathway for dying patients with better at home)<br>• Increased operational pressures across all teams<br>• Recovery phase following COVID | **2nd Line:**<br>Working Group (Acute Trust, Community, Hospice and Primary Care) meeting.<br>• Quality & Safety Committee December 2022. | • Progression of working group<br>• Additional audit to be commissioned looking at the appropriate use of EPaCCS to be completed by Community Palliative Care Lead<br>• Some patients are reluctant to discuss preferred place of death and therefore this information is not available for healthcare professionals at EOL stage<br>• 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** | **23.01.23** | **Risk Rating** | 12. High | 9. High | 6. Moderate | **Risk treatment** | Treat | | |



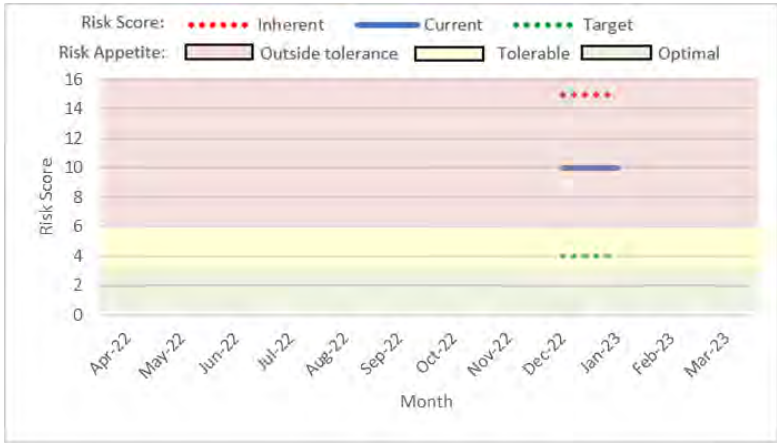

| Strategic Opportunity / Threat Linked risk | Existing controls | Gaps in existing controls | Assurances (and date) | Gap in assurances | Risk Treatment | Due Date / By Whom |
|---|---|---|---|---|---|---|
| **Threat:**<br>**(ID 3322)**<br><br>3323 – Tissue viability team capacity | • Pressure ulcer link nurses trained within areas.<br>• Introduced human factors training with over 330 staff trained so far.<br>• Grade 2/DTI Pressure ulcer Panels in place.<br>• Grade 3/4 & Unstageable Pressure ulcer panels in place.<br>• New pressure ulcer rapid Review template launched for pressure ulcers.<br>• New Pressure ulcer policy and procedure.<br>• Datix improvements started to better capture pressure ulcer management.<br>• Reduced number of pressure ulcers identified as lapses in care by WWL. | • Staff being able to be released to undergo training.<br>• Junior workforce.<br>• Investigation of developed ulcers are not investigated to a level to allow for full identification of learning.<br>• Equipment issues.<br>• Beds owned by individual Divisions.<br>• Under resourcing of Tissue Viability Team. | **2nd Line:**<br>• Quality & Safety Committee December 2022 | • No gaps currently identified. | 1. Harm Free Care Business Case to be drafted.<br>2. Continue to accurately record NEWS, PEWS and MEWS.<br>3. Continue the roll out of human factor training. | March 2023 CN<br>March 2023 CN<br>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** | **23.01.23** | **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:**<br>**(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:**<br>• Quality & Safety Committee December 2022 | **2nd Line:**<br>• 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<br>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. Likely | 5. Likely | 2. Rare | **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** | **24.01.23** | **Risk Rating** | 15. Significant | 10. High | 4. 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:**<br>**(ID 3676)** | • Complaints SOP in place with defined roles, processes and timescales.<br>• How to respond to a complaint training is being delivered with further sessions planned.<br>• Patient relations team provide support and guidance. | • Releasing staff to attend training. | **2nd Line:**<br>• Quality & Safety Committee December 2022 | **2nd Line:**<br>• Objective will not be met within current financial year. | 1. Complaints backlog to be addressed.<br>2. Further training for staff to be arranged with staff given time to attend the training. | April 2023 CN<br>April 2023 CN |

# People

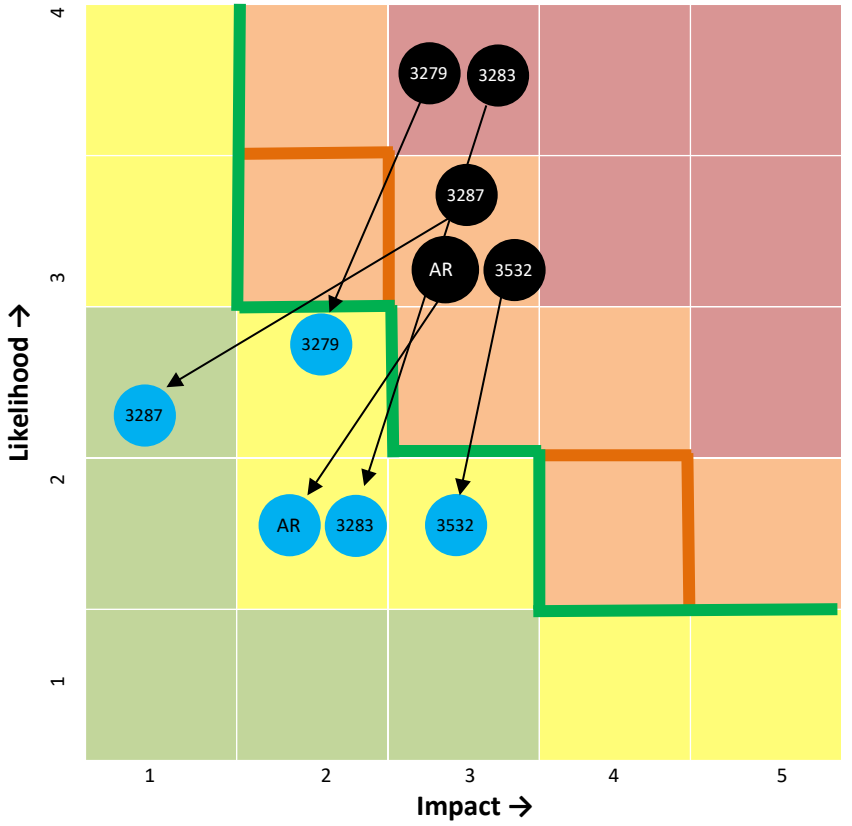
To create an inclusive and people-centred experience at work that enables our WWL family to flourish

Monitoring: People Committee

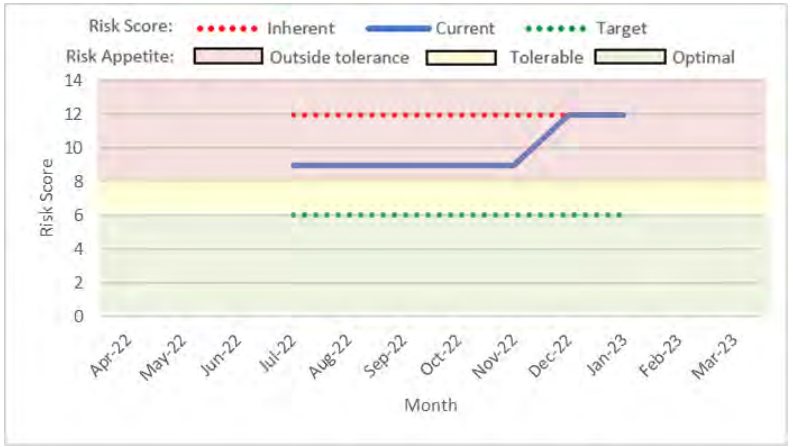
The following corporate objectives are aligned to the **people** strategic priority:

| 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:

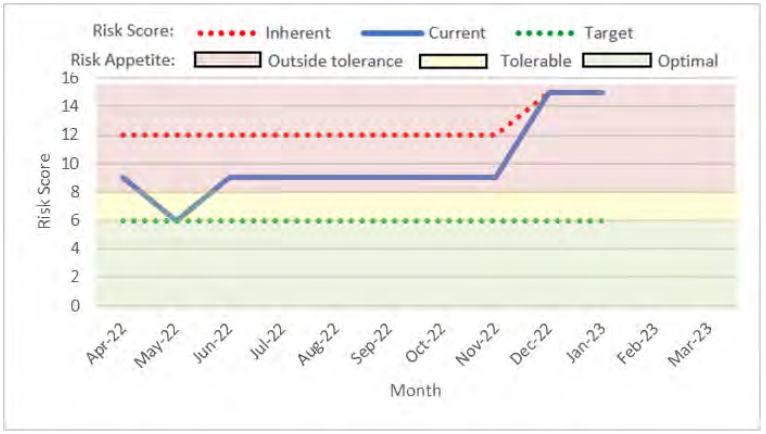


| **Corporate Objective: CO6** Make working at WWL a positive experience, where everyone has a voice that matters | | | | | | | **Overall Assurance Level** | **Medium** |
|---|---|---|---|---|---|---|---|---|
| **Principal risk** What could prevent us achieving our strategic objective | **Risk Title:** | **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** | ID 3572 | |
| **Date of last review** | **19.12.22** | **Risk Rating** | 12. High | 12. High | 6. Moderate | **Risk treatment** | Treat | |



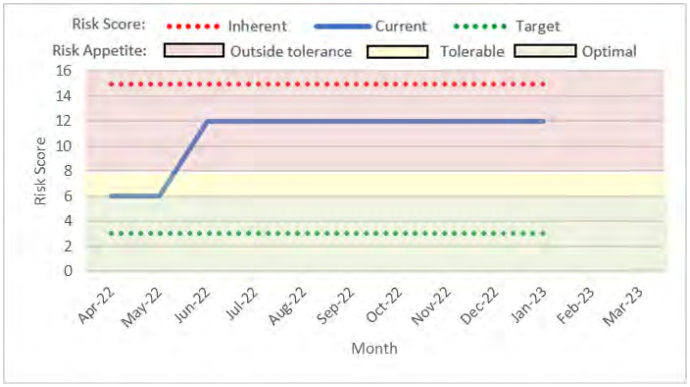

| Strategic Opportunity / Threat | Existing controls | Gaps in existing controls | Assurances (and date) | Gap in assurances | Risk Treatment | Due Date / By Whom |
|---|---|---|---|---|---|---|
| **Threat:**<br>**ID 3532**<br><br>**Linked risk**<br>**3572** Industrial action | • Civility and behaviour framework<br>• Just & learning culture protocol<br>• Divisional HR support<br>• Disciplinary triage panel<br>• Supernumerary ward leaders business case | • HR policy review – person centred policies<br>• Full line manager & HR training programme – people centred people management. | • Feedback from line manager listening sessions (July)<br>• ETM paper (August) – people management training proposal<br>• Just culture & civility training programme place allocation (ETM September 2022)<br>• Verbal update on just & learning culture training roll out – Our FFF Culture Group (October 2022)<br>• Our FFF culture group (November 2022) - highlighting how culture programme learning is being embedded into day to day activities.<br>• Safe staffing report – ward leaders status (Q&S & ETM – November / December 2022) | None identified. | 1. WWL HR policy handbook development (completed in partnership)<br>2. NW well-being and attendance management policy<br>3. NW well-being and attendance management leadership development<br>4. Development of WWL training programme – HR team, staff side & line managers for roll out in 2023/24<br>5. Agree delivery methodology for the roll out of just & learning culture training (as part of people leaders training and at induction)<br>6. Corporate induction review and departments to develop comprehensive and supportive local induction packages, based on learning from positive and negative experiences<br>7. Supernumerary ward leaders – ensure not included in the numbers | 1. March 2023 – Strategic HR Lead<br>2. January 2023 – NW HRDs<br>3. March 2023 – NW HRDs<br>4. March 2023 – Strategic HR Lead<br>5. January 2023 – Associate Director of Employee experience & well-being<br>6. March 2023 – Associate Director of staff experience & departmental leads<br>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. Likely | 5. Likely | 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** | **19.12.22** | **Risk Rating** | 15. High | 15. High | 6. Moderate | **Risk treatment** | Treat | |



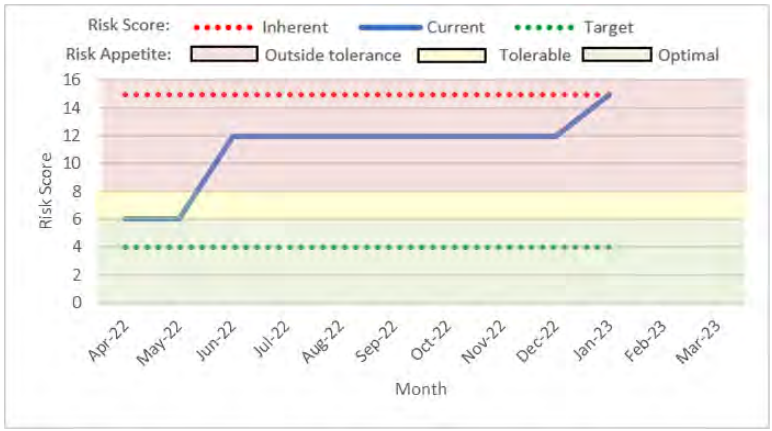

| Strategic Opportunity / Threat | Existing controls | Gaps in existing controls | Assurances (and date) | Gap in assurances | Risk Treatment | Due Date / By Whom |
|---|---|---|---|---|---|---|
| **Threat:**<br>**ID 3279** | • Your Voice Survey – well-being score.<br>• Steps 4 Wellness Service enhancements.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

| **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** | **19.12.22** | **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:**<br>**ID 3287**<br><br>3231- Culture of psychological safety, civility and compassionate leadership | • Workforce EDI specialist recruited (fixed term contract until January 2023).<br>• EDI strategy approved.<br>• Expanded staff networks supported. Training in place for network sponsors and EDI Champions.<br>• 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.<br>• Workforce EDI objectives (People Committee – June 2022).<br>• EDI workshop - October 2022<br>• EDI ER deep dive report (People Committee October 2022)<br>• EDI workshop for leadership (31/11/22)<br>• Trust Board EDI training (2/11/22)<br>• EDI strategy implementation plan (ETM 17/11/2022)<br>• EDI implementation plan approved – risk with business case recognised (People Committee December 2022)<br>• EDI staff networks staff story (People Committee December 2022)<br>**3rd line**<br>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.<br>• Workforce and leadership awareness of EDI and associated responsibilities | 1. Embed colleague diversity networks.<br>2. Gap analyses and action plans from the three assessments.<br>3. Review shadow running of EDS 3 (2022) process in 2022-23.<br>4. Awareness and engagement programme for all (with specific focus on leadership EDI responsibilities) – Board training & senior leaders workshop.<br>5. EDI workforce objectives delivery.<br>6. Business case / business planning process regarding Workforce EDI specialist role.<br>7. EDI corporate objective cascade to all senior leaders. | 1. Complete<br>2. Complete<br>3. Complete<br>4. Complete<br>5. Workforce EDI lead -March 2023<br>In year resolved.<br>6. Substantive business case CPO –October 2022 _ completed. Subject to approval in business planning (December 2022 / January 2023)<br>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** | **19.12.22** | **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:**<br>**ID 3283** | • Full LNA completed and prioritised.<br>• Mandatory and job specific training requirements reviewed and updated.<br>• Agreed principles of apprenticeship and HEE funding allocations first. | • Ability to roll forward HEE funding allocations.<br>• Ability to release staff due to vacancies / workload pressures.<br>• Recurrent budget for training & development aligned to LNA. | **2nd Line:**<br>• ETM review and in principle (LNA and apprenticeship plan) – May 2022<br>• People Committee report – June 2022<br>• HEE CPD investment schedule (Education Governance -July)<br>• 2022/23 LNA business case (ETM September) | None identified. | 1. Business case to deliver 2022-23 LNA.- further analysis with finance and staff group and divisional leads – build into business planning<br>2. Benchmarking review of nurse staffing establishment uplift to cover time for training.<br>3. Recurrent budget setting principles to be agreed as part of annual business planning round.<br>4. Bi-annual staffing review and matching patient acuity / flow with staffing establishment | 1. January 2023 (aligned to business planning timeline) – CPO<br>2.TBC – CNO<br>3. January 2023 (aligned to business planning timeline<br>4. March 2023 - CNO |

# Performance

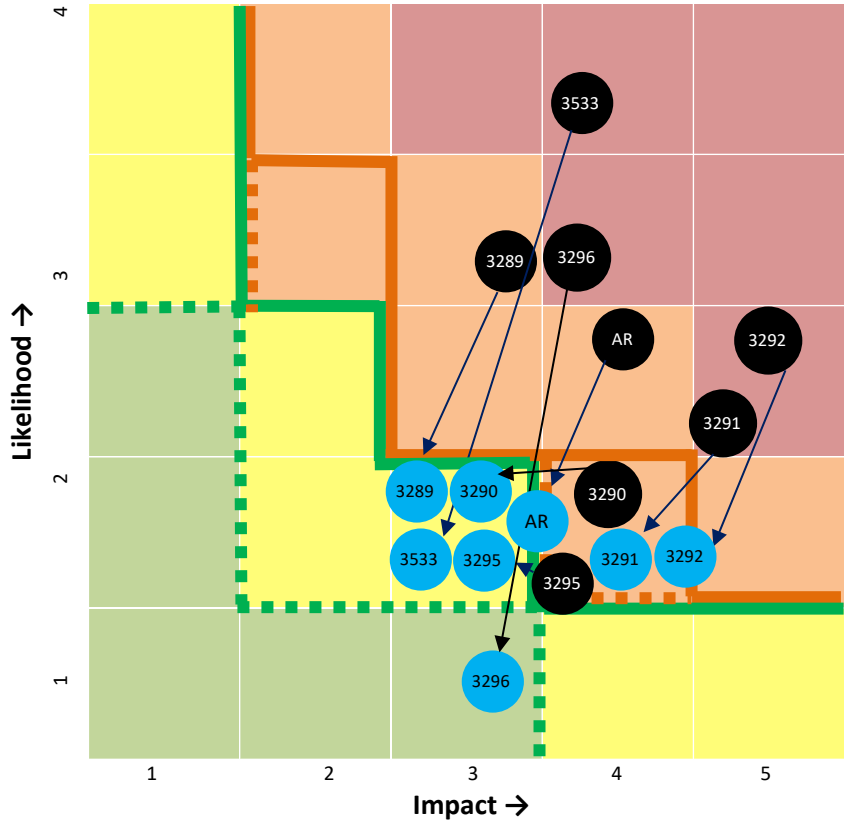
Our ambition is to consistently deliver efficient, effective and equitable patient care

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:<br>• Eradicating 104 week waits by the end of June 2022 (unless patients have chosen to wait longer). *Action Completed.*<br>• Eliminate 78 weeks wait by end of March 2023<br>• Increase elective activity delivered to 110% of the 2019/20 baseline (104% by value). Trust plan to deliver 103% baseline activity<br>• 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:



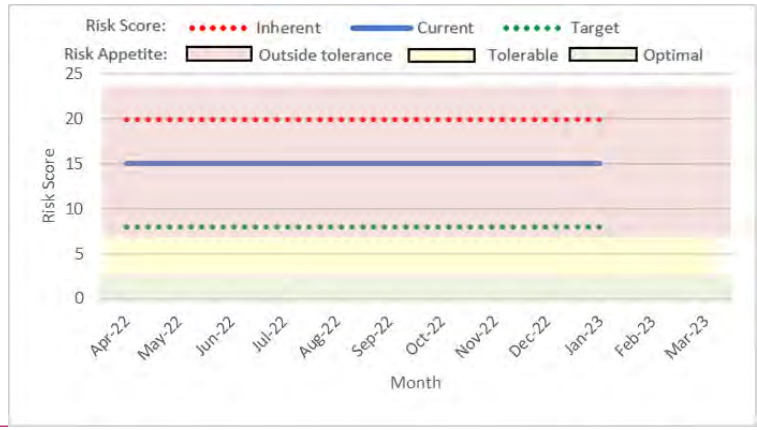

*Risk Appetite*

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

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

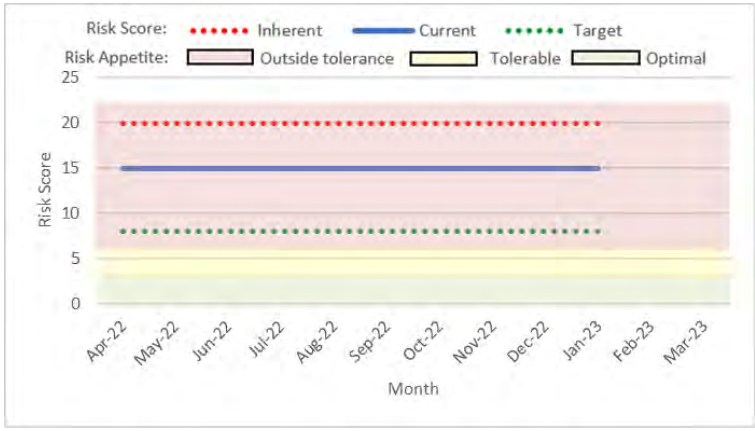
*AR Average risk score for performance strategic priority*

| **Corporate Objective**: **C10** Deliver our financial plan, providing value for money services | | | | | | | **Overall Assurance level** | **Medium** |
|---|---|---|---|---|---|---|---|---|
| **Principal risk** What could prevent us achieving our strategic | **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 | 3. Possible | 2. Unlikely | **Risk category** | Financial Duties | |
| **Date risk opened** | **19.10.21** | **Impact** | 5. Critical | 5. Critical | 4. Major | **Linked risks** | - | |
| **Date of last review** | **23.01.23** | **Risk Rating** | 20. Significant | 15. Significant | 8. High | **Risk treatment** | Treat | |



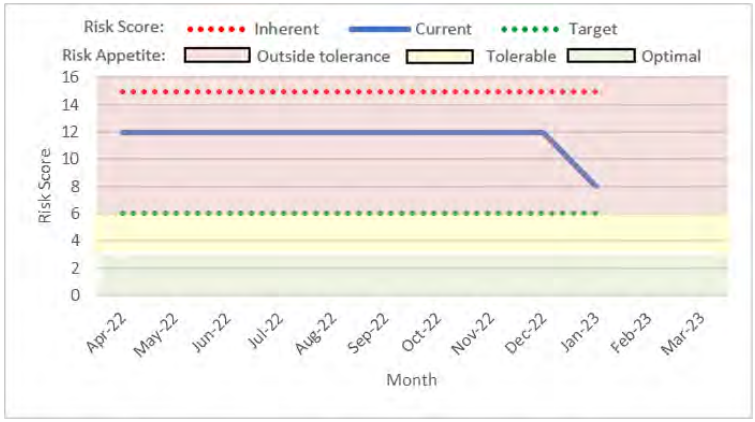

| Strategic Opportunity / Threat | Existing controls | Gaps in existing controls | Assurances (and date) | Gap in assurances | Risk Treatment | Due Date / By Whom |
|---|---|---|---|---|---|---|
| **Threat:**<br>**(ID 3292)** | • Final plan signed off by Board and submitted to NHSEI - 20th June 2022<br>• CIP target agreed with programme for delivery and actions.<br>• Continued lobbying via Greater Manchester in respect of additional funding which is appropriate for current clinical capacity and operational and inflationary pressures (Ext.)<br>• Robust forecasting including scenario planning for worst, most likely and best case<br>• Executive oversight and challenge of CIP & Financial performance through RAPID & Divisional Assurance Meeting<br>• Pay control group established with scrutiny and rigour over agency spend in line with national agency controls<br>• Stringent business case criteria to ensure only business critical investments are approved<br>• Financial Recovery Plan approved by Board Nov 22<br>• ICS Financial Recovery processes underway to improve GM financial position by end of year<br>• FRP meetings held between ICS and WWL CEO and CFO Jan 23.<br>• Forecast for covid spend agreed through Divisional Assurance Meetings with budget adjusted to reflect improvements<br>• HFMA Financial Sustainability: Getting the Basics Right review independently assessed by MIAA with specific actions identified<br>• Operational planning guidance for 23/24 received 23rd Dec 22 | • System and locality reporting in infancy<br>• No additional funding received for NRTR, additional beds and escalation<br>• Awaiting 23/24 detailed finance and contract guidance and the impact on GM contract mechanisms, potential penalties and expected financial envelope. | **1st Line:**<br>Monthly RAPID meetings for applicable divisions<br>**2nd Line:**<br>Finance & Performance Committee January 2023 | • Operational pressures causing some RAPID meetings to be stood down for month 8. | 1. RAPID meetings to be scheduled on less operationally pressured days<br>2. Locality discussions ongoing around additional winter funding, capacity funding and discharge funding to support NRTR, JHRU, escalation areas, etc.<br>3. Discussions with ICS ongoing around support required to deliver agreed I&E position | End Jan 23<br>CFO/DCEO<br>Mar 23<br>CFO/CEO<br>Mar 23<br>CFO |

| **Corporate Objective**: **C10** Deliver our financial plan, providing value for money services | | | | | | | | **Overall Assurance level** | **Medium** |
|---|---|---|---|---|---|---|---|---|---|
| **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 | 3. Possible | 2. Unlikely | **Risk category** | Financial Duties | | |
| **Date risk opened** | **19.10.21** | **Impact** | 5. Critical | 5. Critical | 4. Major | **Linked risks** | - | | |
| **Date of last review** | **23.01.23** | **Risk Rating** | 20. Significant | 15. Significant | 8. High | **Risk treatment** | Treat | | |



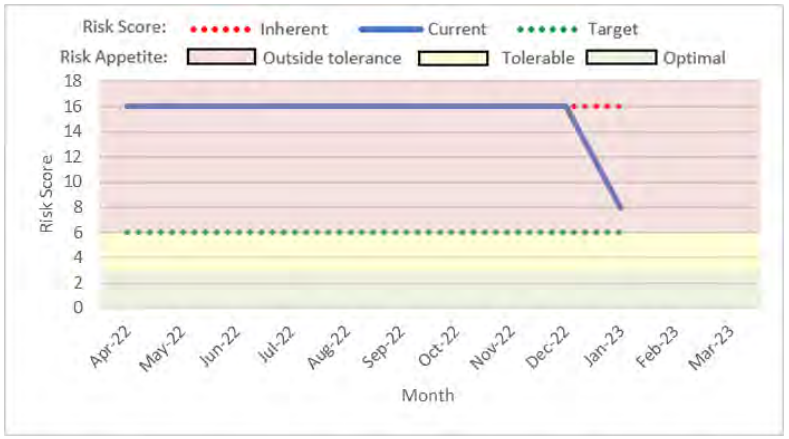

| Strategic Opportunity / Threat | Existing controls | Gaps in existing controls | Assurances (and date) | Gap in assurances | Risk Treatment | Due Date / By Whom |
|---|---|---|---|---|---|---|
| **Threat:** **(ID 3291)** | • Revised CIP delivery approach following review by Mersey Internal Audit Agency.<br>• Monitored via Divisional Assurance Meetings, with additional escalation through RAPID if Divisional delivery is off plan.<br>• Further oversight at Executive Team, F&P Committee and Board of Directors.<br>• Work is ongoing across the GM system on developing a joint approach to productivity and cross cutting efficiency (Ext).<br>• Transformation Board input & oversight of strategic programmes.<br>• Effective credit control including monitoring debtor and creditor days and liquidity with oversight through SFT.<br>• Effective monthly cash flow forecasting reviewed through SFT<br>• In year CIP target forecast to be delivered<br>• RAPID recovery metrics updated in Q3 to include recurrent CIP delivery | • High proportion of CIP is non recurrent and non-cash releasing<br>• High proportion of CIP is transactional<br>• Mechanisms to facilitate delivery of system wide savings<br>• High proportion of non-recurrent measures including balance sheet have been utilised to support the financial position | **1st Line:**<br>Monthly RAPID meetings for applicable divisions<br><br>**2nd Line:**<br>Finance & Performance Committee January 2023 | • Operational pressures causing some RAPID meetings to be stood down for month 8. | 1. Monthly updates on CIP presented to Executive Team, with regular updates to Divisional Teams through<br>2. Engagement in GM Efficiency Programme work including productivity workstream co-chaired by WWL Deputy CEO (Ext)<br>3. Early planning for 2023/24 CIP in recognition of high level of non recurrent CIP in 22/23<br>4. RAPID metrics to be updated for Q4 to include a focus on 23/24 planning | March 2023 CFO/DCEO<br>March 2023 CFO/DCEO<br>March 2023 CFO/DCEO<br>March 2023 CFO/DCEO |

| **Corporate Objective: C10** Deliver our financial plan, providing value for money services | | | | | | | | **Overall Assurance level** | **Medium** |
|---|---|---|---|---|---|---|---|---|---|
| **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. Rare | 2. Rare | **Risk category** | Financial Duties | | |
| **Date risk opened** | **19.10.21** | **Impact** | 5. Critical | 4. Major | 3. Moderate | **Linked risks** | - | | |
| **Date of last review** | **23.01.23** | **Risk Rating** | 15. Significant | 8. High | 6. Moderate | **Risk treatment** | Treat | | |



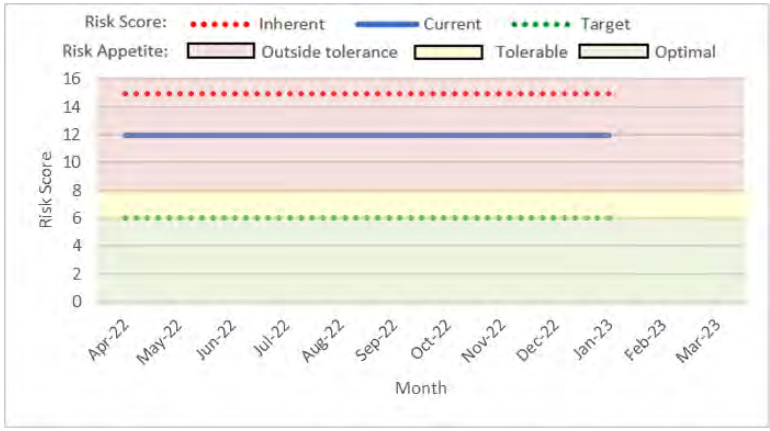

| Strategic Opportunity / Threat | Existing controls | Gaps in existing controls | Assurances (and date) | Gap in assurances | Risk Treatment | Due Date / By Whom |
|---|---|---|---|---|---|---|
| **Threat:**<br><br>**(ID 3295)** | • Lobbying via Greater Manchester (Ext).<br>• Capital Priorities agreed by Executive Team & Trust Board.<br>• Cash for Capital investments identified.<br>• Bids formally approved for centrally funded Community Diagnostic Centre and TIF Additional theatre at Leigh Hospital and MOU's received.<br>• Reprioritisation of additional capital schemes to ensure the capital programme is reflective of organisational priorities<br>• 3 year capital allocations available to inform more longer term system planning<br>• Strategic capital group established with oversight of full capital programme<br>• Capital plan forecast to deliver in full<br>• Programme Boards established for major capital schemes – CDC & Leigh Theatre.<br>• Weekly GM capital planning group with provider leads closely monitoring ICS capital position and forecast<br>• Received notification of formal approval of frontline digitalisation and approved to progress at risk<br>• Initial work started to look at allocation of 23/24 CDEL across GM providers | • Impact of cost of living rise in terms of project costs and timescales<br><br>• Delays in receiving MOU for Frontline Digitalisation<br><br>• No confirmation of 23/24 CDEL allocations and significant demand for capital across GM | **1st Line:**<br><br>Monthly Capital Strategy Group<br><br>**2nd Line:**<br><br>Finance & Performance Committee - January 2023 | • No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk. | 1. Close monitoring of Capital spend in line with trajectory<br><br>2. Development of capital reporting through the refreshed DFM App | March 2023 CFO<br><br>Q4 CFO |

| Corporate Objective: C10 Deliver our financial plan, providing value for money services | | | | | | | Overall Assurance level | Medium |
|---|---|---|---|---|---|---|---|---|
| **Principal risk** What could prevent us achieving our strategic objective | **Risk Title:** | **PR 13: Activity not in line with the funding available** | | | | | | |
| | **Risk Statement:** | There is a risk that the cost of delivering activity exceeds the funding available because we have to use additional bank/agency or independent sector provision, or we are unable to access ERF funding if we exceed our trajectory. If the activity plan is not achieved it could result in clawback of ERF monies already received. | | | | | | |
| **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** | 4. Major | 4. Major | 3. Moderate | 3. Moderate | - | |
| **Date of last review** | **23.01.23** | **Risk Rating** | 16. Significant | 8. High | 6. Moderate | **Risk treatment** | Treat | |



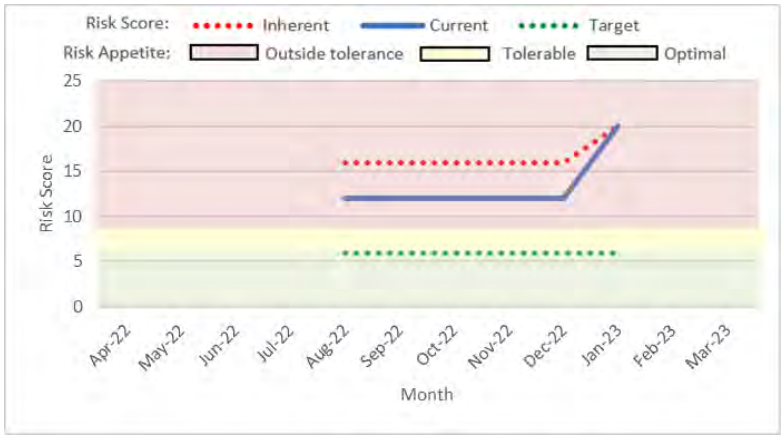

| Strategic Opportunity / Threat | Existing controls | Gaps in existing controls | Assurances (and date) | Gap in assurances | Risk Treatment | Due Date / By Whom |
|---|---|---|---|---|---|---|
| **Threat:** **(ID 3290)** | • The financial plan agreed triangulates with the activity plan.<br>• GM Elective Recovery Reform Group in place with two programmes of work; (1) capacity and demand across GM and (2) reform. Deputy Chief Executive attends for WWL. (Ext.)<br>• Continuing to access independent provider capacity.<br>• Financial reporting webinar (M6) stated there is no intention for NHSE to clawback ERF from ICB's | •Activity is below plan - no formal confirmation that there will be no clawback of ERF for underachievement of the electivity activity plan | **2nd Line:**<br>• Finance & Performance Committee January 2023 | • No gaps currently identified - processes and procedures are in place to support mitigation of the strategic risk. | 1. Follow the national guidance to assume no clawback of ERF funding unless told otherwise. | March 2023<br>CFO |

| **Corporate Objective**: **CO11** To minimise harm to patients through delivery of our elective recovery plan | | | | | | | **Overall Assurance level** | **Medium** |
|---|---|---|---|---|---|---|---|---|
| **Principal risk** What could prevent us achieving our strategic objective | **Risk Title:** | **PR 14: 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 presented by covid, workforce and IPC measures, increase in cancer referrals, discharge 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 | 4. Likely | 2. Unlikely | **Risk category** | Performance Targets | |
| **Date risk opened** | **19.10.21** | **Impact** | 3. Moderate | 3. Moderate | 3. Moderate | **Linked risks IDs** | 3136,3432, 3020,3360 | |
| **Date of last review** | **23.01.23** | **Risk Rating** | 15. Significant | 12. High | 6. Moderate | **Risk treatment** | Treat | |



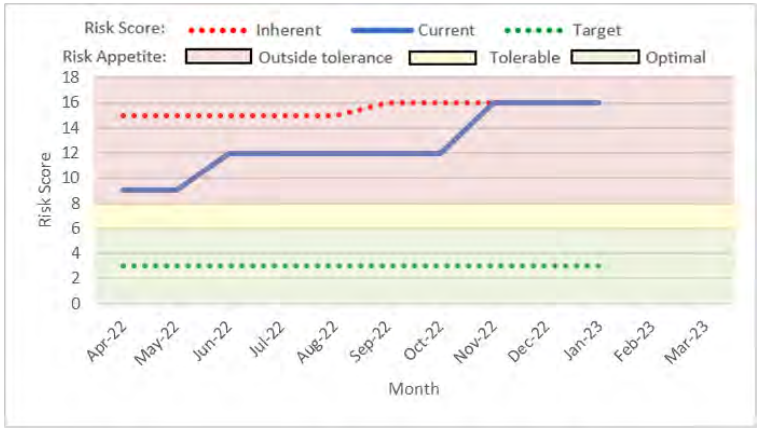

| Opportunity / Threat Linked Risks | Existing controls | Gaps in existing controls | Assurances (and date) | Gap in assurances | Risk Treatment | Due Date / By Whom |
|---|---|---|---|---|---|---|
| **Threat:** **(ID 3289)** **3136** Symptomatic breast imaging waiting times<br><br>**3432**Counselling waiting times<br><br>**3020** Waiting list Dermatology<br><br>**3572** Industrial action | • Robust winter plan in place<br>• Working with partners in the Wigan Borough to tackle pressures.<br>• Achieved 104 weeks by June 2022 and we are on track to deliver 78 weeks by March 2023.<br>• Elective Recovery Plan excelling at Wrightington site.<br>• Wrightington discharge lounge and community assessment units up and running.<br>• Stepped down selective elective care to support urgent care and we continue to do this to support during industrial action.<br>• Streamlining referral process from hospital to out of hospital colleagues. Transformation work to reduce admin burden to slicker services<br>• Community Diagnostic Centre at Leigh Infirmary.<br>• Currently on track for cancer waiting times.<br>• National waiting list guidance - Text reminder service switched on with digital facility to electronically validate appointments. | • 78 week wait to be addressed.<br>• Increase in cancer referral rate.<br>• Lack of capacity to undertake reviews of allocated risk stratification across all specialties.<br>• 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.<br>• 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.<br>• Late repatriations from the independent sector.<br>• National IPC guidance to open up capacity. | **2nd Line:**<br>• Finance & Performance Committee January 2023.<br>• WWL Winter Plan session August 2022 | • No gaps in assurance -currently 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.<br><br>2. Continue with actions applied to improve 52 week position.<br><br>3. Monitor number of P2 on the waiting list through Financial and Performance Report<br><br>4.Monitor number of no right to reside patients - see PR15: Urgent and Emergency Care – Winter Pressures | March 2023<br>DCE<br><br>March 2023<br>DCE<br>Bi-monthly<br>DCE<br><br>Bi-monthly<br>DCE |

| **Corporate Objective: CO12** Improve the responsiveness of urgent and emergency care | | | | | | | **Overall Assurance level** | **Low** |
|---|---|---|---|---|---|---|---|---|
| **Principal risk** What could prevent us achieving our strategic objective | **Risk Title:** | **PR 15: Urgent and Emergency Care – Winter Pressures** | | | | | | |
| | **Risk Statement:** | There is a risk to urgent and emergency care delivery over the winter period, 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** | 5. Almost certain | 5. Almost certain | 2. Unlikely | **Risk category** | Performance Targets | |
| **Date risk opened** | **05.09.22** | **Impact** | 4. Major | 4. Major | 3. Moderate | **Linked risks IDs** | 3500, 3423 | |
| **Date of last review** | **23.01.23** | **Risk Rating** | 20. Significant | 20. 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:**<br>**(ID 3533)**<br>**3500**<br>Prolonged stay in the ED waiting room<br>**3423**<br>ED – Increase in attendances and insufficient patient flow | • **Worst Case Scenario Planning -** Risk stratification – treating in clinical priority order and long waits.<br>• Winter plan signed off with desktop exercises undertaken.<br>• **Additional Capacity** – Local authority commissioning of 10 complex beds delayed from December to February 2023.<br>• 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.<br>• **Admission avoidance** - virtual hub, same day emergency care (SDEC), falls pilot with NWAS.<br>• Cohorting of no right to reside patients.<br>• Part of national hospital only discharge programme.<br>• Safe havens to safely de-escalate A&E<br>• GMMH – urgent care centre due to be commissioned in February 2023.<br>• Fortnightly A&E drop in sessions.<br>• Wellbeing and resilience - 150 dedicated wellbeing champions delivering Steps4Wellness programme.<br>• Daily system escalation calls. | • 12 hour wait not improving.<br>• Delayed ambulance turnover times.<br>• Number of no rights to reside are not improving. | **1st Line:**<br>• Sickness and turnover monitored at divisional assurance meetings.<br>• Safe staffing reports.<br>**2nd Line:**<br>• WWL Winter Plan session – December 2022<br>• 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 patients by 20% and reduce 12 hour waits.<br>2. Communicate Winter Plan focussing on risk stratification, additional capacity and admission avoidance to reduce 12 hour waits in the Emergency Department. | March 2023<br>DCE<br>March 2023<br>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 16: 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** | **CPO** | **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** | **19.12.22** | **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:**<br>**(ID 3296)** | • Sustainability Manager in post. Recruited band 4 support (not yet in post).<br>• Greener WWL comms commenced, supported by recruiting to the Ambassadors programme.<br>• Third party commissioned to complete baseline assessment, develop prioritised investment plan, Net Zero Strategy and update the Trust's Green Plan.<br>• Net Zero and sustainability e-learning programme.<br>• Bidding strategy has been developed with a view to securing Public Sector Decarbonisation Scheme (PSDS) funding. | • Baseline emissions assessment<br>• Prioritised action and investment plan<br>• Climate Change Adaptation plan<br>• Sustainable Travel Plan<br>• Comms and Engagement strategy<br>• Sustainability Impact Assessment<br>• Capital funds should PSDS not be secured | **2nd Line:**<br>• Finance & Performance Committee January 2023.<br>• Surgery Audit Day based around sustainability<br>Bid submitted to Salix Low Carbon Skills Fund 14/06/22 to enable bid to PSDS.<br>• Ricardo progress briefing (ETM Sept 2022)<br>• Business planning process commenced<br>• 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.<br>• Investment schedule aligned to capital programme (based on Ricardo outputs) | 1. Complete baseline assessment.<br>2. Supply chain Net Zero review (national, regional & local).<br>3. Green prescribing plan.<br>4. Sustainability and Net zero to be included in business planning process for 2023-24.<br>5. Estates Net Zero High level Investment Plan to be shared at ETM for prioritisation discussion | 1 Ricardo – December 2022 - complete<br>2 Associate Director of Procurement – TBC awaiting national direction<br>3 Chief Pharmacist – TBC awaiting national direction<br>4 Director of Strategy – December 2022 - complete<br>5 Net Zero Lead – March 2023 |

# Partnerships

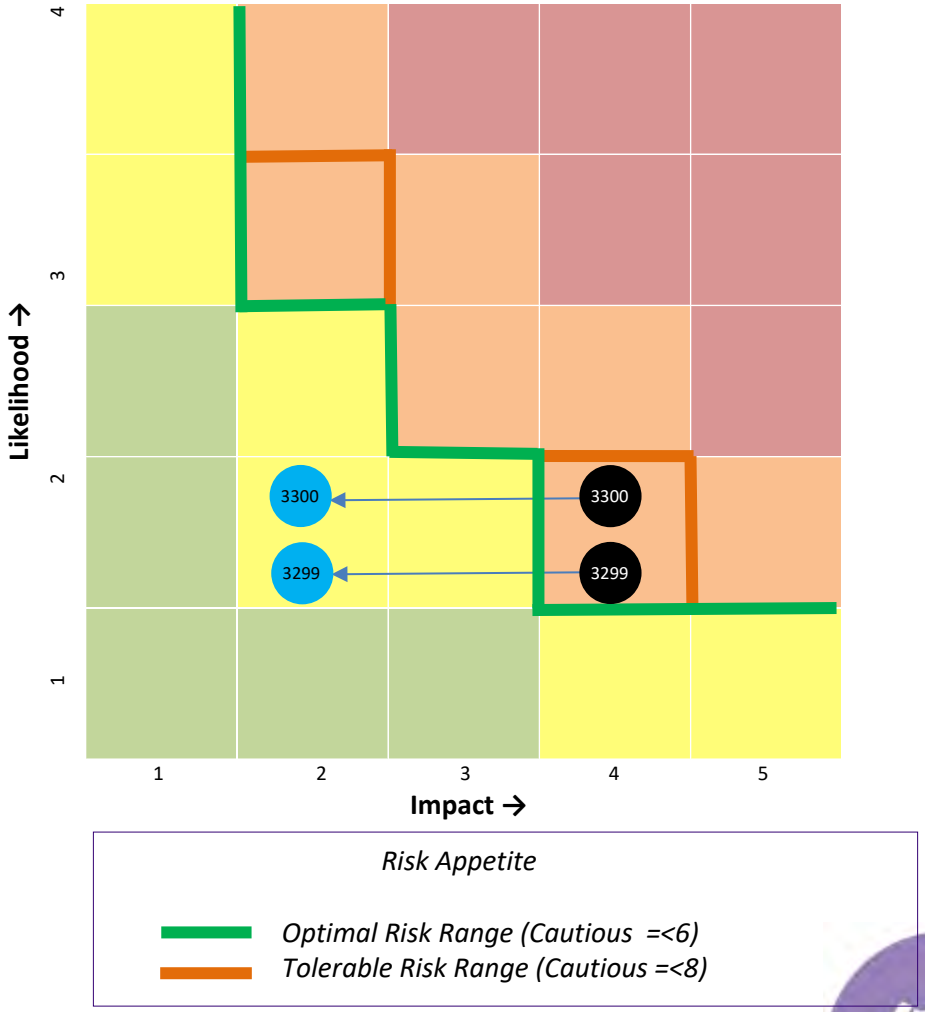
To improve the lives of our community, working with our partners across the Wigan Borough and Greater Manchester

Monitoring: Board of Directors

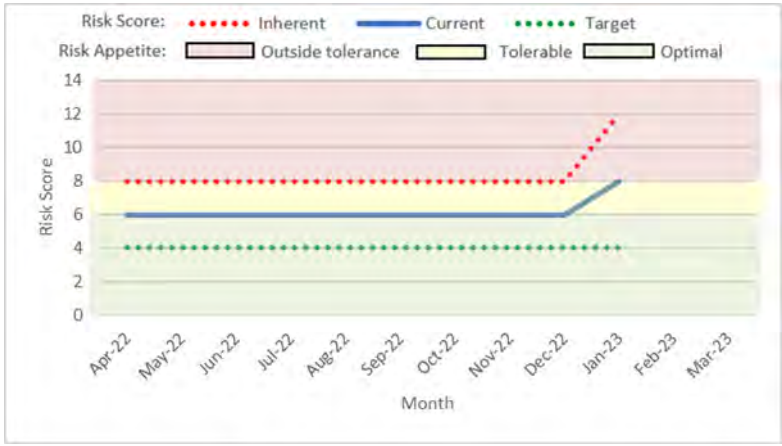
The following objectives are aligned to the **partnerships** strategic priority:

| 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:

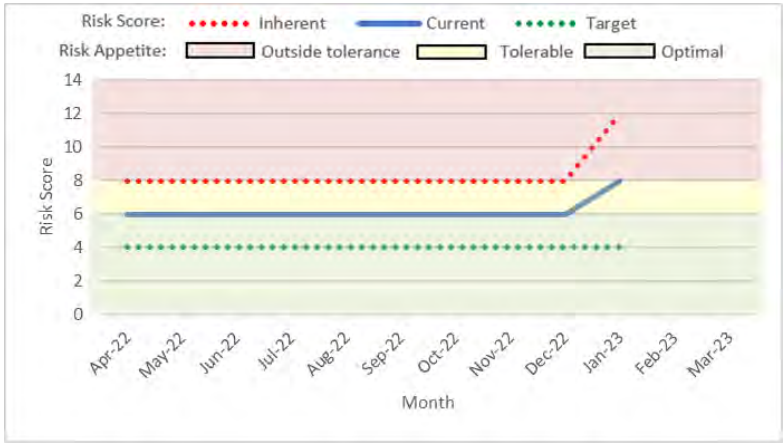


| **Corporate Objective**: **CO15** Develop effective relationships within Wigan Borough and Greater Manchester for the benefit of our patients | | | | | | | **Overall Assurance level** | **Medium** |
|---|---|---|---|---|---|---|---|---|
| **Principal risk** What could prevent us achieving our strategic | **Risk Title:** | **PR 17: 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 December 2022 • **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 18: 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. Possible | 4. Possible | 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 3299)** | • Project documentation including action log in place. | •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.<br>•For Trusts in England, an average Research Capability Funding allocation of at least £200k average p.a. over the previous two years. | **2nd Line:**<br>• Board of Directors<br>• University Hospital Group – October 2022. | • No University Hospital Group meeting in Jan 2023. To be rearranged. | 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.<br>2. For RCF Funding of £200k – the Head of Research has advised that it will be 2024/2025 when we achieve the £200k average that is required. Regular updates will be provided on levels of funding and there is a plan in place to encourage increases in research participation at WWL. | MD March 2023<br>MD March 2023 |

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

| | |
|---|---|
| **Title of report:** | Community Division Performance Report |
| **Presented to:** | Board of Directors |
| **On:** | 01 February 2023 |
| **Presented by:** | Claire Wannell |
| **Prepared by:** | DOP, Heads of Service, Performance Manager |
| **Contact details:** | wwl-tr.communityperformance@nhs.net |

**Executive summary**

The Community division has maintained progress against a reduction in the length of time people are waiting for services. The current longest wait within the division is 64-65 weeks and sits within adult dietetics. This position is improved from Month 7 where the longest wait in the division was 71-72ks. Performance across all new waiting lists in month is showing a sustained improvement from previous months and now stands at 87.9% as at Month 8. Year to date the position is also showing a continuous improvement from 83.7% at the start of the year to Month 8 at 85.98%, the target is 92% in line with National Referral to Treatment outpatient performance metrics. The Community division continues to report no 104-week breaches, is on plan to deliver 78 weeks wait by March 2023 and is working towards improving the 52-week position having stabilised the number of patients waits.

**Link to strategy**

Care Closer to Home

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

- Attendances to A&E continue to increase
- No Right to Reside do not reduce
- Unfunded Escalated areas remain open
- Occupancy levels remain over 90%

- Cancer referrals continue to exceed 115% of pre covid levels
- Impact of unplanned Bank Holiday cancellations on activity levels and cancer performance.
- Winter pressures impact on Elective programme
- Independent Sector contract with GM requires significant work

**Financial implications**

- Penalties linked to non-delivery of elective recovery plan
- Unfunded escalation areas remain open beyond March

**Legal implications**

**People implications**

- Sickness absence and resulting temporary spend
- Impending Industrial Action
- Current BMA position on additional consultant activity pay rates is impacting on capacity available.
- Impact of winter pressures on elective recovery and potential redeployment of staff will have an impact on morale.

**Wider implications**

Greater Manchester ICS failure to achieve Elective recovery times and associated funding.

**Recommendation(s)**

The Committee is asked to note the good progress against the key recovery standards, development of transformational schemes and review & action of key services.

**Key Updates**

**1.1. Virtual Hub Delivery**

The division has shown progress to sustain bed capacity within the virtual ward (VW) at Month 8 to 27 beds. Throughout January to date VW operated at roughly 80% capacity (target trajectory 45 beds) with up to 43 patients in month. The division envisages it will achieve the target trajectory of 60 beds by the end of February/early March.

In addition to VW patients, the division are exploring the reporting of our Monitoring at Home (M@H) cohort of patients. According to the Greater Manchester definition it is thought a number of these patients should count towards VW capacity, due to the intense monitoring they receive.

Recruitment is underway with senior support with leadership responsibilities now appointed, other positions are in process or are awaiting start dates. Funding for consultant sessions is agreed and the medicine division are developing work plans to be implemented in January 23. Surgical Pathways are now incorporated and step-up services for primary care are due to be piloted later in January.

Non-Recurrent Funding of the Virtual Ward remains in place until April 2024, discussions are required to take place with Greater Manchester ICB with regards to identifiable funding linked to clear value savings.

**1.2 Wigan Reduction in Long Lier's (WROLL)**

The WROLL pilot has continued in the division and has increased performance across Month 7 and 8 in which the service responded to fifteen patients all within 30min-1hr, with admission avoidance achieved for 73% of patients (increase from 38% in M6)

For those who transferred, the clinical findings within assessment led to a timelier admission to hospital, positively decreasing the risk of clinical deterioration, with a saving of 8+ hours in time on the floor for these patients before an ambulance crew would have been able to arrive. The immediate and long-term impact of patients who wait too long for assistance following a fall can be catastrophic, resulting in inappropriate hospital admission due to risk of rapid patient deterioration directly caused by the length of time lying on the floor.

Although the numbers of patients seen has increased the numbers remain extremely low. The division is working across medicine to understand data regarding falls admissions to ensure we are maximizing the opportunities during the pilot.

**1.2. Universal 0-19s Children Service Performance**

There has been sustained improved performance seen in quarter 2 across all Health Visiting Mandated Contacts. However, there is variation across some key performance indicators which warrants further investigation, particularly aimed at 2-2.5yr age group where high levels of parental cancellation, delays, covid isolation has been seen.

National delivery of School Age Immunisations continues as directed by NHS England. Sessions within schools and clinic settings have continued, the catch up of immunisations has been very successful which represents a significant undertaking for the team. Performance across the year shows WWL exceeding the overall GM performance across all immunisation programmes other than Boys HPV2 and HPV1. The School Nursing Immunisation Team have identified increase in uptake across all school aged vaccinations

programme for the most vulnerable children in the Borough, including Children in Care, children known to Social Care alongside children identified in schools who are experiencing medical, social, and emotional or anxiety issues which impact their consent.

Delivery of National Child Measurement Programme for primary age children across the Borough has recommenced in September and the team are working closely with local authority colleagues to review processes to maximise communication across the partnership for the benefit of the children.

The early help intervention and safeguarding caseload support has seen a significant increase since the pandemic, sustained 58% increase in the number of families who require support. The 0-19 Specialist Nursing Team are committed to the identification of health needs and recognise the importance of early intervention, however capacity within the teams has been raised as a concern due to the increase in children requiring support at statutory safeguarding level over the past few years. At the end of Q2 the HV service had 1429 families identified as in receipt of Universal Plus level of intervention from the HV service with a range of health needs. Progress has been made by Clinical Leads on focus on most vulnerable children.

### 1.3. Jean Heyes Rabblement Unit – Position update

The aim of the unit was to create a rehabilitation offer with a 7-day therapy model which gives optimum opportunity for excellent outcomes for patients and the system. This will promote faster recovery from illness and help prevent unnecessary acute hospital admissions, supporting timely discharge and maximising independent living.

The rehabilitation delivery model set out a range of measures based on the analysis of the demand, intended cohort and impact across the system. Performance against some of these measures has been possible within current year, including number of admissions, length of stay, occupancy, and discharge to usual place of residence, whilst some of the outcome measures require further development.

Length of stay is significantly below expected number of days (YTD 8.2 days). The short length of stay indicates reablement goals and therapy cannot be fully established as patients are transferring out earlier than anticipated.

Total admissions to the unit show a positive improvement against delivery model target and is reducing following a peak seen in M5. The year-to-date average (65 patients) is only slightly above the maximum number of patients expected to be able to undertake Intermediate care and D2A service delivery of 63 and this has been reducing since M6. Performance shows an increasing trend in patients discharged returned to their usual place of residence, Year to date average is 61.3%. There is emerging evidence that the unit is increasing the number of people moving from pathway 2 to 1 (higher to lower support). Support has been given to patients to improve mobility, including practice safe transfer with equipment and support, chair-based exercises and building confidence with safe transfers at home.

The year-to-date performance of current measures demonstrate the JHRU is not yet functioning as described in the business case delivery model. The unit has been providing support across

the trust as part of winter planning and response, therefore performance is not expected to change until the unit returns to its intended purpose.

A full benefits realisation exercise will be undertaken with system partners when the reablement model can be maintained. In the meantime, the unit continues to contribute to the overall trust General and Acute bed base.

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

| | |
|---|---|
| **Title of report:** | Elective Care |
| **Presented to:** | Board of Directors |
| **On:** | 01 February 2023 |
| **Presented by:** | Claire Wannell |
| **Prepared by:** | Deputy Chief Exec and Director Operations Surgery |
| **Contact details:** | Mary.Fleming@wwl.nhs.uk |

**Executive Summary:**

Progress continues to be made against National Referral To Treatment (RTT) Recovery targets, with 1 104-week waiter due to be declared as at the end of December, which was a patient choice wait. The plan to clear 78 weeks by the end of March is slightly off plan, but there remains a clear plan to achieve zero as forecasted.

Cancer referral rates continue to exceed 19/20 levels and 22/23 planning assumptions; Lower GI is cause for concern; however, a new testing pathway is being implemented nationally from 16th January 23, requiring all patients to be referred with test results, which if followed within primary care will support rapid improvement.

The Trust is currently delivering 92% of the 19/20 baseline activity levels and 93% of the income value. However, once an adjustment is made to recognise the Elective Recovery Fund cap of 85% of 19/20 follow up activity, the income value reduces to 87% of 19/20 levels. No penalties have been applied as yet for exceeding the Follow up activity threshold.

The overall RTT waiting list has started to increase again, due to reduced capacity during the Christmas period, and reduced activity due to a sustained period of operating in critical incident mode during December and early January. This also resulted in the escalation of the Wrightington site to accept medical patients, which also negatively impacted elective recovery. The site is on track to be de-escalated by week commencing 23rd January.

It should 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 (see scorecard position below) - significant pressures are still seen in urgent care demand, cancer referral rates and bed occupancy levels. The Trust continues to work with system partners both at locality and Integrated care Board levels to safely manage both urgent and planned care.

The WWL Way

**SCORECARD**

**Assumptions and Target Achievement to support Elective Recovery**

| | |
|---|---|
| 85% Theatre Utilisation | 80% |
| 105% of 21/22 Activity Levels through independent sector | Not Available |
| Priority to P2's (urgent) then P4 (long waits | |
| G&A bed occupancy below 90% of core baseline adult G&A | |
| Below 85% Critical care Occupancy | |
| Overall G&A bed Non-Elective Demand to return to pre-pandemic levels of which covid demand will relate to 5% by Q2 | |
| Cancer Referral rates at 110% to 115% pre covid levels | |
| Outpatient DNA rates to reduce by minimum 2% | |
| Outpatient utilisation to increase by 5% | Not Available |
| Virtual Outpatient Consultation to be maintained at 25% | |

**Elective Recovery Targets**

| | |
|---|---|
| 110% clock stops and 104% weighted activity of 19/20 baseline | |
| 16 Specialist Advice requests, including advice & guidance per 100 outpatient first attendances by March 2023 | On Track |
| Follow up outpatient appointments – plan submitted delivers 96% of 19/20 activity levels | |
| Expand the uptake of Patient Initiated Follow Up to all major outpatient specialties, moving/discharging 5% of outpatient attendances to PIFU pathways by March 23. | |
| Diagnostic Capacity at 120% of pre pandemic activity | |
| Eliminate 104 week waits as a priority by July 2022 – except patient choice | |
| Cancer – return the number of people waiting over 62 days to Feb 2020 baseline | |

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

- Attendances to A&E continue to increase
- No Right to Reside do not reduce
- Unfunded Escalated areas remain open
- Occupancy levels remain over 90%
- Cancer referrals continue to exceed 115% of pre covid levels
- Impact of unplanned Bank Holiday cancellations on activity levels and cancer performance.
- Winter pressures impact on Elective programme
- Independent Sector contract with GM requires significant work

**Financial implications**

- Penalties linked to non-delivery of elective recovery plan
- Unfunded escalation areas remain open beyond March

**People implications**

- Sickness absence and resulting temporary spend
- Impending Industrial Action
- Impact of winter pressures on elective recovery and potential redeployment of staff will have an impact on morale.

**Wider implications**

Greater Manchester Integrated Care Board failure to achieve Elective recovery times and associated funding.

**Recommendation(s)**

The committee are asked to note the contents of this report, in particular the ongoing progress against Referral to Treatment Targets, despite operating in critical incident mode during December. The committee are also asked to note the escalation of the Wrightington site during December and January, and the impact on elective activity which will be reported in the March F&P report. Cancer referrals remain high, with an increased number of patients waiting longer than 62 days for Treatment following the Christmas holiday period. The Lower GI tumour site is of current concern, although the new FIT testing pathway implemented on 16th Jan is expected to support improvement.

**Elective Recovery Overview as of September 2022**

**Activity v Recovery Plan**

Table 1 below shows the Trust position against the 19/20 baseline, the 22/23 activity plan and against the ERF target in terms of volume, by POD (point of delivery) and the year to date position as at the end of month 8 – it is not possible to report the month 9 position due to coding timescales impacting value weighted activity.

**Table 1**

| POD | Activity - 19/20 Baseline | Activity - 22/23 Plan | Activity - ERF Target | Activity - 22/23 Actual | Recovery (volume) - Against 19/20 Baseline | Recovery (volume) - Against 22/23 Plan | Recovery (volume) - Against ERF Target |
|---|---|---|---|---|---|---|---|
| Day Cases | 24,536 | 23,806 | 25,517 | 21,537 | 88% | 90% | 84% |
| Electives | 4,278 | 4,317 | 4,449 | 3,918 | 92% | 91% | 88% |
| OPA New | 72,819 | 81,691 | 75,732 | 67,257 | 92% | 82% | 89% |
| OPA Follow Up | 176,696 | 166,423 | 150,192 | 166,943 | 94% | 100% | 111% |
| OP Proc New | 19,118 | 18,146 | 19,883 | 18,463 | 97% | 102% | 93% |
| OP Proc Follow Up | 40,237 | 38,660 | 41,846 | 33,423 | 83% | 86% | 80% |
| Total | 337,684 | 333,043 | 317,619 | 311,541 | 92% | 94% | 98% |

Table 2 below shows the same posiiton translated into value weighted activity – the % of 19/20 income generated at POD level once coding is complete and complexity is considered. The ERF target is to deliver 104% of the income value of 19/20 activity.

**Table 2**

| POD | Recovery Value - Against 19/20 Baseline | Recovery Value - Against 22/23 Plan | Recovery Value - Against ERF Target |
|---|---|---|---|
| Day Cases | 88% | 91% | 85% |
| Electives | 99% | 94% | 95% |
| OPA New | 92% | 83% | 89% |
| OPA Follow Up | 98% | 98% | 82% |
| OP Proc New | 96% | 103% | 93% |
| OP Proc Follow Up | 83% | 84% | 80% |
| **Total** | 93% | 92% | 87% |

At a Trust level, during the first 8 months of the year, 92% of the volume of 19/20 activity levels was delivered (Table 1). Once coded, this equates to 93% of 19/20 income (Table 2). Once the income cap of 85% of 19/20 follow up activity is applied, this reduces to 87% (Table 2). This is a reduction of 1% since month 6, where 88% of income value was achieved once penalties had been taken into consideration.

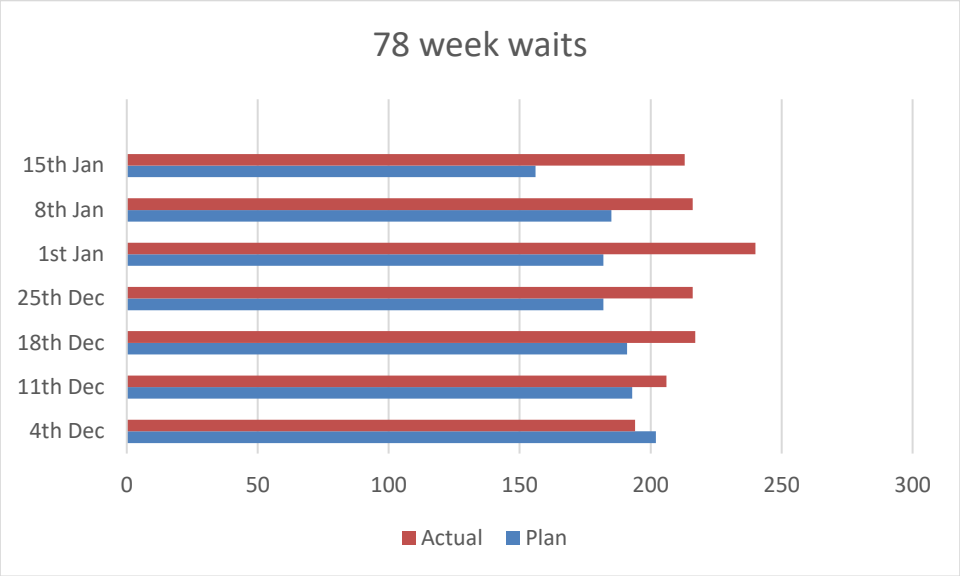
The YTD recovery position based on both volume and value as at month 8 is summarised below at Divisional level. The third column shows the value adjustment once over delivery of follow ups has been accounted for, although to date this penalty has not been applied.

| Division | Volume of 19/20 % | Value of 19/20 % | ERF Value* inc penalty |
|---|---|---|---|
| | | | |
| **Medicine** | 88% | 90% | 86% |
| **Surgery** | 101% | 99% | 90% |
| **Specialist Services** | 87% | 91% | 86% |

Whilst Surgery is delivering the highest volume and value of activity, the division is heavily penalised for over-delivery of outpatient follow ups. Medicine have made timely progress in reducing follow up attendances and therefore are the division least penalised on this metric.

**Referral To Treatment (RTT) Targets**

The Trust continues to make satisfactory progress across all RTT metrics. WWL will be declaring only one 104-week waiter for December, which was a patient choice delay. There are currently 213 patients waiting beyond 78 weeks, against a trajectory of 156, difference of 57 patients. These patients are split across gynaecology, dermatology, and ophthalmology in the main – all can be accommodated before the target date of 31st March. 12 patients within the 78 weeks wait cohort have been impacted by the planned RCN strike action on 18th and 19th January 2023.



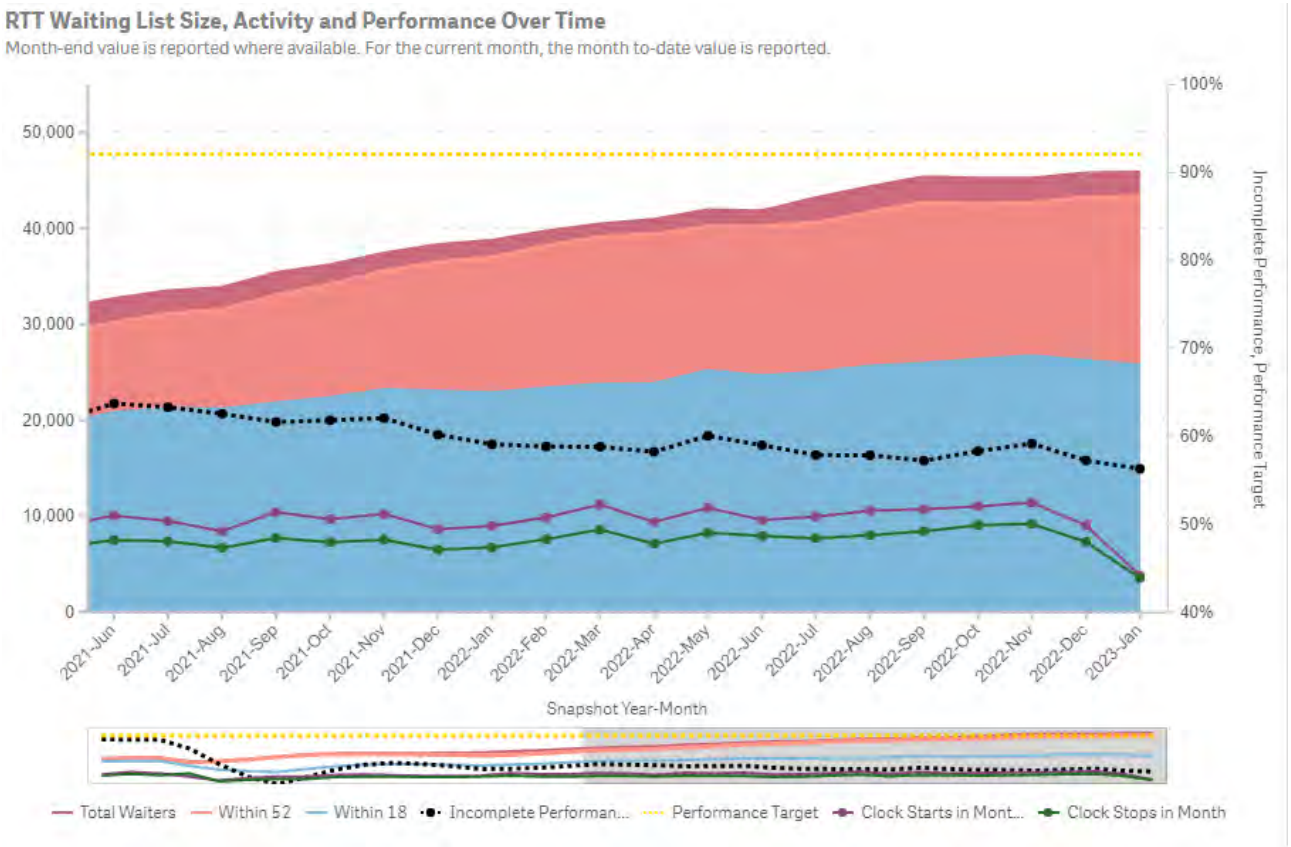

**Referral to Treatment (RTT) Waiting List Size**

The RTT Waiting list size has increased to 45,810 patients, from 45,100 patients at the end of November – this is due to reduced activity throughout December and January due to ongoing critical incidents, and the impact of reduced activity during the Christmas holiday period. At the time of writing, the industrial action on 18th and 19th January was anticipated to have an impact of around 70 daycase/elective cancellations, and around 200 outpatient cancellations.

The text reminder service was re-enabled on 7th November, with a gradual rollout to all specialties across a 2-week period. Early analysis has taken place and demonstrated a 1% improvement in December, when compared to April to November data – the improvement was 0.6% for Medicine, 1.5% for Specialist Services, and 0.8% for Surgery. This overall reduction of 1% equates to approximately 430 additional attendances in month.

Whilst this paper reports the November activity position, it should be noted that the December elective activity position, whilst currently uncoded, is expected to be significantly lower than levels delivered in recent months, particularly in Specialist Services given the escalation of the Wrightington site to support medical patients during the December critical incidents – Wrightington was escalated to accept medically optimised patients onto Ward 6 and Ward B, which required the closure of JCW to support staffing also – this limited orthopaedic capacity to Ward A only. Despite this, the team have continued to focus on elective recovery and maximised daycase activity, whilst continuing to treat trauma, p2 and very long wait patients requiring beds.

A clear de-escalation plan was agreed to work towards reinstating Wrightington back to full elective activity no later than the 6th February – this de-escalation is currently ahead of target and planned to be complete by w/c 23rd Jan. The Wrightington site has continued to operate as a surgical hub and patients treated in priority order as they have been transferred, however this activity has been minimal.




**Cancer**

Cancer referrals remain significantly above 19/20 levels, with referrals received within December 2022, compared to in December 2019 – above the planning assumptions of 110-115%.

The Trust submitted a plan to reduce to 78 patients waiting beyond the 62-day target by the end of December – the final position was 116, with the majority being within the Lower GI tumour site. A newly implemented FIT testing pathway should support rapid improvement of this measure if followed in primary care.

The Trust achieved the 14 day (to first appointment) and 14-day symptomatic breast targets in November (the latest validated cancer performance position). The 31-day target (from decision to treat, to treat) was also achieved, and an improvement seen in both the 28-day (communication of cancer or otherwise) and 62-day (referral to treatment) performance – 62-day performance was the 2nd highest position achieved YTD, at 76.7%.

Agenda item: [18]

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

| | |
|---|---|
| **Title of report:** | WWL M9 Balanced Scorecard |
| **Presented to:** | Board of Directors |
| **On:** | 1 February 2023 |
| **Presented by:** | Executive Directors |
| **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 New Balanced Scorecard is presented to the Board of Directors. For this month, as the board meets on a bi-monthly basis, we have added a column to show the Year-to-Date position to provide further context.

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.

Finally, we would like to thank the Balanced Scorecard Project Board and ETM for their input and continued support to date.

**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 Board are recommended to receive the report and note the content.

**Report:** M9 WWL Balanced Scorecard: December 2022

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

| ID | KPI Title | Period Covered | Total | Target | On Target | Trend | YTD |
|---|---|---|---|---|---|---|---|
| 1 | Never Events | Dec-22 | 0 | 0 | ● | ▼ | 3 |
| 2 | Number of Serious Incidents | Dec-22 | 4 | 0 | ● | ▼ | 66 |
| 3 | Sepsis - Screening and Antibiotic Treatment (IN DEV) | - | - | - | | - | - |
| 4 | STEIS Reportable Category 3, 4 & Unstageable Pressure Ulcers | Dec-22 | 1 | 0 | ● | – | 11 |
| 5 | STEIS Reportable Serious Falls | Dec-22 | 0 | 0 | ● | ▼ | 6 |
| 7 | Complaints Responses | Dec-22 | 57.50% | 90% | ● | ▼ | 37.77% |
| 9 | Patient Experience (FFT) | Dec-22 | 80.44% | TBC | | ▼ | 85.01% |
| 52 | Methicillin-Resistant Staphylococcus Aureus (MRSA) | Dec-22 | 0 | 0 | ● | – | 1 |
| 53 | Methicillin-Susceptible Staphylococcus Aureus (MSSA) | Dec-22 | 6 | 0 | ● | ▲ | 27 |
| 54 | Clostridium Difficile (CDT) | Dec-22 | 9 | 0 | ● | ▼ | 85 |
| 78 | SHMI Rolling 12 Months | Apr-22 | 114 | 100 | ● | ▼ | 114 |

## People (Chief People Officer)

| ID | KPI Title | Period Covered | Total | Target | On Target | Trend | YTD |
|---|---|---|---|---|---|---|---|
| 10 | Vacancy rate | Dec-22 | 7.38% | 5% | ● | ▼ | 8.90% |
| 13 | Rate card adherence (Medical) | Dec-22 | 56.22% | 80% | ● | ▼ | 52.96% |
| 14 | Rostering timeliness | Dec-22 | 56.76% | 75% | ● | ▼ | 50.14% |
| 15 | % Turnover Rate | Dec-22 | 10.19% | 10% | ● | ▼ | 10.34% |
| 16 | Your Voice Score (QTR) - Engagement score | Jun-22 | 3.94 | 4 | ● | ▼ | 11.82 |
| 18 | Your Voice Score (QTR) - Well-being score | Jun-22 | 3.35 | 3.5 | ● | ▼ | 10.05 |
| 19 | Mandatory training compliance | Dec-22 | 93.16% | 95% | ● | ▲ | 90.22% |
| 21 | Sickness - %age time lost | Dec-22 | 7.76% | 4% | ● | ▲ | 6.60% |
| 50 | Usefulness of Trust wide communication | Apr-22 | 82.00% | 70% | ● | ▼ | 82.00% |
| 51 | Leaders Forum reach (Number of Leaders attending the Forum) | Dec-22 | 0 | 110 | ● | ▼ | 1,064 |
| 62 | Number of outputs per month (LF, ASTB, Executive Vlogs, CEO Vlog / Blog) | Dec-22 | 4 | 6 | ● | ▼ | 57 |
| 63 | FTSU contacts | Dec-22 | 5 | n/a | | - | 58 |
| 64 | Your Voice Score (QTR) - Psychological Safety | Jun-22 | 3.71 | 3.75 | ● | ▼ | 3.71 |
| 65 | Appraisal | Dec-22 | 79.78% | 90% | ● | ▼ | 77.75% |

## Performance (Deputy Chief Executive)

| ID | KPI Title | Period Covered | Total | Target | On Target | Trend | YTD |
|---|---|---|---|---|---|---|---|
| 60 | Ambulance handovers 60+ minutes delay | Dec-22 | 412 | 0 | ● | ▼ | 2,445 |
| 59 | Ambulance handovers under 30 minutes | Dec-22 | 58.21% | 95% | ● | ▲ | 68.64% |
| 58 | Ambulance handovers under 15 minutes | Dec-22 | 41.01% | 65% | ● | ▼ | 46.77% |
| 32 | Reduce 12-hour waits in EDs | Dec-22 | 18.00% | 10% | ● | ▲ | 12.55% |
| 25 | G&A Bed Occupancy - Acute Adult Inpatient Wards | Dec-22 | 97.64% | 95% | ● | ▼ | 97.81% |
| 33 | No Right to Reside Patients (excluding Discharges) | Dec-22 | 132.1 | 50 | ● | ▼ | 132.5 |
| 75 | Cancer Referrals - 115% of pre -covid averages | Dec-22 | 1,216 | 1310 | ● | ▼ | 14,262 |
| 31 | Cancer - waits longer than 62 days | Dec-22 | 116 | 61 | ● | ▲ | N/A |
| 24 | Patients waiting over 104+ weeks (except patient choice & clinically complex) | Dec-22 | 0 | 0 | ● | ▼ | N/A |
| 42 | Patients waiting over 78 weeks | Dec-22 | 236 | 182 | ● | ▲ | N/A |
| 28 | Outpatient Utilisation (IN DEV) | - | - | - | | - | N/A |
| 68 | Outpatient DNA Rates | Dec-22 | 9.10% | 6% | ● | ▲ | 9.78% |
| 67 | Virtual Outpatient Consultations | Dec-22 | 24.47% | 25% | ● | ▼ | 27.84% |
| 23 | Elective Theatre Utilisation | Dec-22 | 78.76% | 85% | ● | ▲ | 79.48% |
| 41 | Elective Recovery Plan | Dec-22 | 84.96% | 100% | ● | ▼ | 83.93% |
| 76 | Total Waiting List - RTT position | Dec-22 | 45,841 | - | ● | ▲ | N/A |

## Finance (Chief Finance Officer)

| ID | KPI Title | Period Covered | Total | Target | On Target | Trend | YTD |
|---|---|---|---|---|---|---|---|
| 34 | Surplus / Deficit (£'000s) | Dec-22 | (2,346) | (779) | ● | ▼ | (10,091) |
| 35 | Capital Expenditure (£'000s) | Dec-22 | 956 | 1,950 | ● | ▲ | 5,263 |
| 36 | Cash (£'000s) | Dec-22 | 27,987 | 37,152 | ● | ▼ | 314,945 |
| 39 | Agency Expenditure (£'000s) | Dec-22 | 958 | 692 | ● | ▲ | 9,947 |
| 47 | Cost Improvement Programme (CIP) (£'000s) | Dec-22 | 1,832 | 1,992 | ● | ▼ | 19,196 |
| 48 | Better Payment Practice Code (BPPC) | Dec-22 | 92.40% | 95.00% | ● | ▲ | 96.97% |

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

Latest Commentary - **Dec-22**

**Patient Safety**
4 incidents were escalated to StEIS within the month of December. 1 incident was identified as a Never Event. This related to a cytoscopy procedure using a TRV device. It was found at a later date that the plastic beak at the end of this device had broken within the patient. Whilst the device is part of the checking procedure, the plastic beak is not removable therefore is not specifically checked. However, this is therefore covered under 'retained foreign object' under the framework.
Since this incident, the plastic beak is now checked, it has been reported to the MHRA and to the manufacturer to issue an urgent safety notice.
Other incidents relate to 1 unstageable hospital acquired pressure ulcer, 1 Norovirus and 1 unplanned transfer to ICU

**Complaints**
Whilst there was a reduction in the complaint response timescales, this is still higher than has been reported previously and the improvement plan to ensure that responses are completed within agreed timescales is underway. The current pressures have caused some delays within the response figures within the month of December.

## People (Chief People Officer)

Latest Commentary - **Dec-22**

**Wellbeing**: Cost of living group well established, developing various schemes eg financial advice sessions/discounted staff public transport/free food/drink from our outlets. Free charge cards for use at our tills being explored-communication campaign developed.
Psych Support Team: new referral process now available providing easier access to support and management referral functionality.
**Leadership & teams**: Vacancy forecast includes best/worst case scenario planning.
Pay review group established with divisional check/challenge process, LPV review and oversight of medical, nursing and non-clinical roles.
Medical workforce review underway.
**Culture**: 60 exit interviews now conducted and stay conversation programme in development.
EDI Gold Champions-developing session on anti-racism and cascading amongst local teams. Disability network engaging positively in a project to explore more inclusive signage on accessible facilities.
NSS-high level results: Trust response rate-35%, highest score since full census carried out. Scored in line with sector in 6 out of 7 of the People Promises.
**Comms and visibility**: Critical Incident and Operational Pressures-Exec decision to stand down Dec Leaders' Forum and 2 of the weekly Exec vlogs.
Steps 4 Financial Wellness: face-to-face drop-in sessions with the Citizens Advice Bureau in Jan.
**Personal development**: Review of My Route Plan Appraisal-focus groups delivered across the trust: design of content underway: engaging staff across divisions to do this by Q4.
OD Team-team development work undertaken with various teams.
Learning Hub: Improvements to how Safeguarding training is tracked using inter-collegiate model of recording CPD. Review of locally mandated training for Doctors.

## Performance (Deputy Chief Executive)

Latest Commentary - **Dec-22**

As at the end of December, 1 patient had waited longer than 104 weeks for Surgery - this patient chose to wait. Good progress is being made against the 78 week wait position, with all risks to delivery of clearance by 31st March 2023 well mitigated.
Whilst remaining higher than 19/20 levels, cancer referrals dropped for the first time in year - performance also improved for those patients diagnosed with cancer - 14 and 31 day targets were achieved, and 62 day performance was the second highest within this financial year. However, the number of patients remaining on the cancer pathway beyond 62 days increased - christmas annual leave was a key factor.
The elective recovery activity position decreased slightly in month, to just over 84% of 19/20 volumes - the value of the activity is TBC due to December activity being uncoded. The elective recovery programme was heavily impacted by operational pressures within month, particularly Orthopaedic activity due to the escalation of Wrightington.
The outpatient DNA rate is showing as deteriorating due to the timescales covered, and December being a notoriously poor month for DNA's- however the month period following switch on of the text reminder service actually demonstrated an improvement of 1% against all other months in this financial year combined.

## Finance (Chief Finance Officer)

Latest Commentary - **Dec-22**

**Surplus/Deficit**
The Trust reported an actual deficit of £6.4m in month 9 (December 2022), which is £5.6m adverse to plan. The year to date position is an actual deficit of £14.3m, which is £8.4m adverse to the planned deficit of £5.9m. The position includes a technical impairment of £4.0m following recommendation by the Trust's external auditors KPMG for a capital scheme associated with cycle lanes (part of the Community Health Investment Partnership in last financial year).
**Capital Expenditure**
Capital expenditure is £1.0m in month 9 which is £1m below plan. Year to date, capital spend is £5.3m which is £3.2m below the planned expenditure of £8.5m. Of which, £1.1m relates to internal CDEL backed capital spend and £2.1m relates to external PDC funded schemes (of which £1.5m is Frontline Digitisation).
**Cash**
Cash at the end of the period totalled £28.0m. This has deteriorated by £4.5m from the previous month and deviated from current forecasts due to timing in settlement of debts from customers and the deficit reported in December.
**Agency Expenditure**
Year-to-date, agency expenditure is £3.2m higher than this time last financial year (2022/23 £9.9m; 2021/22 £6.7m). The increase from last year includes £0.6m recoded for IM&T, with an increase of £2.6m when this is excluded.
**Cost Improvement Programme (CIP)**
In month 9, £1.8m of CIP was transacted which is £0.2m adverse to plan. This is split £0.7m Divisional CIP and £1.1m Corporate CIP. Year to date, £19.2m has been transacted which is £1.3m ahead of plan. However, excluding the non-recurrent vacancies CIP is £2.6m below plan year to date. The split between transactional and transformational schemes is £9.4m and £1.1m respectively.
**Better Payment Practice Code (BPPC)**
BPPC year to date is 91.8% by volume and 93.8% by value. Performance has remained stable from the previous month due to the work by SBS, financial services and procurement teams. This work is ongoing, and a training plan is in progress to address the root causes.

| | |
|---|---|
| **Title of report:** | Emergency and Urgent Care |
| **Presented to:** | Board of Directors |
| **On:** | 01 February 2023 |
| **Presented by:** | Claire Wannell, DDOP Surgery |
| **Prepared by:** | Paritosh Desai, DDOP - Medicine |
| **Contact details:** | Mary.Fleming@wwl.nhs.uk |

**Executive Summary:**

WWL continues to be the number one ranked Trust within Greater Manchester for A&E performance against the four-hour standard.

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

- Demand: In December, we have 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. The Trust continues to experience days when attendances exceed the planned capacity of 288 patients per day.
- Flow and Discharge: Since December 2021 and following the Omicron wave, the number of patients whose discharge is delayed has increased. As a Trust we have averaged 100 patients per day over the past 9 months which impacts on the ability to allocate beds for those patients awaiting admission in a timely manner, this is a significant increase when compared with pre-covid levels. December saw an average of 138 patients on the no right to reside (NRTR) list and increase of 10% from November 2022.

The impact of the demand and flow is demonstrated in:

- The number of patients who reside in A&E for 12 hours or more from the point of arrival
- The ability to off load ambulances in a timely manner.

WWL continues to build upon the progress made with the Acute Hospital Discharge programme, with a continued focus on maintaining A&E professional standards alongside improving discharge and increasing the number of people who leave the hospital earlier in the day. We also continue to

work with, and support, system partners to promote alternatives to A&E, seek immediate solutions and additional capacity to reduce the number of patients who no longer have a right to reside, and inform development of demand/capacity modelling of future community nursing and residential bed capacity given the changing acuity of people presenting to urgent and emergency care.
We have instituted several initiatives including enhanced provision of Same Day Emergency Care (SDEC) and cohorting of medically fit for discharge patients across four wards at RAEI site. Working with the system we have established a system response taskforce that now comes on site at RAEI starting with the cohorted wards and provision of additional intermediate care beds in the community.

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

- Attendances to A&E continue to increase
- No Right to Reside do not reduce – patients' de-condition due to length of stay / acquiring infections.
- Unfunded Escalated areas remain open
- Occupancy levels remain over 90%
- Impact on the elective recovery

**Financial implications**

- Penalties linked to non-delivery of elective recovery plan
- Unfunded escalation areas remain open
- Increased cost pressures resulting from the higher number of no right to reside patients and blockages to patient flow in the A&E

**People implications**

- Sickness absence and resulting temporary spend
- Impending industrial action

**Wider implications**

- Greater Manchester ICS failure to achieve Elective recovery times and associated funding.
- Impact on NWAS in responding to those most in need in a timely way.

**Recommendation(s)**

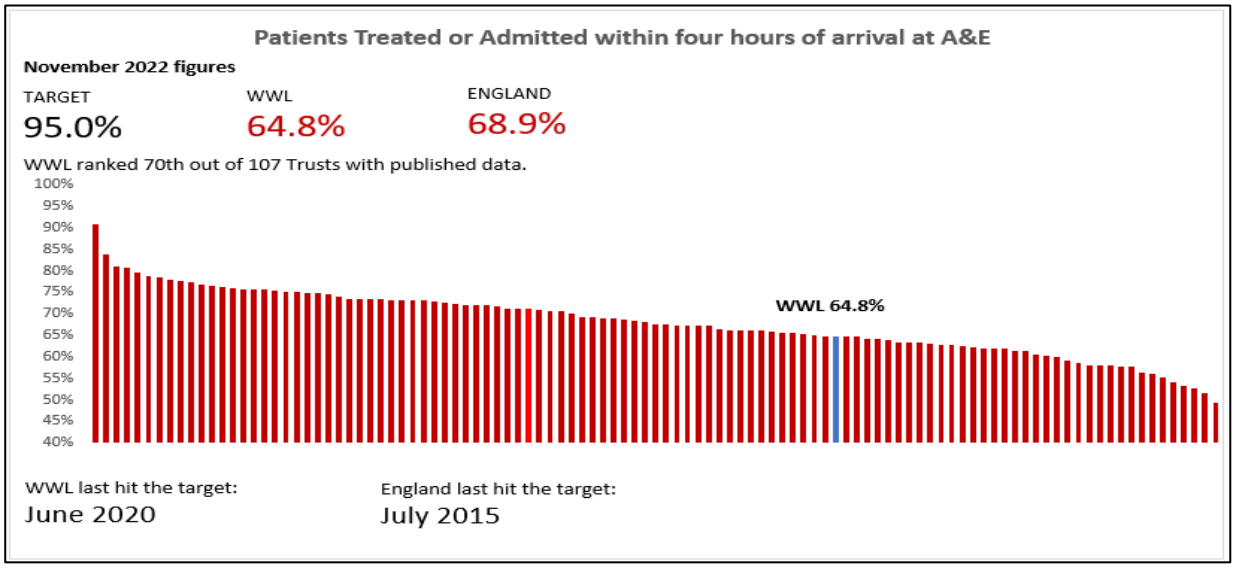
The Committee is asked to note the current challenges, associated risks and plans in place to support provision of safe urgent and emergency care services; challenges relating to fluctuating demand, increase in acuity and the impact of the number of patients who no longer have a right to reside. The committee is also asked to note the risks and mitigations outlined in the report, the complexity of delivery at locality level and the intention to monitor recovery both at locality and system level.

**Position as of November 2022**

When compared to the GM Trusts, the Trust remains the best performing Trust against the 4-hour standard as illustrated in the table below:

| Greater Manchester Area Acute Trust Name | Nov 2022 A&E Performance | Rank |
|---|---|---|
| Wrightington, Wigan And Leigh NHS Foundation Trust | 64.8% | 1 |
| Tameside And Glossop Integrated Care NHS Foundation Trust | 62.0% | 2 |
| Northern Care Alliance NHS Foundation Trust | 60.0% | 3 |
| Stockport NHS Foundation Trust | 58.1% | 4 |
| Manchester University NHS Foundation Trust | 53.2% | 5 |
| Bolton NHS Foundation Trust | 49.4% | 6 |

Nationally in November 2022, WWL ranked 70th out of 107 Acute Trusts with published data, at 64.8%, which is below the England percentage of 68.9%. The Trust dropped in its rankings from 47th amongst the Acute Trusts in England in October 2022.




Note that the A & E performance has declined from 67.6% in October 2022. England performance dropped from 69.3% to 68.9%

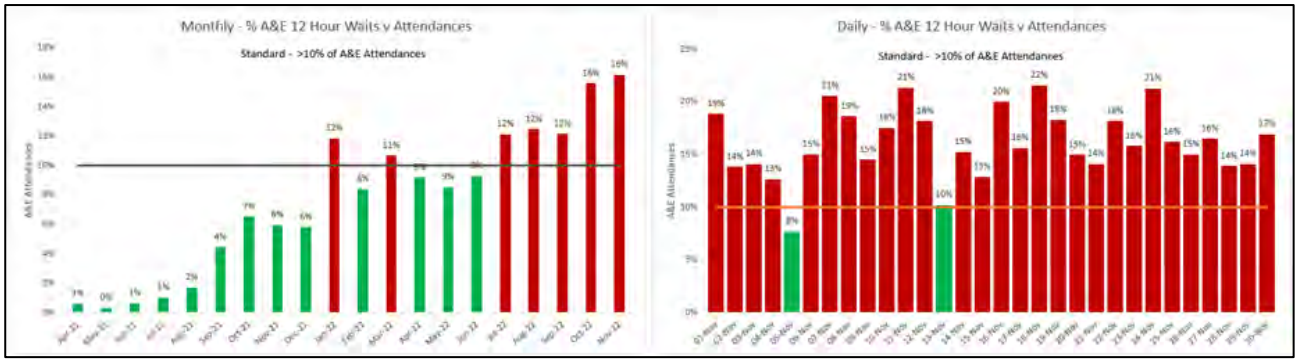
**No Right to Reside:**

For the A&E department to operate effectively, beds need to be available. Without the available beds, patients will remain in A&E until one becomes available. This in turn impacts on the quality of care provided and the overall patient experience. In addition, patients who require an acute bed, but remain in A&E until one is available results in reduced clinical space to see and treat patients. This then impacts on the capacity to offload ambulances in a timely manner. A contributing factor to the flow within the Trust is the number of no right to reside (NRTR) patients. Since December 2021 and following the Omicron wave, the number of patients who no longer require a hospital bed has Increased, averaging around 100 patients per day over the past 9 months. Over the month of December, the number of NRTR patients has averaged around 138 per day. This is an average increase of 12 additional NRTR patients per day compared with November 2022.

Increased acuity of patients attending the A & E resulted in 2790 total non-elective admissions, this combined with a higher number of NRTR patients impacted the discharge and flow process significantly resulting in the Trust calling an internal critical incident between 19th and 24th December 2022.
With the demands on A&E and the impact of the increased number of patients who no longer require an acute bed, the length of stay in A&E and the ability for ambulances to handover in a timely manner is negatively impacted.

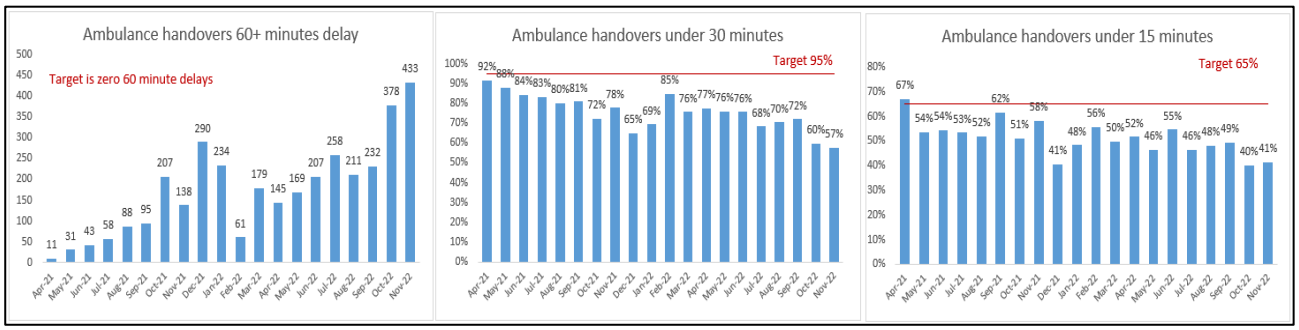
**12-hour length of wait in A&E**

The number of patients waiting over 12 hours from their arrival in A&E has risen since August 2021, with the percentage of patients waiting rising above the new 10% standard. Due to A&E attendances continually rising above capacity levels, together with the increasing presentation of the highest levels of acuity, the position in October & November rose to 16%. It peaked at 22% on two days in the month.



## Ambulance handovers

In November 2022, there were 433 handovers delayed by more than 60 minutes, a significant increase on October 2022 (378 delays). This decline was not replicated in the percentage of handovers under 30 minutes and 15 minutes.




As a Trust we continue to build on the progress made as part of the National Hospital Only Discharge Programme to improve the safety of patients in A&E. With a specific focus on improving the A&E 12-hour length of stay and reducing delays in ambulance handover times through a clinically led programme which provides:

- Two hourly reviews between Patient Flow, Nurse in Charge and Consultant in charge, agreeing and reviewing, the position within the department
- Reviewing the full escalation protocol
- Ensuring triage is undertaken within 15 minutes
- Ensuring patients seen by a doctor within 2 hours
- The application of the A&E safety checklist for patients who have been in the department for a period
- Monthly deep dives into the 12-hour length of stays, reviewing those admitted and their associated length of staff, seeking areas for improvement.
- Ward round improvement plan to support discharges before 12 noon. The discharges before 12 noon are reported weekly, with the aim to discharge 25% of discharges before 12 noon.
- Working in collaboration with our system partners to promote alternatives to A&E. For example:
- Same Day Emergency Care (SDEC) clinical pathway development, which reduces the attendances by directing patients who are in the correct area away from life/ limb saving treatment areas
- Working with Northwest Ambulance service to update the directory of services to ensure NWAS direct the appropriate patients to SDEC

Progress on the various initiatives is outlined below.

**Same Day Emergency Care (SDEC):**

From 14th November, the SDEC provides an enhanced service during the week and re-commenced a weekend service. During the week the SDEC will now have senior medical (consultant) cover from 0800 hours to 2000 hours (compared to 1200 hours to 2000 hours previously). Further it will provide a consultant led service on the weekends from 1100 hours to 1900 hours.
The case mix will include new and review patients with new patients being most of the cases managed. These will be drawn directly from the A & E waiting room and direct GP referrals.
In addition, the SDEC has provided telephone reviews to avoid patients from having to travel to the hospital. We are working with national experts to maximise the utilisation of the SDEC for new patients and reduce pressure on the A & E.

**System Response Taskforce:**

In collaboration with our system colleagues, key people from across the system (social workers, housing teams, care home teams) have initiated working with Trust discharge teams on RAEI site. The teams are working through the initial learning from working together and modifying the processes & protocols to facilitate speedy discharges.

**Cohorting of Medically Optimised for Discharge (MOFD) patients:**

From 16th of January 2023, the Trust have commenced cohorting of MOFD patients on four wards for a period of six weeks.
This programme of work will:

1. Maximise the efficiency of the discharge process
2. The integrated discharge teams will be able to focus their efforts better
3. Borough colleagues will be able to provide dedicated support including face to face MDTs on RAEI site, cementing the work begun at the end of November 2022
4. Reduce the challenge around managing outlier patients
5. Free up senior clinical time to attend to critical patients in other areas of the Trust such as the escalated areas

Effectively the initiative will further improve discharge and flow of the patients through the hospital.

**Trust response to winter surge:**
During the second half of December 2022, the Trust experienced a significant surge in high acuity non-elective admissions combined with reduced flow. Consequently, the organisation worked through an internal critical incident to de-escalate the pressures and keep patients safe. As part of the effort to alleviate the non-elective pressures, the Trust worked closely with system partners to expedite discharges, organised additional clinical input and temporarily escalated areas to care for patients safely.
As a rapid response to the increasing patient numbers, the Trust opened an additional ward at the Wrightington site, appropriately staffed with nurses and medical cover to care for medically optimised patients.
The work that the Trust undertook with system partners enabled us to de-escalate the pressures and the task of decommissioning the extended ward is nearing completion.

**Additional Beds in the Community:**

The Wigan System will now be providing 10 additional intermediate care beds at Bedford Care Home at the beginning of February 2023. These beds will support faster discharge of appropriate patients and improve flow in the hospital.

**Hospital Only Discharges:**

The Trust continues to progress the initiatives under the Hospital Only Discharges programme. The programme is reviewing the various metrics nationally and will inform the trusts within the scheme about their 'graduation out of the programme' towards the end of Q3.

**Key Risks:**

The risks defined below are not WWL's alone but is recognised as a system wide problem with the solutions being owned at a Wigan locality and Greater Manchester ICS level.

1. An unstable and unpredictable bed base as numbers and complexity fluctuate impacts on safety within A&E and impacts on occupancy levels.
2. Patients de-condition due to length of stay and lack of rehabilitation within the acute environment i.e., patients are not in the right place and are at risk of returning medical due to acquired infections etc.
3. Workforce morale is affected as the acuity of patients does not always match staffing levels and experience/competencies.
4. Financial position deteriorates as patients often require enhanced levels of care due to the environment and the risk of falls etc.
5. Other services across the system are pressured and cannot cope with the increased demand on discharge.

**Risk Mitigation:**

WWL and system wide initiatives in place as described above, to mitigate the risks, improve flow and the A & E performance.
There are several workstreams across organisations which will be accountable for achieving the reduction and stabilisation of NRTR patients. Due to the grip, joined up planning and adaptive system behaviour required it is proposed that the accountability sits within the new Integrated System Board.

**Summary and Recommendation:**

The complexity of the risks relating to the NRTR recovery requires a whole system response, in addition to the Trust's improvement initiatives. Expediting safe discharges with support from system partners is pivotal to recovery and safe flow through the winter period, alongside a longer-term Healthier Wigan Partnership strategy. Finance &Performance committee are asked to note the risks and mitigations contained in this section of the report, the complexity of delivery at locality level and the intention to track progress at system level.

Agenda item: [19]

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

| | |
|---|---|
| **Title of report:** | Monthly Trust Financial Report – Month 9 (December 2022) |
| **Presented to:** | Board of Directors |
| **On:** | 1st February 2023 |
| **Presented by:** | Kelly Knowles [Interim Chief Finance Officer] |
| **Prepared by:** | Senior Finance Team |
| **Contact details:** | E: Heather.Shelton@wwl.nhs.uk |

**Executive summary**

| Description | Performance Target | Performance | Explanation |
|---|---|---|---|
| Revenue financial plan | Achieve the financial plan for 2022/23. | Amber | Year to date, the Trust is reporting an actual deficit of £14.3m against the planned deficit of £5.9m, creating an adverse variance of £8.4m. This includes an impairment of £4.0m transacted in month 9. This is excluded from the adjusted financial performance, which is used to measure system performance.<br><br>The adjusted financial performance is a deficit of £10.1m year to date, which is £4.4m adverse to plan. The year to date position now exceeds the full year planned variance of £8.4m by £1.7m.<br><br>At present, the Trust is forecasting to achieve the planned full year deficit of £8.4m, as agreed across the GM system. Options are being explored around achievement of the most likely Financial Recovery Plan (FRP) scenario of a deficit of £10.4m, including discussions with system partners. The best case scenario of a deficit of £8.4m is dependent on £2.0m of additional income associated with the system stretch target. |
| Activity | Achieve the elective activity plan for 2022/23. | Red | The month 9 activity data highlights that the Trust has not achieved the elective activity plan that was submitted to NHSE. There is a risk of a clawback of the elective recovery funding (ERF) to the financial position. NHSE have advised not to make a provision for a penalty at present. |
| Cash & liquidity | Effective cash management ensuring financial obligations can be met as they become due. | Amber | Cash is £28.0m at the end of month 9 which is £9.2m below the plan. This has deteriorated by £4.5m from the previous month and deviated from current forecasts due to timing in settlement of debts from customers and the increased year to date deficit position. |

| | | | |
|---|---|---|---|
| Capital expenditure (CDEL) | Achieve CDEL for 2022/23. | Amber | Expenditure against total CDEL is £1.0m below plan in month 9 and £3.2m below plan year to date. A revised programme has been developed to mitigate risks to ensure delivery of the plan. The profile of the capital plan means there is a significant increase in expenditure planned for quarter 4. |
| 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 £1.3m to the CIP target. The proportion of CIP delivered recurrently remains low (1.1%) 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 £1.0m in month 9 and £9.9m year to date. The Trust is currently £3.7m above the ceiling year to date. Agency expenditure is £3.2m (60%) 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 | COVID-19 expenditure was £0.1m in month, which is the lowest in-month spend since the beginning of the year. This is partly due to expenditure which Medicine has reclassified from COVID to business as usual. |
| Business conduct | Comply with the Better Payments Practices Code (BPPC) of paying 95% of invoices within 30 days. | Amber | BPPC year to date is 91.8% by volume and 93.8% by value. Performance has improved slightly from the previous month due to the work by SBS, financial services and procurement teams. This work is ongoing to address the root causes. |
| Financial Risk | Report the financial risks through the Board Assurance Framework. | Amber | There are multiple risks to delivery of the plan associated with operational pressures, CIP, workforce shortages, COVID-19 expenditure, and the elective recovery. These are reflected within the year to date variance to plan. The best case scenario of a deficit of £8.4m is dependent on £2.0m of additional income associated with the system stretch target which has not yet been agreed. |

**Link to strategy**

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

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

The risk associated with delivering the £8.4 million deficit has increased given the increase in expenditure over the last 2 months and the year to date position. The Trust is currently maintaining the forecast to deliver the full year deficit of £8.4m, which will be reliant on securing system or locality support. A range of options are currently under discussion.

A series of cost reduction and mitigating actions have been implemented as part of the Financial Recovery Plan. These include the introduction of a non-clinical vacancy freeze until the end of the financial year and removal of premium payments associated with activity where there are no operational consequences to national priorities. Further bold actions are being scoped for implementation in Q4 through the Pay Control Group and the Executive Team.

All GM providers were required to submit a financial recovery plan by 30th November 2022. The Trust had already introduced a range of measures to support financial recovery which provided a good foundation for the recovery plan. These include the RAPID process, grip and control measures, the HfMA financial sustainability assessment and the consideration of bold actions at both a divisional and trust wide level. Within the financial recovery plan the best case scenario was delivery of the planned deficit of £8.4m, whilst the most likely scenario was a £10.4m deficit. The best case scenario included an additional £2.0m of income associated with the system stretch which was agreed for the final plan submission. The worst case scenario was a deficit of £14.1m which included sensitivities of £2.0m around winter and operational pressures. The divisional forecast at month 9 shows that these sensitivities have come to fruition with an adverse movement of £2.8m forecast by the end of the financial year.

The cash balance has reduced by £26.1m since 31st March 2022 (from £54.1m to £28.0m at the end of December 2022). As it stands, the Trust has sufficient cash to service this planned deficit and the planned capital programme. However, that assumes that the full value of the efficiency programme is cash releasing and at present the expenditure run rate is increasing.

**Financial implications**

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

**Legal implications**

There are no direct legal implications in this report.

**People implications**

There are no direct people implications in this report.

**Wider implications**

There are no wider implications in this report.

**Recommendation(s)**

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

# Financial Performance

## Key Messages

The Trust has reported an actual deficit of £6.4m in month which £5.6m adverse to plan. The adjusted financial performance is a deficit of £2.3m in month which is £1.6m adverse to plan.

Year to date, the Trust has reported an actual deficit of £14.3m, which is £8.4m adverse to the planned deficit of £5.9m. The adjusted financial performance is a deficit of £10.1m which is £4.4m adverse to plan.

The Trust is forecasting to deliver the full year planned deficit of £8.4m for the adjusted financial performance, as agreed by the GM ICS. Options are being explored with system and locality partners to support delivery of the Financial Recovery Plan most likely scenario.

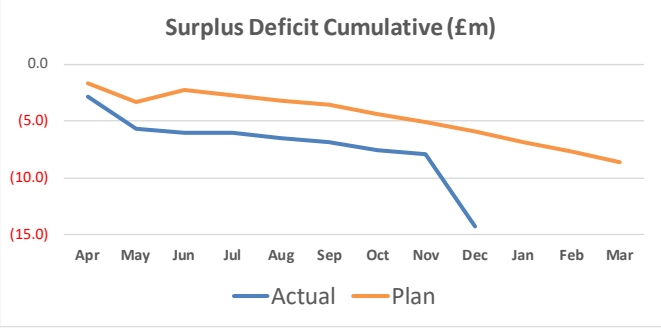
The Trust reported an actual deficit of £6.4m in month 9 (December 2022), which is £5.6m adverse to plan. The year to date position is an actual deficit of £14.3m, which is £8.4m adverse to the planned deficit of £5.9m. The month 9 and year to date position includes a technical impairment of £4.0m for a capital scheme associated with cycle lanes (part of the Community Health Investment Partnership in last financial year). The impairment follows a recommendation by the Trust's external auditors KPMG. The impairment is excluded for the purposes of calculating the 'adjusted financial performance' which is how NHSE measure system performance.

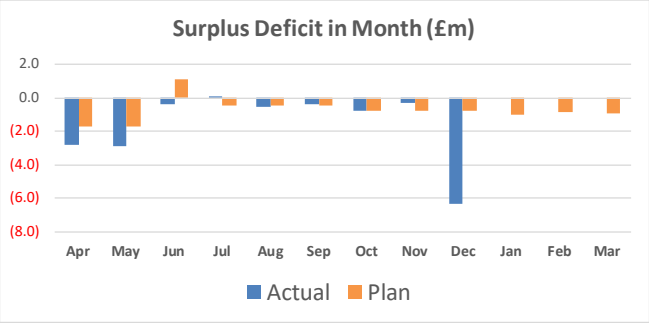
The adjusted financial performance is a deficit of £10.1m year to date, which is £4.4m adverse to plan. The year to date position has now exceeded the full year planned deficit of £8.4m by £1.7m.

The month 9 position is a material deterioration. December was an extremely challenging month for the Trust operationally. A critical incident was declared between 19-23 December due to the exceptional pressure on services and the demand on the Emergency Department. The volume of no right to reside (medically fit for discharge) patients and delays in discharging people home or into social care settings resulted in escalation of several areas. Additional staffing costs have been incurred associated with the escalation areas, including additional premiums, and the need for enhanced care. The cost of escalation is estimated at £0.5m for December.

The GM ICS reported a year to date deficit of £78.1m at the end of month 8, which was an adverse variance of £66.7m to the planned deficit of £11.3m.

The actual income reported in month was £40.0m which is £1.8m favourable to plan.



# Key Financial Indicators

| Key Financial Indicators | In Month (£000) | | | Year to Date (£000) | | | Full Year (£000) |
|---|---|---|---|---|---|---|---|
| | Actual | Plan | Var | Actual | Plan | Var | Plan |
| **Financial Performance** | | | | | | | |
| Income | 39,950 | 38,192 | 1,757 | 359,630 | 342,876 | 16,753 | 457,223 |
| Expenditure | (40,472) | (37,215) | (3,257) | (353,669) | (332,782) | (20,887) | (444,564) |
| Financing / Technical | (5,862) | (1,773) | (4,090) | (20,150) | (15,955) | (4,195) | (21,273) |
| Surplus / Deficit | (6,385) | (795) | (5,589) | (14,252) | (5,861) | (8,391) | (8,615) |
| Adjusted Financial Performance * | (2,346) | (779) | (1,567) | (10,091) | (5,716) | (4,374) | (8,426) |
| **Other** | | | | | | | |
| CIP | 1,832 | 1,992 | (159) | 19,196 | 17,925 | 1,271 | 23,900 |
| COVID-19 Expenditure | 140 | 322 | 182 | 3,674 | 5,344 | 1,670 | 6,311 |
| Agency Spend | 958 | 311 | (647) | 9,947 | 2,798 | (7,148) | 3,731 |
| Cash Balance | 27,987 | 37,152 | (9,165) | 27,987 | 37,152 | (9,165) | 38,123 |
| Capital Spend - CDEL | 659 | 1,350 | 691 | 4,469 | 5,557 | 1,088 | 11,107 |
| Capital Spend - PDC | 297 | 600 | 303 | 794 | 2,917 | 2,123 | 11,843 |

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

## CIP

- £1.8m transacted in month 9 and £19.2m YTD.
- Split in month: Divisional £0.7m; Corporate CIP £1.1m.

## COVID Expenditure

- £0.1m expenditure in month, lowest since start of the year.
- £0.2m less than plan in month.

## Agency

- Expenditure of £1.0m in month 9 and £9.9m YTD.
- Expenditure remains higher than last year.

## Cash

- £28.0m cash balance.
- £9.2m below plan year to date.
- Decrease of £4.5m from month 8.

## Capital

- £1.0m spend in month, £1.0m behind plan.
- £5.2m year to date spend, £3.2m behind plan.
- £1.5m of the variance is due to delay in Frontline Digitisation PDC approval nationally, remaining £1.7m relates to delay in commencement of schemes.

# Divisional Performance

## Medicine

- (£1.1m) adverse to plan in month
- Nursing including 1:1 (£0.4m)
- Medical staffing (£0.4m)
- A&E escalation (£0.2m)
- CIP (£0.1m)

## Surgery

- (£0.5m) adverse to plan in month
- Drugs & hearing aids (£0.1m)
- Theatres non pay (£0.1m)
- Theatres bank and agency (£0.1m)
- CIP (£0.2m)

## Specialist Services

- (£0.1m) adverse to plan in month
- Theatres non-pay / prosthesis (£0.2m)
- Drugs (£0.2m)
- Escalation Ward 6 (£0.1m)
- Private patient income £0.2m
- CIP £0.2m

## Community

- £0.1m favourable to plan in month
- Surgical appliances £0.1m
- CIP on plan

## Estates & Facilities

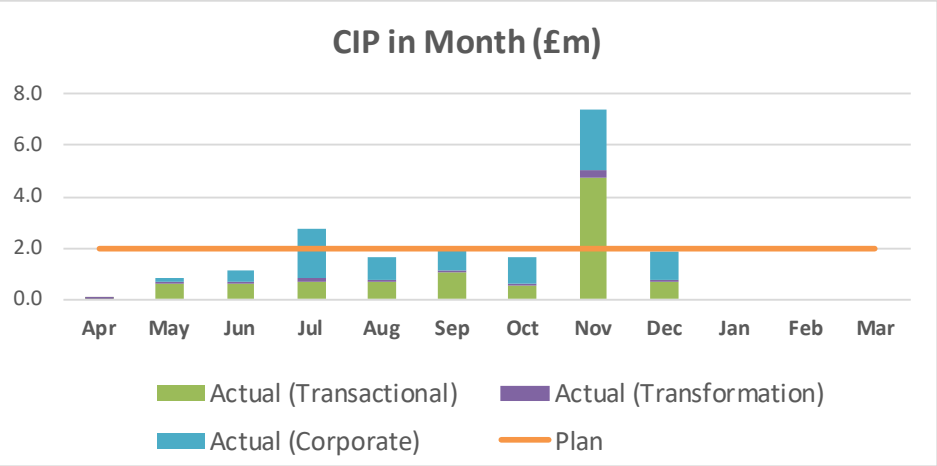
- (£0.3m) adverse to plan in month
- Community premises (£0.1m)
- Linen and Domestics (£0.1m)
- Catering and Security (£0.1m)
- CIP on plan

## Corporate Divisions

- (£0.5m) adverse on aggregate
- International nurse recruitment due to phasing of number of nurses (£0.4m)
- CIP (£0.1m)

All Divisions (Medicine, Surgery, Specialist Services, Community and Estates & Facilities) will be escalated to a RAPID meeting based on the month 9 financial position deteriorating significantly in comparison to budget, run rate and any previously reported forecast positions. The focus of the rapid meetings will be to provide an update on the actions outstanding and the financial recovery actions communicated; understanding the run rate increases observed in the last few months and the impact of these in the forecasted position; and CIP delivery and immediate cost reduction plans.

# Cost Improvement Programme




In month 9, £1.8m of CIP was transacted which is £0.2m adverse to plan. This is split £0.7m Divisional CIP and £1.1m Corporate CIP.

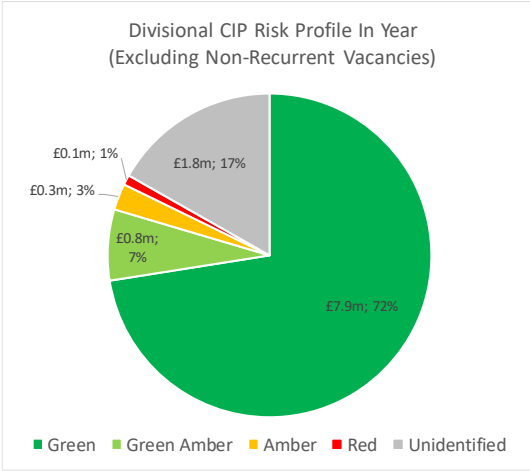
In month, the Corporate CIP of £1.1m is on plan.

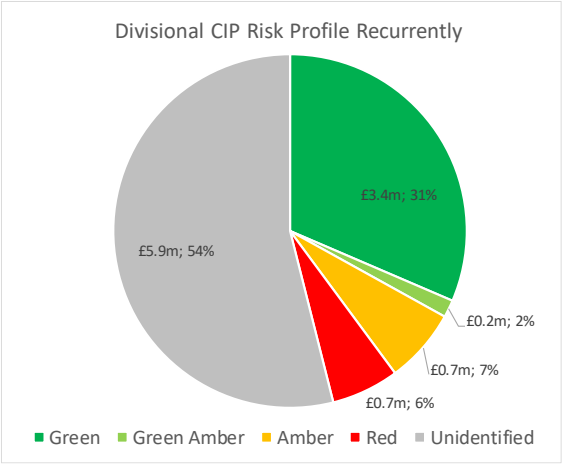
£8.7m of Corporate CIP has been transacted year to date, which is £1.1m below plan. The Trust is on track to deliver the 2022/23 plan of £13.0m by month 12. All the Corporate CIP is non-recurrent in nature.

Year to date, £19.2m has been transacted which is £1.3m ahead of plan. However, excluding the non-recurrent vacancies CIP is £2.6m below plan year to date. The split between transactional and transformational schemes is £9.4m and £1.1m respectively.

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 £5.0m which is a reduction of £0.2m from month 8. The recurrent forecast has deteriorated month on month since month 3, with schemes not progressing as originally planned. There is a greater risk profile associated with the recurrent delivery with 54% currently unidentified. This is a key focus of the RAPID meetings for the remainder of the financial year.



# Forward Look

The 2023/24 planning round is underway and the Strategy & Planning team, Finance and HR teams are working together with Divisional teams. The national planning guidance was released on 23rd December 2022. A baseline planning exercise was presented to ETM in January, where support was agreed for the approach, recognising the significant operational pressures currently being faced.

Discussion continues across GM regarding the financial recovery plans. It has been agreed through PFB that the system should continue to forecast a breakeven position based on the balance of risk and a consideration of further flexibility within some organisations to improve the financial position. Further work is required around establishing system oversight on temporary spend and to understand the issues causing the poor benchmarking on productivity metrics compared to other regions.

The current estimate for the increase in energy expenditure in 2023/24 is £6.0m although the market remains highly volatile. This is based on £5.0m for gas and £1.0m for electricity.

There is still uncertainty related to the funding arrangements for 2023/24. However, the planning guidance indicates that there will be a return, at least in part, to a tariff model for elective care. This would be to incentivise elective recovery and could be a revised model of the current Elective Care Fund. The impact of this will be modelled as part of the planning round. There is the potential for penalties where systems do not meet activity targets.

The Finance team has been formally awarded reaccreditation at level 3 for Finance Skills Development (FSD) and One NHS Finance by the national Finance Leadership Council in January 2023. This follows a presentation to the North-West Towards Excellence Finance Assurance Group in December 2022, where the panel highlighted several areas of best practice, which the finance team have been asked to showcase across the region. This includes the RAPID process which was recently accepted by the Innovation Forum for publishing nationally. Level 3 accreditation is the highest level achievable and lasts for three years.

# Trust Board – Maternity Incentive Scheme Update.

Presented by Cathy Stanford. Divisional Director of Midwifery and Child Health.

Dr Shatha Attarbashi. Clinical Director Consultant Obstetrician and Gynaecologist.

Trust Board 1 February 2023.

# 10 Safety Standards Year 4

**In December 2022, the Trust Board received a paper outlining compliance against Year 4 of the Maternity Incentive Scheme 10 Safety Standards, and the intention to request the Board to approve the submission of declaring compliance against all 10 safety Standards to NHSR.**

**A board Declaration form is to be signed by the CEO following Board approval and forwarded to the ICB nominated officer prior to submission to NHSR**

**Safety Action 1.** Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?

**Safety Action 2.** Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

**Safety Action 3.** Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into the Neonatal units Programme?

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

**Safety Action 5.** Can you demonstrate an effective system of midwifery workforce planning to the required standard?

**Safety Action 6.**Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2 80% compliance is required for all metrics within all 5 elements, or the Trust will be required to submit an action plan.

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

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

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

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

# Safety Action 1

**In line with best practice, the Trust uses the Perinatal Mortality Tool to standardise perinatal mortality reviews held at the Trust.**

Work is continually being undertaken to make the PMRT process more robust, ensuring that through a multi-disciplinary approach organisational learning is maximised. The statistics are as follows for each element:

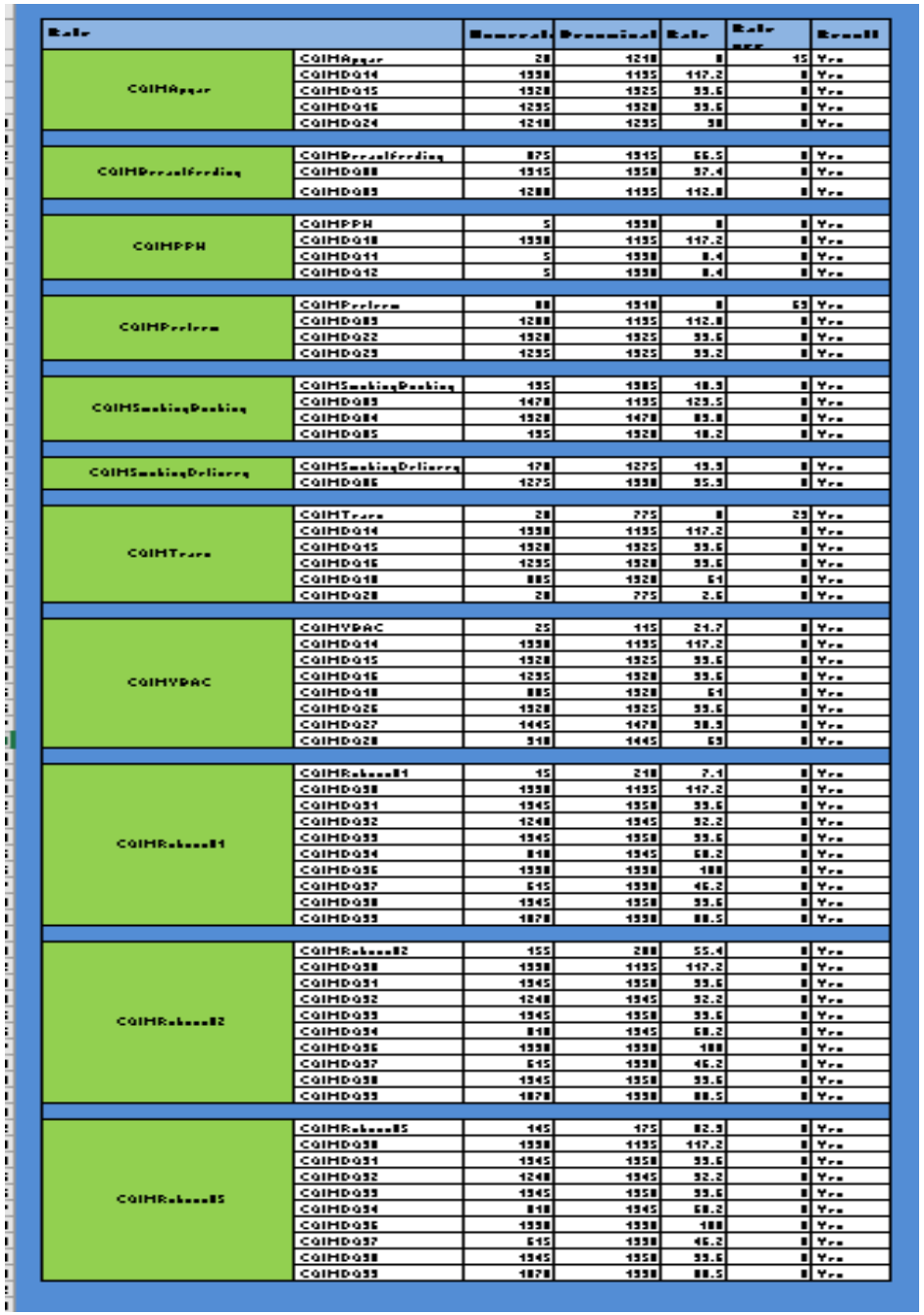
There were 4 eligible cases in the reporting period of 6 May 2022 – 20 January 2023

- Notification to MBRRACE with 7 days – 100%
- Surveillance completed within 1 month – 100%
- PMRT review commenced within 2 months – 100%
- Draft report produced within 4 months – 100% (only one case eligible for draft report)
- Final report completed by 6 months – 0 eligible for final report
- Parents informed + questions asked – 100 %
- During the reporting period WWL had 3 Neonatal Deaths ( 2 were following medical termination of pregnancy) all cases were reported to the coroner and do not meet the criteria for PMRT due to gestation of extreme prematurity and termination.

# Safety Action 2

**WWL are committed to taking part in the National Maternity Quality Improvement Programme and report into the maternity services data set and other key data sets.**

- The Maternity Digital Strategy has been submitted and approved . This includes the 7 success measures within the What good looks like framework.
- The Trust has achieved 11 of the 11 Clinical Quality Improvement Metrics (CQIMS )
- There are 5 additional metrics of which 4 were fully compliant
- WWL failed on one metric as the metric for continuity of carer being recorded by 29 weeks of pregnancy was not fully compliant. An action Plan as agreed by NHS Digital has demonstrated compliance against this action in accordance with CNST Guidance.



| Rule | | Numerator | Denominator | Rate | Rate per | Result |
|---|---|---|---|---|---|---|
| CQIMAspar | CQIMAspar | 28 | 1248 | 0 | 15 | Yes |
| | CQIMDQ14 | 1338 | 1135 | 117.2 | 0 | Yes |
| | CQIMDQ15 | 1328 | 1325 | 99.6 | 0 | Yes |
| | CQIMDQ16 | 1255 | 1328 | 99.6 | 0 | Yes |
| | CQIMDQ24 | 1248 | 1255 | 98 | 0 | Yes |
| CQIMBreastfeeding | CQIMBreastfeeding | 875 | 1345 | 66.5 | 0 | Yes |
| | CQIMDQ88 | 1345 | 1358 | 97.4 | 0 | Yes |
| | CQIMDQ83 | 1288 | 1135 | 112.8 | 0 | Yes |
| CQIMPPH | CQIMPPH | 5 | 1358 | 0 | 0 | Yes |
| | CQIMDQ18 | 1338 | 1135 | 117.2 | 0 | Yes |
| | CQIMDQ11 | 5 | 1358 | 0.4 | 0 | Yes |
| | CQIMDQ12 | 5 | 1358 | 0.4 | 0 | Yes |
| CQIMPreterm | CQIMPreterm | 88 | 1348 | 0 | 69 | Yes |
| | CQIMDQ83 | 1288 | 1135 | 112.8 | 0 | Yes |
| | CQIMDQ22 | 1328 | 1325 | 99.6 | 0 | Yes |
| | CQIMDQ23 | 1255 | 1325 | 99.2 | 0 | Yes |
| CQIMSmokingBooking | CQIMSmokingBooking | 155 | 1385 | 10.3 | 0 | Yes |
| | CQIMDQ83 | 1478 | 1135 | 129.5 | 0 | Yes |
| | CQIMDQ84 | 1328 | 1478 | 83.8 | 0 | Yes |
| | CQIMDQ85 | 155 | 1328 | 10.2 | 0 | Yes |
| CQIMSmokingDelivery | CQIMSmokingDelivery | 178 | 1275 | 13.3 | 0 | Yes |
| | CQIMDQ86 | 1275 | 1358 | 93.3 | 0 | Yes |
| CQIMTrans | CQIMTrans | 28 | 775 | 0 | 23 | Yes |
| | CQIMDQ14 | 1338 | 1135 | 117.2 | 0 | Yes |
| | CQIMDQ15 | 1328 | 1325 | 99.6 | 0 | Yes |
| | CQIMDQ16 | 1255 | 1328 | 99.6 | 0 | Yes |
| | CQIMDQ18 | 885 | 1328 | 61 | 0 | Yes |
| | CQIMDQ28 | 28 | 775 | 2.6 | 0 | Yes |
| CQIMVBAC | CQIMVBAC | 25 | 115 | 21.7 | 0 | Yes |
| | CQIMDQ14 | 1338 | 1135 | 117.2 | 0 | Yes |
| | CQIMDQ15 | 1328 | 1325 | 99.6 | 0 | Yes |
| | CQIMDQ16 | 1255 | 1328 | 99.6 | 0 | Yes |
| | CQIMDQ18 | 885 | 1328 | 61 | 0 | Yes |
| | CQIMDQ26 | 1328 | 1325 | 99.6 | 0 | Yes |
| | CQIMDQ27 | 1445 | 1478 | 98.9 | 0 | Yes |
| | CQIMDQ28 | 318 | 1445 | 69 | 0 | Yes |
| CQIMRubeol1 | CQIMRubeol1 | 15 | 218 | 7.1 | 0 | Yes |
| | CQIMDQ38 | 1338 | 1135 | 117.2 | 0 | Yes |
| | CQIMDQ31 | 1345 | 1358 | 99.6 | 0 | Yes |
| | CQIMDQ32 | 1248 | 1345 | 92.2 | 0 | Yes |
| | CQIMDQ33 | 1345 | 1358 | 99.6 | 0 | Yes |
| | CQIMDQ34 | 818 | 1345 | 60.2 | 0 | Yes |
| | CQIMDQ35 | 1338 | 1338 | 100 | 0 | Yes |
| | CQIMDQ37 | 615 | 1338 | 46.2 | 0 | Yes |
| | CQIMDQ38 | 1345 | 1358 | 99.6 | 0 | Yes |
| | CQIMDQ33 | 1078 | 1338 | 80.5 | 0 | Yes |
| CQIMRubeol2 | CQIMRubeol2 | 155 | 288 | 55.4 | 0 | Yes |
| | CQIMDQ38 | 1338 | 1135 | 117.2 | 0 | Yes |
| | CQIMDQ31 | 1345 | 1358 | 99.6 | 0 | Yes |
| | CQIMDQ32 | 1248 | 1345 | 92.2 | 0 | Yes |
| | CQIMDQ33 | 1345 | 1358 | 99.6 | 0 | Yes |
| | CQIMDQ34 | 818 | 1345 | 60.2 | 0 | Yes |
| | CQIMDQ35 | 1338 | 1338 | 100 | 0 | Yes |
| | CQIMDQ37 | 615 | 1338 | 46.2 | 0 | Yes |
| | CQIMDQ38 | 1345 | 1358 | 99.6 | 0 | Yes |
| | CQIMDQ33 | 1078 | 1338 | 80.5 | 0 | Yes |
| CQIMRubeol5 | CQIMRubeol5 | 145 | 175 | 82.9 | 0 | Yes |
| | CQIMDQ38 | 1338 | 1135 | 117.2 | 0 | Yes |
| | CQIMDQ31 | 1345 | 1358 | 99.6 | 0 | Yes |
| | CQIMDQ32 | 1248 | 1345 | 92.2 | 0 | Yes |
| | CQIMDQ33 | 1345 | 1358 | 99.6 | 0 | Yes |
| | CQIMDQ34 | 818 | 1345 | 60.2 | 0 | Yes |
| | CQIMDQ35 | 1338 | 1338 | 100 | 0 | Yes |
| | CQIMDQ37 | 615 | 1338 | 46.2 | 0 | Yes |
| | CQIMDQ38 | 1345 | 1358 | 99.6 | 0 | Yes |
| | CQIMDQ33 | 1078 | 1338 | 80.5 | 0 | Yes |

| Rule | | Numerator | Denominator | Rate | Rate per | Result |
|---|---|---|---|---|---|---|
| BMIDQ | BMIDQ | 1238 | 1255 | 95 | 0 | Yes |
| CSPDQ | CSPDQ | 1478 | 1478 | 100 | 0 | Yes |
| PCSPDQ | PCSPDQ | 1465 | 1478 | 99.7 | 0 | Yes |
| ElbirthDQ | ElbirthDQ | 1335 | 1478 | 90.8 | 0 | Yes |
| MCOC | MCOC | | | | | No |
| | COC_DQ04 | 1048 | 1358 | 77 | 0 | Yes |
| | COC_DQ05 | 78 | 78 | 100 | 0 | Yes |
| | COCDQCarePrefIID | 5628 | 14868 | 21.8 | 0 | No |

| Help with CQIM Measure | | | |
|---|---|---|---|
| Select Measure >>>>>> | | BMIDQ | |
| Threshold | >=0.91 | Annualised Measure/Rate | BMIDQ |
| Percentage of women who reach 15 weeks gestation (105 days) in the month, with a valid BMI recorded | | | |

| | | |
|---|---|---|
| Total CQIMs | 11 | |
| CQIMs Passed | 11 | Yes |

| Criteria Passed | 5 / 6 | These figures are based on your latest quad submission that you have made for July 2022 |
|---|---|---|

# Safety Action 3
# ATAIN (Avoiding Term Admissions Into Neonatal Units)

**Quarterly audit of Term admissions to NNU following birth, enables identification of themes and trends in neonatal morbidity. These are completed 2-4 weekly and submitted quarterly**

- **A live action plan has been ongoing since the introduction of ATAIN in 2018 to support continuous service improvement.**
- The Maternity Incentive Scheme Safety Action 3 requires an operational Transition care (TC) unit to be in place. **This was commenced in 2019 but required suspending during the Pandemic, However in June 22 we introduced a limited service until August 22 then fully re-instated.**
- Findings of ATAIN reviews are shared quarterly with the Board Level Safety Champion and through the quarterly perinatal Quality Surveillance report .
- Point (c) relates to the requirement for a data recording process to be in place for capturing all term babies transferred to the neonatal unit, regardless of the length of stay. These babies are all captured on BadgerNet
- An action plan – to address local findings from pathway audits and ATAIN reviews – must be agreed with the maternity and neonatal safety champions, including Board-level champions (and signed off by Board by 29 July). Action plan not submitted by deadline although completed. Tabled at Safety Champions and agreed in August 2022 . Sent to LMNS and ICS within agreed time frames. Action plan with mitigation to be submitted within Board Declaration to request full compliance.

# Safety Action 4

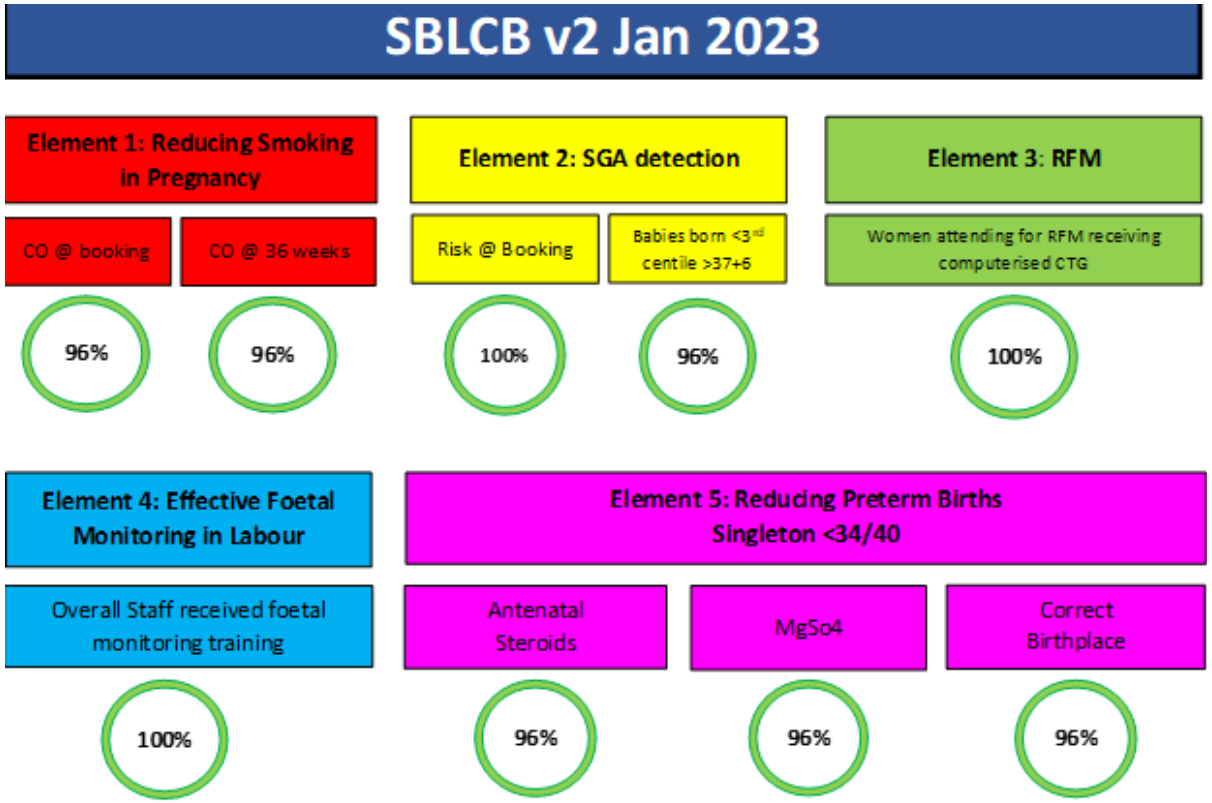
- **Obstetric Medical workforce.** An audit has been completed capturing situations where a consultant must attend (RCOG 2021). It is planned to capture this data by 'exception' reporting – and quarterly cross reference with Euroking the Maternity information system where this is evidenced,
- **Anaesthetic workforce.** Anaesthetic workforce planning has been evidenced and is compliant. Rotas are available to demonstrate compliance and show that a duty anaesthetist is available for the Obstetric unit 24/7 in accordance with ACSA standard 1.7.2.1
- **Neonatal Medical workforce. The Tier 1 rota remains not fully compliant. Mitigations are in place and were submitted via the action plan to Board in December 2022. This has also been submitted to the Northwest Neonatal Operational Delivery Network (NWNODN). The action plan that is in place demonstrates compliance against this action. The mitigation is to increase the Advanced Neonatal Nurse Practitioners (ANNP) to support the rota alongside MCH doctors. One post is currently out to recruitment and as funding becomes available further posts will be sought, additionally confirmation of additional funding to support the Neonatal Critical Care workforce has been received from Specialist commissioning which has been used to support funding for the ANNP. In times of high acuity and activity bank and agency staff are utilised to support the rota to free up substantive staff for NNU.**
- **Neonatal Nursing workforce.** The neonatal unit meets the service specification for neonatal BAPM nursing standards.

# Safety Action 5

- An updated Birth-rate plus review has been undertaken and was completed in December 2022. The service is currently analysing the findings which will be included in the 2023 safer staffing report.
- 1:1 labour care – **Is compliant.**
- Supernumerary status for Band 7 coordinator on Delivery Suite – This **is compliant and non-compliance only occurs on an infrequent basis usually due to short notice sickness or excessive acuity and activity,** if this occurs regularly then non-compliance would need to be declared as MIS doesn't allow for an action plan.
- Biannual Safer Staffing papers were submitted to Trust Board in December 2021 and October 2022.

# Safety Action 6

All Elements compliant



# Safety Action 7

- This relates to co-production of maternity services with the Maternity Voices Partnership (MVP). Work continues to build on the excellent relationship WWL has with the Wigan Borough MVP.
- There is good evidence towards this Safety Action detailing guidelines and Patient Information Leaflets, website development and Facebook pages ’. Additionally, 15 steps walkabouts have been undertaken regularly within then clinical areas by services users and MVP leads This is in line with their annual workplan agreed within the LMNS .
- WWL Maternity services have a standing invitation to the Bimonthly MVP where there is an opportunity for discussion of agenda items, and for service-user feedback to be discussed and actioned.
- The MVP Chair and deputy Chair also have an open invitation to attend various Governance forums as available and are also actively involved in the Safety Champions Forum.
- A cross check of evidence has been carried out with the Chair of MVP and this is fully compliant.

# Safety Action 8

Fully Compliant with all actions

**NLS Compliance Paediatrics 2022**

| | |
|---|---|
| Consultants | 93.33% |
| Middle Grades | 100% |
| Nurses | 100% |
| Tier 1 ( on induction) | 100% |

**Mandatory Training compliance Midwifery**

| | Number attended | Percentage of staff | Rolling percent |
|---|---|---|---|
| BLS | 26 | 17% | 93% |
| NLS | 26 | 17% | 93% |
| PROMPT | 37 | 25% | 91% |
| Fetal Physiology | 24 | 16% | 93% |
| Fetal Physiology 2 | 73 | 48% | 91% |

All Maternity mandatory training achieved 90% compliance throughout December to achieve CNST compliance.

**Mandatory training compliance other specialities**

| | PROMPT | |
|---|---|---|
| | Number attended | Rolling percentage |
| Consultant Obstetrician | 1 | 91% |
| Obstetric registrar | 5 | 91% |
| Anaesthetist | 9 | 100% |
| MSW | 14 | 94% |

All specialities achieved 100% compliance by December.

**Fetal Physiology**

| | Oct 22 | Rolling % | Nov 22 | Rolling % | Dec 22 | Rolling % |
|---|---|---|---|---|---|---|
| **Midwives** | 9 | 96% | 13 | 96% | 57* | 91% |
| **Obstetric Consultants** | 0 | 100% | 0 | 90% | 0 | 100% |
| **Obstetric Registrars** | 1 | 90% | 1 | 90% | 3 | 90% |

*Due to standards for fetal physiology requiring all staff to attend full day training – additional sessions put on to meet 90% compliance of staf

# Safety Action 9

**This relates to maternity and Neonatal safety. Compliance has been demonstrated against the required below actions.**

- Work continues towards evidencing all elements of this Safety Action, such as the Perinatal Quality Surveillance report, maternity dashboard
- Safety walkabouts are continued Bi-Monthly with the designated NED or Executive Director and any concerns escalated and actioned accordingly
- Pathways for reporting are in place with submission of evidence to the LMNS/ ICS now in place
- Staff are aware of Safety Champions, and these are visible within the units.
- The Trust claims Score card for 2021 has been reviewed and 2022 will be tabled and discussed at Safety Champions ( received in Nov22)
- An action plan was submitted to Q&S in May 2022 outlining plans to implement Continuity of Carer (CoC) as the default model of care by 2024, and therefore prove compliance with MIS Year 4. This target date was subsequently removed, and the emphasis is to target areas that would most benefit from this model and move forward in a more measured approach in line with workforce capacity.
- Following a letter of recommendation from NHS England, MIS now requires that a review of COC is carried out against the safe staffing model. This is currently compliant as staffing does not allow for the re-introduction of a full continuity model of care. However, the Maternity Service are developing enhanced Community care teams which will target those at most need and who will benefit from additional support.
- The Perinatal Quality Surveillance Dashboard is submitted to Trust Board and to Quality and Safety Committee alongside the quarterly Perinatal Quality Surveillance report.
- The MatNeoSip Quality Improvement Programme is discussed, and staff supported to engage and participate with protected time allocated.
- The SCORE culture survey is due to be rolled out across the network with dedicated support to undertake the briefing of staff with the outcomes. No other culture surveys have been in place however several staff have been on the internal culture programme with others attending external courses

# Safety Action 9 Minimum Data Set for Trust Board

| Item | Description |
|---|---|
| 1 | Findings of PMRT reviews |
| 2 | Findings of all HSIB cases |
| 3 | Number of incidents logged (graded moderate or above) and actions taken |
| 4 | Training compliance (all staff groups, competency framework) |
| 5 | Minimum safe staffing in maternity (including obstetrics) |
| 6 | Service User Feedback |
| 7 | Staff feedback from frontline staff engagement by safety champions |
| 8 | CQC / NHSR / HSIB concerns or requests for action of the Trust |
| 9 | Regulation 28 report (HM Coroner) |
| 10 | Progress in achievement of the CNST 10 |

# Ockenden Compliance

- The initial Ockenden Report was released in December 2020
- It consisted of 7 Immediate & Essential Safety Actions (IEA's) and 1 workforce action
- The final Ockenden Report was released in March 2022
- It consisted of 15 Immediate & Essential Safety Actions (IEA's)
- Compliance with the Ockenden IEAs is monitored monthly to demonstrate progress and areas of continued focus
- Compliance and progress against the gaps is monitored in detail via Divisional Assurance groups and Quality and Safety Committee.

# Ockenden Compliance

| Q3 Update | | Local Actions | | | N/A | Trust Corp Action | National/ regional Action |
|---|---|---|---|---|---|---|---|
| | | Red | Amber | Green | | | |
| EA1 | Workforce planning and sustainability | 0 | 2 | 5 | | | 4 |
| EA2 | Safe staffing | 0 | 2 | 7 | | | 1 |
| EA3 | Escalation and accountability | 0 | 3 | 1 | | | 1 |
| EA4 | Clinical governance- leadership | 0 | 2 | 4 | | 1 | |
| EA5 | Clinical governance – incident investigation and complaints | 0 | 1 | 6 | | | |
| EA6 | Learning from maternal deaths | 0 | 0 | 2 | | | 1 |
| EA7 | Multidisciplinary training | 0 | 2 | 5 | | | |
| EA8 | Complex antenatal care | 0 | 2 | 3 | | | |
| EA9 | Preterm birth | 0 | 0 | 4 | | | |
| EA10 | Labour and birth | 0 | 1 | 3 | 2 | | |
| EA11 | Obstetric anaesthesia | 0 | 1 | 6 | | | 1 |
| EA12 | Postnatal care | 0 | 1 | 3 | | | |
| EA13 | Bereavement care | 0 | 0 | 4 | | | |
| EA14 | Neonatal care | 0 | 3 | 4 | | | 1 |
| EA15 | Supporting families | 0 | 2 | 1 | | | |
| | Total | 0 | 22 | 58 | 2 | 1 | 9 |

# Safety Action 10

This Safety Action relates to HSIB and reporting of all qualifying cases to the Early Notification Scheme. The Trust are currently 100% Compliant.

The reporting period since the relaunch of MIS  is from 1stApril 2021 – 5th December 2022.

All families have been fully informed and Duty of Candour completed

**Summary of Compliance**

- WWL are fully complaint against 7 of the Safety Standards

**Safety Standard 2 MSDS** has one element of non compliance. However the action plan that has been presented to The Trust Board in December 2022 is fully compliant against the Safety Standard and in line with NHS Digital and NHSR requirements .

- **Highly likely to be accepted as compliant**

**Safety Standard 4 Neonatal Medical staffing .** Action plan in place as with Year 3 in regard to Tier 1 Medical rota and was submitted to Trust Board in December 2022. Mitigating actions have been accepted by the NWNODN.

- **Highly likely to be accepted as compliant**

**Safety Standard 3. Transitional Care Services in place**. One element of non compliance as action plan not signed off by the Trust Board or designated Committee in July 2022. The action plan has been submitted within the Board Declaration form outlining the reasons, mitigations and remedial actions now in place.

- **Likely to be accepted as compliant**

## Recommendations

The Board are asked to review the evidence within the presentation and the action plans within the Board Declaration form and agree CEO sign off prior to submission to the ICB and NHSR by 12 noon on February 2nd 2022.

# Thank You
# Any Questions?

## Maternity incentive scheme - Guidance

| | |
|---|---|
| Trust Name | **Wrightington, Wigan and Leigh NHS Foundation Trust** |
| Trust Code | **T588** |

This document must be used to complete your trust self-certification for the maternity incentive scheme safety actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. **Your trust name will populate each tab. If the trust name box is coloured pink please update**

**Guidance Tab** - This has useful information to support you to complete the maternity incentive scheme safety actions excel spreadsheet. **Please read the guidance carefully.**

The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested.

There are multiple additional tabs within this document:

**Tab A - safety actions entry sheets (1 to 10) -** Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed within the condition of the scheme with each maternity incentive scheme safety action. Note, 'N/A' (not applicable) is available only for set questions. The information which has been populated in this tab, will automatically populate onto tab D which is the board declaration form.

**Tab B** - action plan summary sheet - This will provide you information on your Trust's progress in completing the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. This will feed into the board declaration sheet - tab D.

**Tab C - action plan entry sheet** - This sheet will enable your Trust to insert action plan details for any safety actions not achieved.

**Tab D - Board declaration form -** This is where you can track your overall progress against compliance with the maternity incentive scheme safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the trust board, commissioners and before submission to NHS Resolution.

Upon completion of the following processes please add an electronic signature into the allocated spaces within this document. Two electronic signatures of the Trust's CEO and AO of the ICS will be required in Tab D as outlined in order to declare compliance stated in the board declaration form with the safety actions and their sub-requirements, one signature to confirm that the declaration form has been submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services and two signatures to declare that there are no external or internal reports covering either 2021/22 financial year or 2022/23 that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 2 February 2023.

If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **nhsr.mis@nhs.net**
Technical guidance and frequently asked questions can be accessed here:
https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

Submissions for the maternity incentive scheme must be received no later than 12 noon on **Thursday 2 February 2023** to nhsr.mis@nhs.net
You are required to submit this document signed and dated. Please do not send evidence to NHS Resolution.

*Version Name: MIS_SafetyAction_2023_V10*

## Safety action No. 1

**Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?**

| Requirements number | Safety action requirements | Requirement met? (Yes/ No /Not applicable) |
|---|---|---|
| 1 | Have all eligible perinatal deaths from 6 May 2022 onwards been notified to MBRRACE-UK within seven working days? | Yes |
| 2 | Was the surveillance information for eligible deaths where required, completed within one month of the death? | Yes |
| 3 | Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 been started within two months of each death?<br>This includes deaths after home births where care was provided by your Trust. | Yes |
| 4 | Have at least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022, been reviewed using the PMRT, by a multidisciplinary review team? | Yes |
| 5 | Were each of these reviews completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death? | Yes |
| 6 | Were the reports published within 6 months of death? | Yes |
| | **Q7 and Q8 are linked questions** | |
| 7 | For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, were parents told that a review of their baby's death will take place? | Yes |
| 8 | If parents have not been informed about the review taking place, were the reasons for this documented within the PMRT review? | N/A |

**Safety action No. 2**
**Are you submitting data to the Maternity Services Data Set to the required standard?**

| Requirements number | Safety action requirements | Requirement met? (Yes/ No /Not applicable) |
|---|---|---|
| 1 | By 31 October 2022, did your Trusts have an up-to-date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework? | Yes |
| 2 | Was the strategy shared with Local Maternity Systems? | Yes |
| 3 | Was the strategy signed off by the Integrated Care Board? | Yes |
| 4 | Is a dedicated Digital Leadership in place in the Trust? | Yes |
| 5 | Has the Digital Leadership at the Trust engaged with the NHSE Digital Child Health and Maternity Programme? | Yes |
| 6 | Was your Trust compliant with at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) data quality criteria in the “CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria” data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022? | Yes |
| Did your Trust's July 2022 data contain: | | |
| 7 | Height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month? | Yes |
| 8 | Complex social factor Indicator (at antenatal booking) data for 95% of women booked in the month? | Yes |
| 9 | Antenatal personalised care plan fields completed for 95% of women booked in the month (MSD101/2)? | Yes |
| 10 | A valid ethnic category (Mother) for at least 90% of women booked in the month (MSD001) ? | Yes |
| Has the Trust Board confirmed that they have passed the associated data quality criteria in the “CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria” data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022 for the following metrics: | | |
| 11 | i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the Continuity of Carer (CoC) pathway indicator completed. | No |
| | **Q12 is for information only** | |

| | | |
|---|---|---|
| 12 | ii. Over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided. | No |
| 13 | iii. At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion. | Yes |

**Safety action No. 3**

**Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?**

| Requirements number | Safety action requirements | Requirement met? (Yes/ No /Not applicable) |
|---|---|---|
| a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care by Thursday 16 June 2022 at the very latest | | |
| 1 | Was the pathway(s) of care into transitional care jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies?<br><br>Evidence should include:<br>● Neonatal involvement in care planning<br>● Admission criteria meets a minimum of at least one element of HRG XA04 but could extend beyond to British Association of Perinatal Medicine (BAPM) transitional care framework for practice<br>● There is an explicit staffing model<br>● The policy is signed by maternity/neonatal clinical leads and should have auditable standards.<br>● The policy has been fully implemented and quarterly audits of compliance with the policy are conducted. | Yes |
| 2 | Are neonatal teams involved in decision making and planning care for all babies in transitional care? | Yes |
| b) The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, Local Maternity and Neonatal Systems (LMNS), commissioner and Integrated Care | | |
| 3 | Has the pathway of care into transitional care been fully implemented? | Yes |
| 4 | Has the pathway of care into transitional care been audited quarterly? | Yes |

| | | |
|---|---|---|
| Audit findings must be shared each quarter. If for any reason, reviews were paused, they must have been recommenced using data from quarter 1 of 2022/23 financial year.<br>Has audit findings been shared with: | | |
| 5 | The neonatal safety champion? | Yes |
| 6 | The LMNS? | Yes |
| 7 | The commissioner and Integrated Care System (ICS) quality surveillance meeting? | Yes |
| 8 | If your Trust have encountered barriers to achieving full implementation of the policy, has an action plan been agreed and progress overseen by both the board and neonatal safety champions? | Yes |
| c) A data recording process (electronic and/or paper based) for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place. | | |
| 9 | Is standard (c) in place? | Yes |
| d) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered. | | |
| | **Q10 and Q11 are linked** | |
| 10 | Is standard (d) in place?<br>This should be achieved by no later than 16 June 2022. | Yes |
| 11 | If not already in place is a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered | N/A |
| e) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies. | | |
| 12 | Is standard (e) in place (as per ODN request)? | Yes |

| | | |
|---|---|---|
| f) Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis. | | |
| 13 | Is an audit trail available which provides evidence that ongoing reviews from year 3 of the maternity incentive scheme of term admissions are being completed as a minimum of quarterly? If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year. | Yes |
| 14 | Is an audit trail available which provides evidence that reviews from Monday 18 July 2022 included **all** term babies transferred or admitted to the NNU, irrespective of their length of stay, are being completed as a minimum of quarterly. If your reviews already included all babies transferred or admitted to the NNU then this should continue using data from quarter 1 of 2022/23 financial year? | Yes |
| 15 | Do you have evidence that the review includes the number of transfers or admissions to the neonatal unit that would have met current TC admission criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues and the number of babies that were transferred or admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there? | Yes |
| 16 | Do you have evidence that findings of all reviews of term babies transferred or admitted to a neonatal unit are reviewed quarterly and the findings have been shared quarterly with the maternity and neonatal safety champions and Board level champion, the LMNS and ICS quality surveillance meeting on a quarterly basis? | Yes |
| g) An action plan to address local findings from the audit of (standard b) Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, and (standard f) been agreed with the maternity and neonatal safety champions and Board level signed off by the Board no later than 29 July 2022? | | |
| 17 | Is standard (g) in place? | No |
| h) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting each quarter following sign off at the Board. | | |
| 18 | Has progress with the revised ATAIN action plan been shared with the maternity, neonatal and Board level safety champions each quarter, following sign off at the Board? | Yes |

| | | |
|---|---|---|
| 19 | Has progress with the revised ATAIN action plan been shared with the LMNS each quarter, following sign off at the Board? | Yes |
| 20 | Has progress with the revised ATAIN action plan been shared at the ICS quality surveillance meeting each quarter, following sign off at the Board? | Yes |

**Safety action No. 4**
**Can you demonstrate an effective system of clinical workforce planning to the required standard?**

| Requirements number | Safety action requirements | Requirement met? (Yes/ No /Not applicable) |
|---|---|---|
| 1 | **Obstetric medical workforce**<br>Have your Trust Board signed off their engagement with the principles outlined in the Royal College of Obstetricians and Gynaecologists (RCOG) workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service:<br>https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/? | Yes |
| | **Q2 and Q3 are linked** | |
| 2 | Was compliance of consultant attendance monitored when a consultant was required to attend in person? | Yes |
| 3 | Were episodes where attendance was not possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance? | N/A |
| Do you have evidence that your position with the above RCOG document was shared at least once from May 2022: | | |
| 4 | At Trust Board? | Yes |
| 5 | With Board level safety champions? | Yes |
| 6 | At LMNS meetings? | Yes |

| | | |
|---|---|---|
| 7 | **Anaesthetic medical workforce**<br><br>Do you have evidence of compliance with Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1?<br><br>The rota should be used to evidence compliance with ACSA standard 1.7.2.1 *(A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients)* | Yes |
| | **Q8 and Q9 are linked** | |
| 8 | **Neonatal medical workforce**<br><br>Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing? | No |
| 9 | If the requirement above has not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS and also include new relevant actions to address deficiencies.<br>If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies. Do you have evidence of this? | No |
| | **Q10, Q11 and Q12 are all linked** | |
| 10 | **Neonatal nursing workforce**<br><br>Does the neonatal unit meet the service specification for neonatal nursing standards? | Yes |
| 11 | If the requirement above had not been met in both year 3 and year 4 of MIS, has the Trust Board evidenced progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies? | N/A |
| 12 | Has the above action plan been shared with the Royal College of Nursing, LMS and Neonatal Operational Delivery Network (ODN) Lead? | N/A |

**Safety action No. 5**
**Can you demonstrate an effective system of midwifery workforce planning to the required standard?**

| Requirements number | Safety action requirements | Requirement met? (Yes/ No /Not applicable) |
|---|---|---|
| 1 | a) Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed?<br><br>Evidence should include:<br>A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated | Yes |
| 2 | b) Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated in a) above?<br><br>Evidence should include:<br>● Midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations.<br>●The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.<br>● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. -The midwife to birth ratio -The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.<br>● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls. | Yes |

| | | |
|---|---|---|
| 3 | c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.<br><br>The Trust can report compliance with this standard if this is a one off event and the coordinator is not required to provide 1:1 care for a woman in established labour during this time.<br><br>If this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above.<br>Do you have evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status? | Yes |
| | **Q4 is for information only** | |
| 4 | If you answered **no** to standard c, have you completed an action plan detailing how the maternity services intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board, and includes a timeline for when this will be achieved?<br><br>Please note, completion of an action plan **will no**t enable the trust to declare compliance with this sub-requirement in year four of MIS. | N/A |
| | **Q5, Q6 and Q7 are all linked** | |
| 5 | d) Have all women in active labour received one-to-one midwifery care? | Yes |
| 6 | If you have answered **no** to standard d, have you submitted an action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour? | N/A |
| 7 | Does the action plan include a timeline for when this will be achieved and has this been signed off by Trust Board? | N/A |
| 8 | e) Have you submitted a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period? | Yes |

**Safety action No. 6**

**Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle V2?**

| Requirements number | Safety action requirements | Requirement met? (Yes/ No /Not applicable) |
|---|---|---|
| 1 | Do you have evidence that Trust Board level consideration of your organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019?<br>Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract. | Yes |
| 2 | Has each element of the SBLCBv2 been implemented?<br><br>Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (ICB). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network. | Yes |
| 3 | The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements.<br><br>Have you completed and submitted this? | Yes |
| **Element 1 -** Reducing smoking in pregnancy<br><br>Standard a*) Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.*<br>*Standard b) Percentage of women where CO measurement at 36 weeks is recorded.* | | |
| 4 | Has the Trust Board received data for **standard a)** from the organisation's Maternity Information System (MIS) evidencing an average of 80% compliance over a four month period (i.e. four consecutive months in during the MIS year 4 reporting timeframe)? | Yes |
| 5 | Has the Trust Board received data for **standard b)** from organisation's Maternity Information System or has an audit of 60 consecutive cases been provided to demonstrate >80% of women having a CO measurement recorded at 36 weeks? | Yes |

| | | |
|---|---|---|
| 6 | Is the audit accompanied by a brief description of the stop smoking strategy within the Trust and any plans for improvement? | Yes |
| 7 | If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%. Has this been completed? | Yes |
| Do you have evidence that the Trust Board has specifically confirmed that within their organisation they: | | |
| 8 | Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric. | Yes |
| 9 | Have a referral pathway to smoking cessation services (in house or external)? | Yes |
| 10 | Have evidence of an audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service? | Yes |
| 4) Have you generated and reviewed the following outcome indicators within the Trust for four consecutive months within the MIS year 4 reporting period: | | |
| 11 | Percentage of women with a CO measurement ≥4ppm at booking? | Yes |
| 12 | Percentage of women with a CO measurement ≥4ppm at 36 weeks? | Yes |
| 13 | Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level <4ppm at the 36 week appointment? | Yes |
| **Element 2** - *Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)* | | |
| 14 | Standard 1)<br>Have you provided evidence showing the percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan?<br><br>The relevant data items for these process indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital<br><br>If your Trust has implemented the Tommy's Centre Risk Assessment and Clinical Decision Tool within a research programme then confirmation of the latter by the Trust Board will meet the requirement that Standards 1, 2 and 3 of Element 2 have been implemented | Yes |

| | | |
|---|---|---|
| 15 | Has the Trust board received data from the organisation's MIS evidencing 80% compliance or has an in house audit of 40 consecutive cases of women at 20 weeks scan using locally available data or case records been undertaken and submitted to Board to assess compliance with this indicator? | Yes |
| Do you have evidence that the Trust Board has specifically confirmed within their organisation: | | |
| 16 | Standard 2)<br>Women with a BMI>35 kg/$m^2$ are offered ultrasound assessment of growth from 32 weeks' gestation onwards?<br><br>If a Trust has implemented the Tommy's Centre Risk Assessment and Clinical Decision Tool within a research programme then confirmation of the latter by the Trust Board will meet the requirement that Standards 1, 2 and 3 of Element 2 have been implemented | Yes |
| 17 | Standard 3)<br>In pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation?<br><br>If a Trust has implemented the Tommy's Centre Risk Assessment and Clinical Decision Tool within a research programme then confirmation of the latter by the Trust Board will meet the requirement that Standards 1, 2 and 3 of Element 2 have been implemented | Yes |
| 18 | Standard 4)<br>There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation? | Yes |
| 19 | Standard 5)<br>They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT)? | Yes |
| 20 | Standard 6)<br>Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (ICBs) following advice from the Clinical Network? | Yes |

| | | |
|---|---|---|
| 21 | Standard 7)<br>You have undertaken a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems. Trusts can omit the above mentioned quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation for quarter 3 of this financial year (2021/22) if staffing is critical and this directly frees up staff for the provision of clinical care. | Yes |
| **Element 3** *Raising awareness of reduced fetal movement.*<br><br>A. Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy.<br>B. Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short term variation).<br>The SNOMED CT code is still under development for RFM and therefore an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM whichever is the smaller to assess compliance with the element three process indicators.<br><br>If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.<br><br>**A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.** | | |
| | **Q22 and Q23 are linked** | |
| 22 | Have you completed an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM (whichever is the smaller) demonstrating 95% compliance with the element three process indicators? | Yes |
| 23 | If the process indicator scores are less than 95% , have you submitted an action plan for achieving >95%? | N/A |
| **Element 4** *Effective fetal monitoring during labour* | | |
| | You do not need to submit evidence within element 4, as it is included within safety action 8 | |
| **Element** 5 *Reducing preterm births* | | |
| | **Q24, Q26, Q27 and Q28 are linked** | |

| | | |
|---|---|---|
| 24 | a) Has the Trust Board received data from the organisation's MIS evidencing 80% compliance or an in house audit demonstrating that 80% of singleton live births (less than 34+0 weeks) received a full course of antenatal corticosteroids, within seven days of birth? | Yes |
| 25 | b) Has the percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids been recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding? | Yes |
| 26 | c) Has the Trust Board received data from the organisation's MIS evidencing 80% compliance or an in house audit demonstrating that 80% of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth? | Yes |
| 27 | d) Has the Trust Board received data from the organisation's MIS evidencing 80% compliance or an in house audit demonstrating that 80% of women have given birth in an appropriate care setting for their gestation (in accordance with local ODN guidance)? | Yes |
| 28 | If your process indicator scores for standards a,c or d are less than 80%, do you have an action plan for achieving >80%? | N/A |
| 29 | Do you have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention? | Yes |
| | **Q30 and Q31 are linked** | |
| 30 | Do women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided? | Yes |
| 31 | If this is not the case, has the board described the alternative intervention that has been agreed with their commissioner (ICB) and that their Clinical Network and has agreed this is acceptable clinical practice? | N/A |
| 32 | Has an audit of 40 consecutive cases of women booking for antenatal care been completed to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway?<br><br>The assessment should use the criteria in Appendix F of SBLCBv2 or an alternative which has been agreed with local ICBs following advice from the Clinical Network. | Yes |
| 33 | Does the risk assessment and management in multiple pregnancy comply with NICE guidance or a variant that has been agreed with local commissioners (ICBs) following advice from the provider's clinical network? | Yes |

**Safety action No. 7**

**Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?**

| Requirements number | Safety action requirements | Requirement met? (Yes/ No /Not applicable) |
|---|---|---|
| 1 | Have you submitted Terms of Reference for your MVP?<br>Do they reflect the core principles for Terms of Reference for a MVP as outlined in annex B of Implementing Better Births: A resource pack for Local Maternity Systems | Yes |
| 2 | Do your minutes of MVP meetings demonstrating how service users are listened to and how regular feedback is obtained, that actions are in place to demonstrate that listening has taken place and evidence of service developments resulting from coproduction between service users and staff? | Yes |
| 3 | Have you submitted written confirmation from the service user chair that they are being remunerated as agreed and that this remuneration reflects the time commitment and requirements of the role given the agreed work programme?<br>Remuneration should take place in line with agreed Trust processes. | Yes |
| 4 | Have you provided minutes of the MVP's work programme, minutes of the MVP meeting which agreed it and minutes of the LMNS board that ratified it? | Yes |
| 5 | Do you have written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including travel, parking and childcare costs in a timely way. | Yes |
| 6 | Do you have evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality | Yes |
| 7 | Do you have evidence that the MVP Chair is invited to attend maternity governance meetings and that actions from maternity governance meetings, including complaints' response processes, trends and themes, are shared with the MVP | Yes |

**Safety action No. 8**

**Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?**
**In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?**

| Requirements number | Safety action requirements | Requirement met? (Yes/ No /Not applicable) |
|---|---|---|
| Can you evidence that: | | |
| 1 | A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over 3 years, starting from the launch of MIS year 4 in August 2021.<br><br>should include the following 6 core modules:<br>• Saving Babies Lives Care Bundle<br>• Fetal surveillance in labour<br>• Maternity emergencies and multi-professional training<br>• Personalised care<br>• Care during labour and the immediate postnatal period<br>• Neonatal life support | Yes |
| Can you demonstrate at the end of 12 consecutive months within the period of 1st August 2021 until 5th December 2022, 90% of each relevant maternity unit staff group has attended an 'in house' one day multi-professional training day, that includes maternity emergencies? | | |
| 2 | 90% of Obstetric consultants? | Yes |
| 3 | 90% All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota, including GP trainees? | Yes |

| | | |
|---|---|---|
| 4 | 90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)? | Yes |
| 5 | 90% of Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum)? | Yes |
| 6 | 90% of Obstetric anaesthetic consultants? | Yes |
| 7 | 90% of all other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota? | Yes |
| Can you demonstrate at the end of 12 consecutive months within the period of 1st August 2021 until 5th December 2022, 90% of each relevant maternity unit staff group attended an 'in-house' one day multi-professional training day that includes antenatal and intrapartum fetal monitoring? | | |
| 8 | 90% of Obstetric consultants? | Yes |
| 9 | 90% of all other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota? | Yes |
| 10 | 90% of GP trainees who have any obstetric commitment to intrapartum care? | Yes |
| 11 | 90% of midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres (if applicable)? | Yes |
| 12 | Are fetal monitoring sessions consistent with the Ockenden Report recommendations, and include: intermittent auscultation, electronic fetal monitoring with system level issues e.g. human factors, escalation and situational awareness? | Yes |
| 13 | Has the Trust board specifically confirmed that within their organisation 90% of eligible staff have attended local multi-professional fetal monitoring training annually as above? | Yes |
| Can you demonstrate at the end of 12 consecutive months within the period of 1st August 2021 until 5th December 2022, 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended in-house neonatal life support training or a Newborn Life Support (NLS) course? | | |
| 14 | 90% of neonatal Consultants or Paediatric consultants covering neonatal units | Yes |
| 15 | 90% Neonatal junior doctors (who attend any births) | Yes |
| 16 | 90% of Neonatal nurses (Band 5 and above) | Yes |
| 17 | 90% of advanced Neonatal Nurse Practitioner (ANNP) | Yes |

| | | |
|---|---|---|
| 18 | 90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and Maternity theatre midwives who also work outside of theatres. | Yes |

## Safety action No. 9

**Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?**

| Requirements number | Safety action requirements | Requirement met? (Yes/ No /Not applicable) |
|---|---|---|
| Have you submitted evidence of a revised pathway which describes how frontline midwifery, obstetric and Board safety champions share safety intelligence between: | | |
| 1 | a) each other? | Yes |
| 2 | b) the Board? | Yes |
| 3 | c) new LMNS/ICS quality group? | Yes |
| 4 | d) regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action and support is provided for areas of concern or need in line with the perinatal quality surveillance model? | Yes |
| Have you submitted evidence of a revised pathway which describes how frontline neonatal Board safety champions share safety intelligence between: | | |
| 5 | a) each other? | Yes |
| 6 | b) the Board? | Yes |
| 7 | c) new LMNS/ICS quality group? | Yes |
| 8 | d) regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action and support is provided for areas of concern or need in line with the perinatal quality surveillance model? | Yes |
| Have you submitted evidence that a clear description of the pathway and names of safety champions are visible to: | | |
| 9 | Maternity staff? | Yes |
| 10 | Neonatal staff? | Yes |
| 11 | Have you submitted evidence that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified and actions being taken to address any issues? | Yes |
| 12 | Have you submitted evidence that discussions regarding safety intelligence, including staff feedback from frontline champions and engagement sessions? | Yes |

| | | |
|---|---|---|
| 13 | Have you submitted evidence that discussions regarding safety intelligence, including minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022?<br><br>NB- The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022. | Yes |
| 14 | Have you submitted evidence of the engagement sessions (e.g. staff feedback meeting, staff walkaround sessions etc.) being undertaken by a member of the Board? | Yes |
| 15 | Have you submitted evidence of progress with actioning named concerns from staff workarounds are visible to maternity staff and reflects action and progress made on identified concerns raised by staff and service users? | Yes |
| 16 | Have you submitted evidence of progress with actioning named concerns from staff workarounds are visible to neonatal staff and reflects action and progress made on identified concerns raised by staff and service users? | Yes |
| 17 | Have you submitted evidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions to help target interventions aimed at improving patient safety at least twice in the MIS reporting period at a Trust level quality meeting. This can be a board or directorate level meeting? | Yes |
| 18 | Has a decision been made by the Board as to whether staffing meets safe minimum requirements to continue rollout of current or planned MCoC teams, or whether rollout should be suspended?<br><br>This is to be evidenced by a minuted Board level discussion and decision since 1 April 2022 on how a Trust's current workforce position should determine current and future rollout of MCoC. Where more than one discussion has taken place, the most recent discussion should be included in the trust Board submission. | Yes |
| Is there Evidence of how the Board and Safety Champions have supported staff involved in part d) of the required standard and specifically in relation to: | | |
| 19 | Active participation by staff in contributing to the delivery of the collective aims of the MatNeo Patient Safety Networks, and undertaking of specific improvement work aligned to the MatNeoSIP national driver diagram and key enabling activities | Yes |
| 20 | Engagement in relevant improvement/capability building initiatives nationally, regionally or via the MatNeo Patient Safety Networks, of which the Trust is a member | Yes |

| | | |
|---|---|---|
| 21 | clinicians identified as MatNeoSIP Improvement Leaders to facilitate and lead work through the MatNeo Patient Safety Networks and the National MatNeoSIP network? | Yes |
| 22 | Utilise insights from culture surveys undertaken to inform local quality improvement plans? | Yes |
| 23 | oversight of improvement outcomes and learning, and ensure intelligence is actively shared with key system stakeholders for the purpose of improvement | Yes |
| 24 | Attendance or representation at a minimum of two engagement events such as Patient Safety Network meetings, MatNeoSIP webinars and/or the annual national learning event by 5th December 2022. | Yes |
| 25 | Evidence that insights from culture surveys undertaken have been used to inform local quality improvement plans by 5th December 2022. | Yes |

**Safety action No. 10**

**Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?**

| Requirements number | Safety action requirements | Requirement met? (Yes/ No /Not applicable) |
|---|---|---|
| 1 | Have you reported all qualifying cases to HSIB from 1 April 2021 to 5 December 2022? | Yes |
| 2 | Have you reported all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2022 until 5 December 2022? | Yes |
| For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that: | | |
| 3 | The family have received information on the role of HSIB and NHS Resolution's EN scheme | Yes |
| 4 | There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour | Yes |
| Can you confirm | | |
| 5 | Sight of Trust legal services and maternity clinical governance records of qualifying HSIB/EN incidents and numbers reported to HSIB and NHS Resolution. | Yes |
| 6 | Sight of evidence that the families have received information on the role of HSIB and EN scheme | Yes |
| 7 | Sight of evidence of compliance with the statutory duty of candour. | Yes |
| 8 | Complete the field on the Claims Reporting Wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated. | Yes |

NHS Resolution

# Section A : Maternity safety actions - Wrightington, Wigan and Leigh NHS Foundation Trust

| Action No. | Maternity safety action | Action met? (Y/N) |
|---|---|---|
| 1 | Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard? | Yes |
| 2 | Are you submitting data to the Maternity Services Data Set to the required standard? | No |
| 3 | Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme? | No |
| 4 | Can you demonstrate an effective system of clinical workforce planning to the required standard? | No |
| 5 | Can you demonstrate an effective system of midwifery workforce planning to the required standard? | Yes |
| 6 | Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle V2? | Yes |

| | | |
|---|---|---|
| 7 | Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services? | Yes |
| 8 | Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?<br>In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4? | Yes |
| 9 | Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues? | Yes |
| 10 | Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022? | Yes |

## Section B : Action plan details for Wrightington, Wigan and Leigh NHS Foundation Trust

**An action plan should be completed for each safety action that has not been met**

### Action plan 1

| | | | |
|---|---|---|---|
| **Safety action** | Q2 MSDS | **To be met by** | Q1 = 2023/24 |
| **Work to meet action** | *Regular / Monthly use of the Data Quality Submission Tool as a backup measure . Mapping against the action has been completed by the Maternity Information System Provider( Euroking)* | | |
| **Does this action plan have executive level sign off** | Yes | **Action plan agreed by head of midwifery/clinical director?** | Yes |
| **Action plan owner** | *Digital Midwife* | | |
| **Lead executive director** | *Rabina Tindale Chief Nurse* | | |
| **Amount requested from the incentive fund, if required** | *£0.00* | | |
| **Reason for not meeting action** | *This oversight is due to a miscommunication between NHS digital, Euroking and WWL which meant that the provisional figures that were provided were not correct. This led to the misconception that this metric had originally passed.* | | |
| **Rationale** | *As advised by NHS Digital all the criteria have now been met by evidencing sustained engagement with NHS Digital which at a minimum, included monthly use of the Data Quality Submission Summary Tool supplied by NHS Digital. WWL were advised that that Trusts must show evidence of using the tool for at least three consecutive months prior to the submission of evidence to the Trust Board. and this has been* | | |
| **Benefits** | *All actions are now compliant* | | |
| **Risk assessment** | *There are currently no risks associated with this action* | | |

| | How? | Who? | When? |
|---|---|---|---|
| **Monitoring** | Ongoing monthly | Digital Midwife | Monthly submissions |

## Action plan 2

| | | | |
|---|---|---|---|
| **Safety action** | Q4 Clinical workforce planning | **To be met by** | Q4 = 2023/24 |

| | |
|---|---|
| **Work to meet action** | *WWL currently have one Advanced Neonatal Nurse Practitioner in post. There is an agreed plan within the Division to recruit additional Advanced Neonatal Nurse Practitioners which will cover the shortfalls going forward and provide additional skilled senior support to the Neonatal unit. A business case was submitted for 2 additional Advanced Neonatal Nurse Practitioners and agreed in principle however funding was not* |

| | | | |
|---|---|---|---|
| **Does this action plan have executive level sign off** | Yes | **Action plan agreed by head of midwifery/clinical director?** | Yes |

| | |
|---|---|
| **Action plan owner** | *Divisional Medical Director Consultant Paediatricain. NNU Lead* |
| **Lead executive director** | *Professor Sanjay Arya Medical Director* |
| **Amount requested from the incentive fund, if required** | *£0.00* |
| **Reason for not meeting action** | *In January 2022, the Trust submitted its action plan against the maternity Incentive Scheme Year 3 Standard 4 Neonatal Workforce to declare compliance against this action, The action plan remains in place and WWL have trained one of our neonatal nurses fully and she is now working on the unit as an ANNP. This year, we have secured some funding from the critical care fund and topped it up in the Division so that we can* |
| **Rationale** | *Currently the shortfall in the Tier 1 rota is in overnight cover as there only one Tier 1 SHO covering both neonates and paediatrics. The service will continue to pursue any funding options that may become available through the Neonatal Critical Care workstreams or National initiatives* |
| **Benefits** | *The funding received from NWNODN to support the Tier 1 Rota Gap will help to address the shortfall in 24/7 Tier 1 rota cover and provide a dedicated clinician solely responsible for the neonatal unit that can address immediate concerns on the unit and help with training of all colleagues in Child Health as well as allow for better continuity of care.* |
| **Risk assessment** | *There remains a shortfall in overnight cover as only one Tier 1 SHO covering both neonates and paediatrics. At times of high acuity and activity additional staff can be booked to provide additional support, and WWL will cover with locum/agency any gaps to maintain safety until the additional ANNP posts are recruited to. Rota Gaps for Tier I added to risk register.* |

| | **How?** | **Who?** | **When?** |
|---|---|---|---|
| **Monitoring** | Divisional Quality Executive Group | Divisional Director of Operations and Divisional Medical | Bi Monthly |

## Action plan 3

| | | | |
|---|---|---|---|
| **Safety action** | Q3 Transitional care | **To be met by** | Q1 = 2023/24 |

| | |
|---|---|
| **Work to meet action** | *The ATAIN action plan has been in place since the Introduction of the ATAIN programme. This is monitored at Divisional assurance meetings and the Safety Champions forum which is chaired by either the Divisional Director of Midwifery or the Chief Nurse, who is the Executive Board Level Safety Champion. In 2021 the ATAIN audit was completed annually , following which the recommendation was made to complete quarterly* |

| | | | |
|---|---|---|---|
| **Does this action plan have executive level sign off** | Yes | **Action plan agreed by head of midwifery/clinical director?** | Yes |

| | |
|---|---|
| **Action plan owner** | *Cathy Stanford Divisional Director of Midwifery and Child Health* |
| **Lead executive director** | *Rabina Tindale Chief Nurse* |
| **Amount requested from the incentive fund, if required** | *£0.00* |
| **Reason for not meeting action** | *WWL Transistional Care provision was halted during the pandemic, due to staffing issues, redeployment of staff and Zoning of the Postnatal ward area to accomodate Covid Positive patients. A full staffing review was undertaken following funding recieved from the Neonatal Critical Care fund which allowed for recruitment against the shortfall in nurse numbers and the re-introduction of the TC service. The service was reintroduced in* |
| **Rationale** | *The action plan document has been reviewed and considered as explained in several governance and oversight arenas but was not formally signed off by the Trust Board as it did not coincide with trust level reporting requirements . although it was agreed by the Quality and Safety Committee in August as the delegated subcommittee of the Board. This committee provides assurance to the Trust Board as it is tasked with* |
| **Benefits** | *The action plan will continue to be reviewed quarterly alongside the Audit findings at both Safety Champions and Quality and Safety Committee as these forums are able to allocate more time for discussion and challenge, as the relevant clinicians are in attendance who have the knowledge of the service and can articulate the findings and recommendations to the group effectively.* |
| **Risk assessment** | *Since the re-introduction of the service the audits have been strengthened and monitoring of compliance is more robust. There are no risks to the Trust in not meeting the time frame of Trust Board sign off for the action plan as it had been reviewed and agreed within several forums which included Safety Champions Quality and Safety Committee as the delegated assurance committee. The one action outstanding will require* |

| | **How?** | **Who?** | **When?** |
|---|---|---|---|
| **Monitoring** | Divisional Governace Forums and Safety Champions meeting prior to submission to Quality and Safety | Head of Governance Maternity and Child Health | Bi-Monthly |

## Action plan 4

| | | | |
|---|---|---|---|
| **Safety action** | | **To be met by** | |
| **Work to meet action** | *Brief description of the work planned to meet the required progress.* | | |
| **Does this action plan have executive level sign off** | | **Action plan agreed by head of midwifery/clinical director?** | |
| **Action plan owner** | *Who is responsible for delivering the action plan?* | | |
| **Lead executive director** | *Does the action plan have executive sponsorship?* | | |
| **Amount requested from the incentive fund, if required** | | | |
| **Reason for not meeting action** | *Please explain why the trust did not meet this safety action* | | |
| **Rationale** | *Please explain why this action plan will ensure the trust meets the safety action.* | | |
| **Benefits** | *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.* | | |
| **Risk assessment** | *What are the risks of not meeting the safety action?* | | |

| | **How?** | **Who?** | **When?** |
|---|---|---|---|
| **Monitoring** | | | |

## Action plan 5

| | | | |
|---|---|---|---|
| **Safety action** | | **To be met by** | |
| **Work to meet action** | *Brief description of the work planned to meet the required progress.* | | |
| **Does this action plan have executive level sign off** | | **Action plan agreed by head of midwifery/clinical director?** | |
| **Action plan owner** | *Who is responsible for delivering the action plan?* | | |
| **Lead executive director** | *Does the action plan have executive sponsorship?* | | |
| **Amount requested from the incentive fund, if required** | | | |
| **Reason for not meeting action** | *Please explain why the trust did not meet this safety action* | | |
| **Rationale** | *Please explain why this action plan will ensure the trust meets the safety action.* | | |
| **Benefits** | *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.* | | |
| **Risk assessment** | *What are the risks of not meeting the safety action?* | | |

| | **How?** | **Who?** | **When?** |
|---|---|---|---|
| **Monitoring** | | | |

## Action plan 6

| | | | |
|---|---|---|---|
| **Safety action** | | **To be met by** | |
| **Work to meet action** | *Brief description of the work planned to meet the required progress.* | | |
| **Does this action plan have executive level sign off** | | **Action plan agreed by head of midwifery/clinical director?** | |
| **Action plan owner** | *Who is responsible for delivering the action plan?* | | |
| **Lead executive director** | *Does the action plan have executive sponsorship?* | | |
| **Amount requested from the incentive fund, if required** | | | |
| **Reason for not meeting action** | *Please explain why the trust did not meet this safety action* | | |
| **Rationale** | *Please explain why this action plan will ensure the trust meets the safety action.* | | |
| **Benefits** | *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.* | | |
| **Risk assessment** | *What are the risks of not meeting the safety action?* | | |

| | **How?** | **Who?** | **When?** |
|---|---|---|---|
| **Monitoring** | | | |

## Action plan 7

| | | | |
|---|---|---|---|
| **Safety action** | | **To be met by** | |
| **Work to meet action** | *Brief description of the work planned to meet the required progress.* | | |
| **Does this action plan have executive level sign off** | | **Action plan agreed by head of midwifery/clinical director?** | |
| **Action plan owner** | *Who is responsible for delivering the action plan?* | | |
| **Lead executive director** | *Does the action plan have executive sponsorship?* | | |
| **Amount requested from the incentive fund, if required** | | | |
| **Reason for not meeting action** | *Please explain why the trust did not meet this safety action* | | |
| **Rationale** | *Please explain why this action plan will ensure the trust meets the safety action.* | | |
| **Benefits** | *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.* | | |
| **Risk assessment** | *What are the risks of not meeting the safety action?* | | |

| | **How?** | **Who?** | **When?** |
|---|---|---|---|
| **Monitoring** | | | |

## Action plan 8

| | | | |
|---|---|---|---|
| **Safety action** | | **To be met by** | |
| **Work to meet action** | *Brief description of the work planned to meet the required progress.* | | |
| **Does this action plan have executive level sign off** | | **Action plan agreed by head of midwifery/clinical director?** | |
| **Action plan owner** | *Who is responsible for delivering the action plan?* | | |
| **Lead executive director** | *Does the action plan have executive sponsorship?* | | |
| **Amount requested from the incentive fund, if required** | | | |
| **Reason for not meeting action** | *Please explain why the trust did not meet this safety action* | | |
| **Rationale** | *Please explain why this action plan will ensure the trust meets the safety action.* | | |
| **Benefits** | *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.* | | |
| **Risk assessment** | *What are the risks of not meeting the safety action?* | | |

| | **How?** | **Who?** | **When?** |
|---|---|---|---|
| **Monitoring** | | | |

## Action plan 9

| | | | |
|---|---|---|---|
| **Safety action** | | **To be met by** | |
| **Work to meet action** | *Brief description of the work planned to meet the required progress.* | | |
| **Does this action plan have executive level sign off** | | **Action plan agreed by head of midwifery/clinical director?** | |
| **Action plan owner** | *Who is responsible for delivering the action plan?* | | |
| **Lead executive director** | *Does the action plan have executive sponsorship?* | | |
| **Amount requested from the incentive fund, if required** | | | |
| **Reason for not meeting action** | *Please explain why the trust did not meet this safety action* | | |
| **Rationale** | *Please explain why this action plan will ensure the trust meets the safety action.* | | |
| **Benefits** | *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.* | | |
| **Risk assessment** | *What are the risks of not meeting the safety action?* | | |

| | **How?** | **Who?** | **When?** |
|---|---|---|---|
| **Monitoring** | | | |

## Action plan 10

| | | | |
|---|---|---|---|
| **Safety action** | | **To be met by** | |
| **Work to meet action** | *Brief description of the work planned to meet the required progress.* | | |
| **Does this action plan have executive level sign off** | | **Action plan agreed by head of midwifery/clinical director?** | |
| **Action plan owner** | *Who is responsible for delivering the action plan?* | | |
| **Lead executive director** | *Does the action plan have executive sponsorship?* | | |
| **Amount requested from the incentive fund, if required** | | | |
| **Reason for not meeting action** | *Please explain why the trust did not meet this safety action* | | |
| **Rationale** | *Please explain why this action plan will ensure the trust meets the safety action.* | | |
| **Benefits** | *Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.* | | |
| **Risk assessment** | *What are the risks of not meeting the safety action?* | | |

| | **How?** | **Who?** | **When?** |
|---|---|---|---|
| **Monitoring** | | | |

NHS Resolution

## Maternity incentive scheme - Board declaration Form

| | |
|---|---|
| **Trust name** | **Wrightington, Wigan and Leigh NHS Foundation Trust** |
| **Trust code** | **T588** |

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

| | Safety actions | Action plan | Funds requested | Validations |
|---|---|---|---|---|
| Q1 NPMRT | Yes | | - | |
| Q2 MSDS | No | Yes | - | |
| Q3 Transitional care | No | Yes | - | |
| Q4 Clinical workforce planning | No | Yes | - | |
| Q5 Midwifery workforce planning | Yes | | - | |
| Q6 SBL care bundle | Yes | | - | |
| Q7 Patient feedback | Yes | | - | |
| Q8 In-house training | Yes | | - | |
| Q9 Safety Champions | Yes | | - | |
| Q10 EN scheme | Yes | | - | |
| **Total safety actions** | **7** | **3** | | |
| **Total sum requested** | | | - | |

**Sign-off process:**

**Electronic signature**

**For and on behalf of the board of** Wrightington, Wigan and Leigh NHS Foundation Trust

**Electronic signature**

**For and on behalf of the board of** Wrightington, Wigan and Leigh NHS Foundation Trust

**Confirming that:**
The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

**Electronic signature**

**For and on behalf of the board of** Wrightington, Wigan and Leigh NHS Foundation Trust

**Electronic signature**

**For and on behalf of the board of** Wrightington, Wigan and Leigh NHS Foundation Trust

**Confirming that:**
The content of this form has been discussed with the commissioner(s) of the trust's maternity services

**Electronic signature**

**For and on behalf of the board of** Wrightington, Wigan and Leigh NHS Foundation Trust

**Electronic signature**

**For and on behalf of the board of** Wrightington, Wigan and Leigh NHS Foundation Trust

**Confirming that:**
There are no reports covering either **this year (2022/23) or the previous financial year (2021/22)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.

**Electronic signature**

**For and on behalf of the board of** Wrightington, Wigan and Leigh NHS Foundation Trust

**Electronic signature**

**For and on behalf of the board of** Wrightington, Wigan and Leigh NHS Foundation Trust

**Confirming that:**
If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering

| | |
|---|---|
| **Name:** | Silas Nicholls |
| **Position:** | Chief Executive Officer |
| **Date:** | 01-Feb-23 |

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

**Actions Following Audit of Term Admission to the Neonatal Unit in supporting ATAIN– Maternity Incentive Scheme Year 4**

| No. | Issue Identified/ Recommendation | Actions to be taken (Clear and specific identify resources where appropriate) | Lead Responsibility (Job Title) | Time Frame (Date to be completed) | Risk to Completion (Any risks that would prevent delivery of the action) | Progress towards Completion (Include date the narrative relates to) | Date completed (RAG rate the column) | Evidence of completion |
|---|---|---|---|---|---|---|---|---|
| 1 | Clear pathways and guidelines for all staff for Transitional Care | Review of current guidelines and pathways used within the Maternity/ Neonatal Service to assess if they require any changes; and to identify if any additional guidelines/flowcharts/ pathways require development.<br>Pathways of care into transitional care have been jointly approved by | Shift Coordinator NNU Transitional Care Lead<br><br>Delivery Suite/ Maternity Ward manager | October 2022 | None | July 2022<br>Guideline updated and criteria agreed. | July 2022<br><br>October 2022 | Guideline awaiting ratification at Clinical Cabinets<br>STANDARD OPERATING PROCEDURE<br>Transitional care SOP V1.1.doc |

RR/CS August 2022

**Actions Following Audit of Term Admission to the Neonatal Unit in supporting ATAIN– Maternity Incentive Scheme Year 4**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care. | | | | | | Updated version. Awaiting ratification. |
| 2 | The Transitional Care Service within the Maternity ward to be re-implemented | Strategy for re-implementation to be developed. Including:<br>• Ensuring there is a reserved bay for transitional care available.<br>• Ensuring Neonatal Nurse Allocation on a Day-to-day basis to care for babies require transitional care<br>• Communicating of the Pathways and guidance supporting transitional care | Maternity Ward manager<br><br>NNU Manager | December 2022<br><br>Ongoing | Reduced staffing levels and High Acuity. | Staffing review undertaken, to ensure 5.38 WTE staff available to support TC on a daily basis.<br><br>TC lead now in place to drive service forward and ensure that TC is considered as an option for term infants or those who meet the criteria | | Remains ongoing. Rota's available as evidence of allocation. |

**Actions Following Audit of Term Admission to the Neonatal Unit in supporting ATAIN– Maternity Incentive Scheme Year 4**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | across the Maternity Floor | | | | | | |
| 3. | Introduce Midwife as second checker for infants receiving IV antibiotics. | • Training plan to be implemented<br>• Competency assessment to be developed by Training and development leads<br>• SOP to be developed | Training and Development leads for maternity and NNU | ~~Dec 2022~~ March 2023 | | SOP available on intranet,<br><br>Staff training and competency logs. | | Training not commenced due to staffing issues, will be planned for early 2023 |
| 4 | The pathway of care into transitional care has been fully implemented and is audited monthly. Audit findings are shared with the neonatal safety champion. | • Update Audit proforma<br>• Monthly audit of transitional care admission<br>• Develop Action Plan from Findings | NNU Transitional Care Lead,<br><br>NNU Manager | Ongoing | | Ongoing audits undertaken monthly with Quarterly presentation of Findings, to be tabled at Clinical Cabinet and Safety Champions | Ongoing Monthly . | audit<br>NTC Audit.docx<br>TC Audit OCTOBER 2022.docx<br>TC Audit November .docx |

RR/CS August 2022

**Actions Following Audit of Term Admission to the Neonatal Unit in supporting ATAIN– Maternity Incentive Scheme Year 4**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | TC Audit December 22.docx |
| 5. | A data recording process for capturing transitional care activity, (regardless of place - which could be<br>• Transitional Care (TC),<br>• Postnatal ward,<br>• Virtual outreach pathway etc<br>has been embedded. | • capturing the data for transitional care via Badger<br><br>• Data capture of infants to include infants admitted 34-36+6 weeks who are admitted to NNU and did not require any support or interventions. | NNU manager | December 2022 | None | Functionality available on Badger<br><br>Data to be requested from NWODN | | Remains ongoing |
| 6. | Audit results to be cascaded to staff | Audit presented at Clinical Issues and Audit Meeting | Governance Leads | Ongoing. | None | Minutes of at Clinical cabinet and audit meetings. | | Term Admissions to NNU Jan to March 2 |

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

**Actions Following Audit of Term Admission to the Neonatal Unit in supporting ATAIN– Maternity Incentive Scheme Year 4**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Summary to be shared in Safety Dashboard | | | | Audits to be displayed in unit for staff. | | Term Admissions to NNU 2022 Q2.pptx |

RR/CS August 2022

Greater Manchester Integrated Care Partnership

NHS
Greater Manchester and Eastern Cheshire
Strategic Clinical Networks

3 Piccadilly Place
London Road
Manchester
M1 3BN

Email address: julie.cheetham2@nhs.net

***Sent via email***

20 December 2022

**To:**
Chief Executive Officer
Chief Nurses
Directors/Heads of Midwifery

Dear Colleagues

**Re: Confirmation of CNST Declaration sign off by GM Integrated Care Board: Submission date 12 noon 2nd February**

On behalf of Greater Manchester and Eastern Cheshire Local Maternity & Neonatal System, I would like to share details of the process for sign-off of the Maternity Clinical Negligence Scheme for Trusts (CNST) declaration.

The CNST is the incentive scheme for Maternity Services which incentivises NHS Trusts who have taken action to improve maternity safety. This is a yearly submission and as we are currently in Year 4 and there are additional steps to be completed prior to final sign-off:

- *The declaration form is submitted to Trust Board with an accompanying joint presentation detailing the position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery (DoM/HoM) and Clinical Director for Maternity Services*
- *The Board declaration form must be signed and dated by the Trust's **Chief Executive Officer** (CEO) to confirm that:*
  - *The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.*
  - *There are no reports covering either year 2021/22 or 2022/23 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the Maternity Information System team's attention before Thursday 2 February 2023.*
  - *The Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.*

- *In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions' evidence and declaration form.*

- *The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution*

To facilitate the sign-off by Mark Fisher CEO for Greater Manchester ICB, the LMNS has requested the dates on which your declarations will be presented to your board from your DoM/ HoM.

**Please alert the LMNS if the submission date *for your declaration forms to the LMNS* is likely to be within a week of the *CNST* submission date of the 2nd February 2023.**

Your completed declaration forms should be:

- Emailed to GMEC.LMNS@NHS.net. as' High priority'
- Subject title 'CNST final declaration sign off for ICB' .
- Cc karen.clough5@nhs.net (Safety Lead Midwife, who will be facilitating the process)

Your declaration form will then be sent to David Dobson (ICB Business Manager), who will facilitate the sign-off from the ICB Accountable Officer.

The Declaration Form will be returned to you via email, for your submission.

If you require any further information regarding the process, please contact Karen Clough, LMNS Safety Lead Midwife karen.clough5@nhs.net.

Yours faithfully,

**Julie Cheetham**
SRO GMEC LMNS

Director Strategic Clinical Networks / Deputy Director Improvement

Cc Mark Fisher / David Dobson
Karen Clough

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

| | |
|---|---|
| **Title of report:** | Maternity Dashboard Report |
| **Presented to:** | Trust Board |
| **On:** | 01 February 2023 |
| **Presented by:** | Rabina Tindale |
| **Prepared by:** | Gemma Weinberg for Cathy Stanford |
| **Contact details:** | gemma.weinberg@wwl.nhs.uk |

## Executive summary

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

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

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

• Green – Performance within an expected range.

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

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

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

## Recommendation(s)

The board are asked to note the December 2022 dashboard and overview of indicators as outlined below.

# Maternity Dashboard December 2022

## Introduction

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

## December 2022 Exception report
## Summary

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

- There have been 2 cases reported to the Healthcare Safety Investigation Branch (HSIB) or babies diagnosed with HIE 2 or 3.
- There were 5 midwifery red flags reported. The shift coordinator was unable to remain supernumerary for one shift in December, so the figure is 98.3%. 1-2-1 care in labour was 100%.
- There were no Maternity complaints received in December and the service continues to receive positive feedback letters and messages from Women regarding the excellent care they have received.

## Steis reportable Incidents

There was 1 stillbirth in December which means we had a total of 5 in 2022.

## Green

**The Midwife to Birth ratio** currently remains static at 1:28. Despite the ongoing challenges with staffing and high levels of activity and acuity the service has been able to maintain good standards of care with good outcomes demonstrated. Work to recruit new staff remains an ongoing priority. We are currently taking part in birth-rate plus. Following this our staffing levels will be reviewed looking at up to date activity and acuity.

**Women booked by 12+6 weeks** This has seen a rise in December and has remained green for 3 consecutive months.

**Smoking at the time of Delivery (SATOD).** Despite a small rise, this has remained green for the seventh consecutive month after a significant spike in May. Work continues to promote and encourage smoking cessation throughout pregnancy.

**1:1 care in labour** This has remained 100% for five consecutive months after a drop in July.

**3rd / 4th degree tear**. This has been green for six consecutive months and despite a rise from last months figures we remain one of the lowest across GM for this parameter.

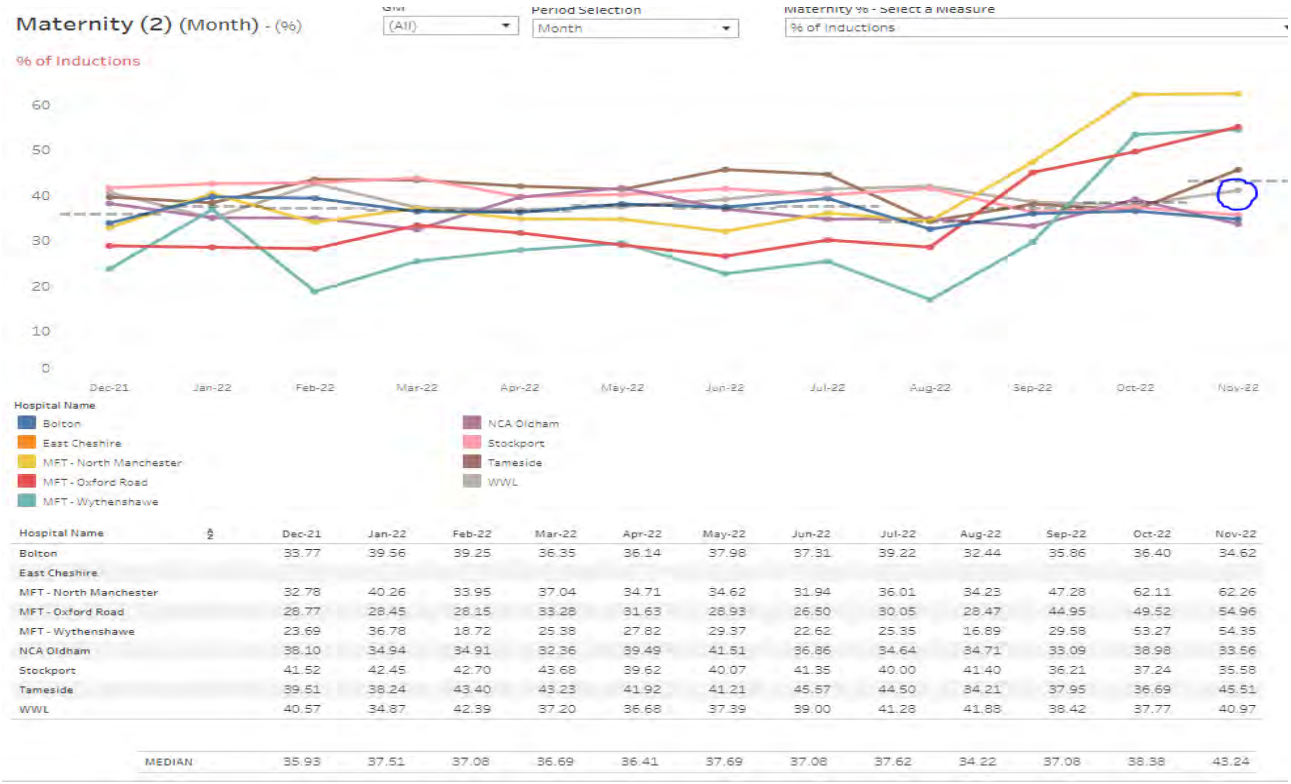
**Number of registerable births.** September saw a drop to amber levels. These have returned to normal levels and green for the past 3 months.

**Attendance at skills drills / mandatory training** – This has now remained green for three consecutive months after a drop to amber.

**The number of mothers who have opted to breastfeed –** This has returned to green levels in December after seeing a significant drop in November. Work continues to improve these figures.

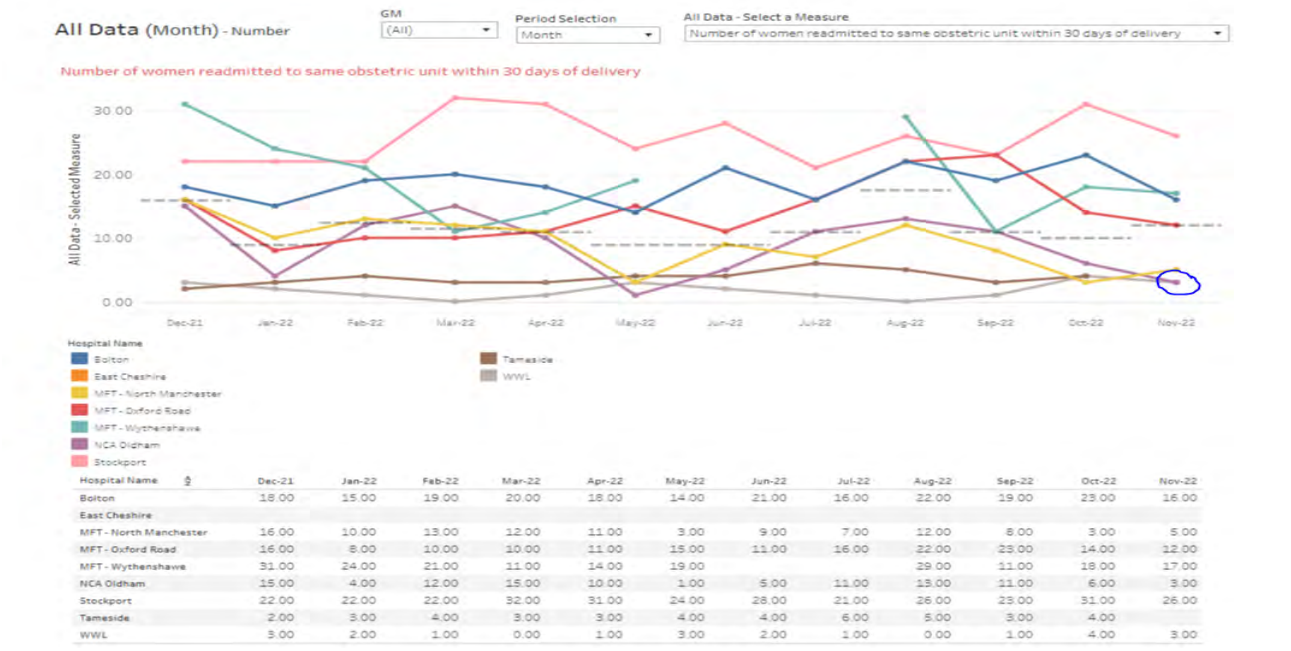
## Amber

**Induction of Labour (IOL)** This remains at amber level for the past 2 months. All cases continue to be reviewed for appropriate medical reasons, gestations, and outcomes. It can be seen below that our figures remain similar to the rest of GM.




| Hospital Name | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bolton | 33.77 | 39.56 | 39.25 | 36.35 | 36.14 | 37.98 | 37.31 | 39.22 | 32.44 | 35.86 | 36.40 | 34.62 |
| East Cheshire | | | | | | | | | | | | |
| MFT - North Manchester | 32.78 | 40.26 | 33.95 | 37.04 | 34.71 | 34.62 | 31.94 | 36.01 | 34.23 | 47.28 | 62.11 | 62.26 |
| MFT - Oxford Road | 28.77 | 28.45 | 28.15 | 33.28 | 31.63 | 28.93 | 26.50 | 30.05 | 28.47 | 44.95 | 49.52 | 54.96 |
| MFT - Wythenshawe | 23.69 | 36.78 | 18.72 | 25.38 | 27.82 | 29.37 | 22.62 | 25.35 | 16.89 | 29.58 | 53.27 | 54.35 |
| NCA Oldham | 38.10 | 34.94 | 34.91 | 32.36 | 39.49 | 41.51 | 36.86 | 34.64 | 34.71 | 33.09 | 38.98 | 33.56 |
| Stockport | 41.52 | 42.45 | 42.70 | 43.68 | 39.62 | 40.07 | 41.35 | 40.00 | 41.40 | 36.21 | 37.24 | 35.58 |
| Tameside | 39.51 | 38.24 | 43.40 | 43.23 | 41.92 | 41.21 | 45.57 | 44.50 | 34.21 | 37.95 | 36.69 | 45.51 |
| WWL | 40.57 | 34.87 | 42.39 | 37.20 | 36.68 | 37.39 | 39.00 | 41.28 | 41.88 | 38.42 | 37.77 | 40.97 |
| MEDIAN | 35.93 | 37.51 | 37.08 | 36.69 | 36.41 | 37.69 | 37.08 | 37.62 | 34.22 | 37.08 | 38.38 | 43.24 |

**Women readmitted within 28 days of Delivery.** There were three readmissions in December. Two were admitted with chest pain and ? PE (nil found) and one with postpartum pneumonia. No omissions in care were noted. It can be seen below that WWL continue to have the lowest figures across GM.




| Hospital Name | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bolton | 18.00 | 15.00 | 19.00 | 20.00 | 18.00 | 14.00 | 21.00 | 16.00 | 22.00 | 19.00 | 23.00 | 16.00 |
| East Cheshire | | | | | | | | | | | | |
| MFT - North Manchester | 16.00 | 10.00 | 13.00 | 12.00 | 11.00 | 3.00 | 9.00 | 7.00 | 12.00 | 8.00 | 3.00 | 5.00 |
| MFT - Oxford Road | 16.00 | 8.00 | 10.00 | 10.00 | 11.00 | 15.00 | 11.00 | 16.00 | 22.00 | 23.00 | 14.00 | 12.00 |
| MFT - Wythenshawe | 31.00 | 24.00 | 21.00 | 11.00 | 14.00 | 19.00 | | | 29.00 | 11.00 | 18.00 | 17.00 |
| NCA Oldham | 15.00 | 4.00 | 12.00 | 15.00 | 10.00 | 1.00 | 5.00 | 11.00 | 13.00 | 11.00 | 6.00 | 3.00 |
| Stockport | 22.00 | 22.00 | 22.00 | 32.00 | 31.00 | 24.00 | 28.00 | 21.00 | 26.00 | 23.00 | 31.00 | 26.00 |
| Tameside | 2.00 | 3.00 | 4.00 | 3.00 | 3.00 | 4.00 | 4.00 | 6.00 | 5.00 | 3.00 | 4.00 | |
| WWL | 3.00 | 2.00 | 1.00 | 0.00 | 1.00 | 3.00 | 2.00 | 1.00 | 0.00 | 1.00 | 4.00 | 3.00 |

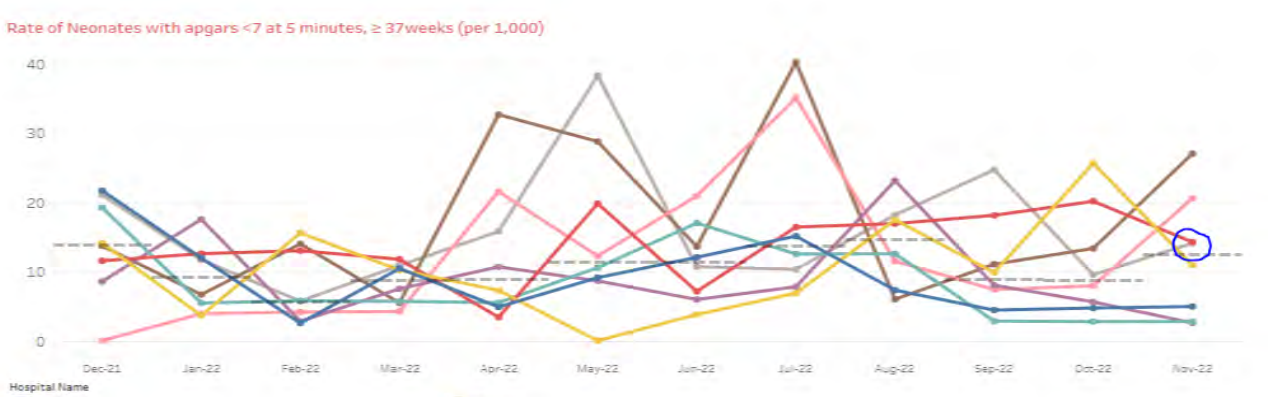
**Bookings**. This has seen a drop to amber levels in December. This pattern was also seen in December 2021.

**Skin to skin contact –** This remains amber for the fifth consecutive month. Work continues to improve this number.

**Red**

**Maternal steroids** - are given to mature the fetal lungs when premature labour is suspected, or early delivery is required. There were six eligible mothers in December. One mother presented in premature labour with a concealed pregnancy so did not receive steroids. The five other mothers received a full course of steroids prior to delivery. No omissions in care were noted. It should be noted here that there were no mothers eligible for **Magnesium Sulphate** in December.

**All infants with Apgar's less than 7**. This has seen a significant spike in December. All cases will be fully investigated for patterns or concerns. It can be seen that we are middle across GM for this parameter.




| Hospital Name | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bolton | 21.69 | 11.96 | 2.54 | 10.44 | 4.88 | 9.11 | 12.05 | 15.11 | 7.30 | 4.42 | 4.73 | 4.94 |
| East Cheshire | | | | | | | | | | | | |
| MFT - North Manchester | 14.08 | 3.64 | 15.56 | 10.20 | 7.27 | 0.00 | 3.79 | 6.87 | 17.48 | 9.85 | 25.64 | 10.91 |
| MFT - Oxford Road | 11.55 | 12.58 | 13.01 | 11.76 | 3.39 | 19.60 | 7.13 | 16.42 | 16.92 | 18.12 | 20.15 | 14.26 |
| MFT - Wythenshawe | 19.23 | 5.45 | 5.76 | 5.70 | 5.49 | 10.55 | 17.00 | 12.53 | 12.56 | 2.63 | 2.76 | 2.77 |
| NCA Oldham | 8.55 | 17.54 | 2.60 | 7.50 | 10.67 | 8.65 | 5.95 | 7.79 | 23.14 | 8.02 | 5.60 | 2.57 |
| Stockport | 0.00 | 3.91 | 4.15 | 4.22 | 21.55 | 12.24 | 20.92 | 35.09 | 11.49 | 7.38 | 7.94 | 20.58 |
| Tameside | 13.70 | 6.67 | 13.99 | 5.46 | 32.68 | 28.78 | 13.61 | 40.23 | 5.99 | 11.05 | 13.33 | 27.03 |
| WWL | 21.05 | 11.70 | 5.71 | 10.87 | 15.79 | 38.30 | 10.70 | 10.31 | 18.18 | 24.69 | 9.52 | 14.08 |
| MEDIAN | 13.89 | 9.18 | 5.74 | 8.85 | 8.97 | 11.40 | 11.37 | 13.82 | 14.74 | 8.94 | 8.73 | 12.50 |

**Term admissions to NNU.** This has seen a slight drop from November figures but still remains red. All cases continue to be reviewed within the ATTAIN audit to ensure admissions are appropriate. It can be seen below that we are around the middle for figures across GM.

**PN length of stay**. This has been amber for 5 consecutive months but sees a spike to red in December. This will be observed and investigated if the rise continues.

**Supernumerary Shift coordinator** This had been 100% for several months. In December there was one shift that the shift coordinator was unable to remain supernumerary due to high activity across the maternity floor, taking the figure to 98.3% and red.

**Re-admissions of babies within 30 days** This has seen a spike to red levels in December. Most cases were to jaundice. All cases were managed appropriately and there were no omissions in care.

**Conclusion**

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

| | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Q | Q | Q | YTD | Q4 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Women Delivered | 241 | 224 | 238 | 205 | 212 | 195 | 184 | 207 | 199 | 238 | 200 | 218 | 234 | 190 | 233 | 227 | 212 | # | # | # | | # |
| Number of Registerable Births | 241 | 229 | 242 | 205 | 213 | 198 | 187 | 211 | 203 | 242 | 209 | 220 | 238 | 191 | 234 | 228 | 213 | # | # | # | | # |
| Number of Bookings( retrospective 1 month ) | 222 | 242 | 227 | 244 | 233 | 271 | 235 | 255 | 267 | 250 | 216 | 214 | 220 | 232 | 254 | 258 | 215 | # | # | # | | # |
| Normal Births as % of births | 137 | 127 | 143 | 112 | 116 | 103 | 109 | 110 | 110 | 134 | 110 | 130 | 123 | 106 | 93 | 119 | 99 | # | # | # | | # |
| % of Successful Planned Home Births | 2 | 2 | 1 | 1 | 4 | 1 | 2 | 2 | 2 | 4 | 1 | 1 | 4 | 4 | 1 | 3 | 2 | 7 | 6 | # | 6 | # |
| Instrumental Deliveries as % of births | 29 | 26 | 19 | 27 | 23 | 22 | 19 | 20 | 25 | 21 | 21 | 20 | 34 | 16 | 29 | 17 | 15 | # | # | # | | # |
| Total Caesarean Sections as % of births | 75 | 76 | 80 | 61 | 73 | 72 | 59 | 81 | 68 | 88 | 79 | 70 | 80 | 73 | 111 | 91 | 98 | # | # | # | | # |
| % Emergency Caesaean Sections | 36 | 36 | 57 | 38 | 41 | 39 | 32 | 42 | 40 | 50 | 44 | 44 | 42 | 43 | 67 | 58 | 65 | # | # | # | | # |
| % Elective Caesarean Sections | 39 | 40 | 23 | 23 | 32 | 33 | 27 | 39 | 28 | 38 | 35 | 26 | 38 | 30 | 44 | 33 | 33 | # | # | # | | # |
| Number of successful VBAC deliveries | 6 | 7 | 5 | 4 | 4 | 4 | 3 | 5 | 3 | 4 | 5 | 3 | 5 | 3 | 6 | 5 | 4 | # | # | # | | # |
| %of Caesarean Sections at Full Dilatation | 2 | 4 | 7 | 7 | 3 | 5 | 5 | 3 | 1 | 4 | 2 | 5 | 1 | 3.00 | 4 | 7 | 6 | 7 | # | # | | # |
| Induction of Labour as % of women delivered | 100 | 80 | 107 | 78 | 86 | 68 | 78 | 77 | 73 | 89 | 78 | 90 | 98 | 73 | 88 | 93 | 87 | # | # | # | | # |
| % of women induced when RFM is the only indication <39 weeks | 4 | 3 | 0 | 0 | 0 | 2 | 3 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 1 | 1 | 0 | 0 | 2 | # | | 0 |
| % of women induced for Suspected SGA | 16 | 28 | 27 | 23 | 15 | 19 | 18 | 19 | 11 | 14 | 7 | 22 | 17 | 17 | 10 | 10 | 16 | # | # | # | | # |
| Average Postnatal Length of Stay | 1.2 | 1.3 | 1.4 | 1.6 | 1.6 | 1.6 | 1.5 | 1.5 | 1.6 | 1.5 | 1.5 | 1.8 | 1.6 | 1.7 | 1.8 | 1.6 | 2 | 5 | 5 | # | | 5 |
| Number of In-utero transfers in from other units | 1 | 3 | 1 | 0 | 0 | 0 | 0 | 0 | 6 | 3 | 1 | 4 | 2 | 2 | 1 | 1 | 1 | # | 3 | # | | 1 |
| Number of In-utero transfers out to other units | 0 | 0 | 2 | 0 | 0 | 1 | 0 | 0 | 2 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 0 | 6 | | 2 |
| %of Women Smoking at Booking | 11.20% | 13.83% | 13.02% | 13.93% | 12.90% | 13.65% | 13.61% | 12.50% | 16.47% | 14.34% | 14.81% | 16.43% | 17.72% | 12.10% | 12.20% | 14.30% | 11.62% | 0 | 0 | 2 | | 0 |
| % of Women Smoking at Delivery | 8.60% | 12.50% | 9.24% | 10.73% | 12.26% | 9.74% | 16.75% | 15.63% | 12.56% | 14% | 13.50% | 11.92% | 12.9% | 8.94% | 9.44% | 11.89% | 10.84% | 0 | 0 | 1 | | 0 |
| Babies in Skin-to-Skin within 1 hour of birth | 192 | 170 | 183 | 148 | 166 | 159 | 148 | 169 | 168 | 201 | 161 | 181 | 184 | 141 | 175 | 172 | 161 | # | # | # | | # |
| Percentage of Women Initiating Breastfeeding | 114 | 110 | 134 | 103 | 104 | 109 | 87 | 108 | 106 | 126 | 106 | 125 | 136 | 118 | 125 | 107 | 121 | # | # | # | | # |
| Percentage of Women booked by 12+6 weeks | 198 | 228 | 206 | 215 | 215 | 230 | 205 | 226 | 233 | 238 | 206 | 200 | 199 | 206 | 236 | 242 | 206 | # | # | # | | # |
| Prospective Consultant hours on Delivery Suite | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | # | # | # | | # |
| Midwife: Birth Ratio | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | # | # | # | | # |
| 1:1 Care in Labour | 200 | 184 | 215 | 204 | 100% | 99% | 100% | 100% | 99% | 100% | 100% | 98.60% | 100% | 100% | 100% | 100% | 100.00% | 3 | 3 | # | | # |
| Percentage of shifts where shift Co-ordinator able to remain supernumerary | 95% | 93% | 95% | 100% | 100.00% | 98% | 100% | 100% | 98% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 98% | 3 | 3 | # | | 3 |
| Diverts: Number of occasions unit unable to accept admissions | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 2 | 4 | | 1 |
| Diverts: Number of women during period affected by unit closure | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 1 |
| Number of Midwives in Post | 144 | 145 | | 130 | 128 | 129 | 128 | 128 | 128 | 129 | 130 | 128 | 128 | 133 | 131 | 131 | 131 | # | # | # | | # |
| Attendance at Skills Drills/Mandatory Training | 12 | 12 | 12 | 0 | 15 | 0 | 14 | 14 | 14 | 19 | 18 | 15 | 0 | 9 | 11 | 12 | 12 | # | # | # | | # |
| 3rd/4th Degree Tear as % of births | 3 | 4 | 5 | 8 | 7 | 4 | 1 | 2 | 3 | 8 | 6 | 1 | 7 | 4 | 4 | 3 | 5 | # | # | # | | # |
| with unassisted births (normal) | 2 | 1 | 3 | 7 | 5 | 3 | 1 | 1 | 3 | 7 | 5 | 1 | 6 | 3 | 2 | 3 | 3 | # | 8 | # | | # |
| with assisted births (Instrumental) | 1 | 3 | 2 | 1 | 2 | 1 | 0 | 1 | 0 | 1 | 1 | 0 | 1 | 1 | 2 | 0 | 2 | 2 | 4 | # | | 5 |
| Episiotomies in Normal Birth | 10 | 5 | 10 | 6 | 3 | 4 | 3 | 5 | 3 | 4 | 2 | 4 | 4 | 7 | 4 | 7 | 5 | 9 | # | # | | # |
| PPH >2.5L as % of births | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 3 | 1 | 1 | 0 | 0 | 2 | 1 | 2 | 1 | 3 | 2 | 6 | # | | 1 |
| Number of Blood Transfusions > 4 Units | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | | 2 | 0 | 4 | | 1 |
| Number of Women Requiring Level 2 Critical Care | 4 | 0 | 1 | 1 | 2 | 3 | 1 | 2 | 1 | 0 | 1 | 2 | 3 | | 3 | | 3 | 2 | 6 | # | | 4 |
| Number of Women Requiring Level 3 Critical Care | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | | 0 | 0 | 0 | 0 | | 0 |
| Maternal Deaths | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 |
| Number of women re-admitted within 28 days of delivery | 1 | 3 | 1 | 2 | 3 | 2 | 1 | 0 | 1 | 3 | 2 | 1 | 0 | 1 | 4 | 3 | 3 | 6 | # | # | | 6 |
| Stillbirths ** | 1 | 0 | 0 | 0 | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 1 | 0 | 2 | 5 | | 2 |
| Early Neonatal Deaths (before 7 days) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 3 | 0 | 0 | 0 | 3 | 4 | | 0 |
| Number of Neonates with Apgars <7 at 5 minutes (>37 weeks oestation) | 3 | 1 | 1 | 1 | 4 | 2 | 0 | 2 | 3 | 9 | 2 | 2 | 4 | 4 | 2 | 3 | 7 | # | # | # | | 6 |
| HIE 2 &3 > 37 weeks (reported retrospectively) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | | | 0 | 2 | 2 | 2 | 4 | | 0 |
| Shoulder Dystocia | 1 | 4 | 1 | 2 | 0 | 1 | 2 | 4 | 4 | 3 | 3 | 0 | 4 | 3 | 0 | 2 | 5 | # | 7 | # | | 3 |
| Singleton Babies born <30 weeks gestation | 1 | 0 | 0 | 2 | 0 | 0 | 2 | 2 | 1 | 0 | 2 | 0 | 0 | 0 | 1 | 0 | 0 | 3 | 1 | 8 | | 2 |
| % whose mother received magnesium sulphate | 1 | 0 | 0 | 2 | 0 | 0 | 0 | 1 | 100% | N/A | 2 | N/A | N/A | N/A | 1 | N/A | N/A | 3 | 1 | 5 | | 2 |
| Singleton Babies born <34 weeks gestation | 5 | 3 | 6 | 3 | 4 | 4 | 3 | 5 | 3 | 0 | 3 | 2 | 4 | 2 | 2 | 2 | 6 | 6 | # | # | | # |
| % whose mother received full course steriods (1 week prior to delivery) | 3 | 2 | 4 | 1 | 1 | 2 | 1 | 4 | 2 | N/A | 2 | 0 | 2 | 2 | 2 | 0 | 5 | 4 | 7 | # | | 6 |
| Births >37 weeks gestation | 223 | 211 | 214 | 179 | 190 | 171 | 175 | 184 | 190 | 235 | 187 | 194 | 220 | 162 | 210 | 213 | 196 | # | # | # | | # |
| Unexpected Term Admissions to NNU as % of births > 37 weeks gestation. | 10 | 10 | 12 | 1 | 6 | 4 | 2 | 3 | 4 | 20 | 7 | 7 | 4 | 15 | 8 | 18 | 16 | # | # | # | | # |
| Number of babies re-admitted with 28 days of birth | 28 | 18 | 12 | 15 | 19 | 11 | 14 | 10 | 14 | 10 | 7 | 10 | 16 | 14 | 21 | 12 | 22 | # | # | # | | # |
| Number of indicents reported | 65 | 46 | 74 | 57 | 51 | 49 | 43 | 72 | 44 | 66 | 79 | 56 | 80 | 63 | 66 | 51 | 59 | # | # | # | | # |
| Number of Concise Investigations | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 2 | | 2 | 1 | 0 | 2 | 3 | 7 | | 1 |
| Number of StEIS Reported Incidents | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | | 2 | 0 | 0 | 1 | 2 | 4 | | 0 |
| Number of Midwifery Red Flags Reported | 3 | 4 | 3 | 3 | 0 | 4 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 2 | 1 | 2 | 5 | 1 | 8 | # | | 6 |
| Number of Complaints | 0 | 0 | 0 | 1 | 2 | 3 | 2 | 1 | 0 | 3 | 0 | 1 | 2 | 0 | 0 | 1 | 0 | 3 | 1 | # | | 3 |
| Number of Letters of Claim Received | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | | | 0 | 1 | 1 | 1 | 2 | | 0 |
| | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | | 0 |
| Live Births | 240 | 229 | 242 | 204 | 211 | 198 | 187 | 211 | 203 | 242 | 209 | 220 | 237 | 191 | 230 | 227 | 212 | # | # | # | | |
| **REGIONAL METRICS** | | | | | | | | | | | | | | | | | | | | | | |
| Number of Live Births born ≥16 weeks to <24 weeks | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | | | | | |
| Number of Live Births born ≥24 weeks to <37 weeks | 16 | 18 | 27 | 21 | 22 | 24 | 12 | 22 | 18 | 12 | 21 | 24 | 16 | 24 | 20 | 13 | 17 | | | | | |
| Number of Live Births born ≥24 weeks to <34 weeks | 5 | 3 | 6 | 3 | 4 | 6 | 3 | 7 | 5 | 4 | 3 | 5 | 9 | 4 | 2 | 2 | 5 | | | | | |
| Number of Live Births ≥38 weeks | 203 | 180 | 194 | 165 | 169 | 150 | 153 | 160 | 172 | 212 | 170 | 172 | 202 | 143 | 193 | 192 | 170 | | | | | |
| Number of Live Births ≥39 weeks | 163 | 147 | 164 | 131 | 136 | 127 | 124 | 126 | 138 | 160 | 127 | 143 | 160 | 112 | 146 | 158 | 138 | | | | | |
| Number of Episiotomies performed | 37 | 30 | 27 | 30 | 19 | 21 | 15 | 21 | 24 | 19 | 19 | 22 | 34 | 22 | 32 | 24 | 20 | | | | | |
| Number of babies born <3rd centile | 9 | 8 | 8 | 6 | 11 | 15 | 10 | 13 | 8 | 15 | 10 | 17 | 11 | 14 | 16 | 14 | 14 | | | | | |
| Number of Major Haemorrhages ≥ 2500mls | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 3 | 1 | 1 | 0 | 0 | 2 | 1 | 2 | 1 | 3 | | | | | |
| Intrapartum Stillbirths | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | |
| Number of Early Neonatal Deaths 20+0 to 23+6 weeks | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | | | | | |
| Number of Early Neonatal Deaths > 24 weeks | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | | | | | |
| Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received magnesium sulphate | 4 | 3 | 4 | 3 | 2 | 5 | 1 | 5 | 4 | 0 | 3 | 0 | 5 | 3 | 2 | 0 | 4 | | | | | |
| Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received steroids | 5 | 2 | 6 | 3 | 2 | 4 | 1 | 5 | 4 | 2 | 2 | 0 | 5 | 4 | 2 | 0 | 5 | | | | | |
| Number of babies less than 3rd centile delivered >38 weeks | 5 | 1 | 1 | 1 | 3 | 7 | 3 | 4 | 6 | 6 | 4 | 5 | 5 | 5 | 8 | 9 | 4 | | | | | |
| Number of women smoking at the time of booking | 27 | 31 | 31 | 34 | 30 | 37 | 32 | 32 | 44 | 36 | 32 | 35 | 39 | 27 | 31 | 37 | 25 | | | | | |
| Number of women smoking at delivery | 21 | 28 | 22 | 22 | 26 | 19 | 31 | 33 | 25 | 34 | 27 | 26 | 30 | 17 | 22 | 27 | 23 | | | | | |
| Friends & Family Test:Q2 Birth:Percentage returned complete | | | | | | | | | | | | | | | | | | | | | | |
| Friends & Family Test:Q2 Birth:Percentage of completed surveys returned as recommended | | | | | | | | | | | | | | | | | | | | | | |
| Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were symptomatic | 2 | 2 | 2 | 2 | 22 | 54 | 4 | 11 | 5 | 2 | 4 | 5 | 2 | 0 | 2 | 0 | 3 | | | | | |
| Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were asymptomatic | 5 | 2 | 1 | 2 | 2 | 9 | 1 | 2 | 2 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | |
| Number of babies born at Home Midwife NOT present | 1 | 1 | 0 | 0 | 4 | 1 | 1 | 1 | 0 | 0 | 1 | 2 | 2 | 1 | 0 | 0 | 1 | | | | | |
| Number of babies born in Other location Midwife NOT present | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 3 | 1 | 0 | | | | | |
| Episiotomies with Episcissors | 32 | 26 | 21 | 28 | 14 | 21 | 14 | 20 | 24 | 16 | 15 | 16 | 28 | 21 | 26 | 21 | 17 | | | | | |
| Mothers who did not receive full course and omissions in care noted | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

# Maternity Dashboard 2022

| | | Goal | Red Flag | Measure | 2021 Data Aug | Sept | Oct | Nov | Dec | 2022 Data Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Q1 | Q2 | Q3 | Q4 | YTD | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Activity | Number of Registerable Births | >200 | <180 | 2020 Births | 241 | 229 | 242 | 205 | 213 | 198 | 187 | 211 | 203 | 242 | 209 | 220 | 238 | 191 | 234 | 228 | 213 | 596 | 654 | 649 | 675 | 2574 | |
| | Number of Bookings( retrospective 1 month ) | ≥240 | ≤200 | 2020 Bookings | 222 | 242 | 227 | 244 | 233 | 271 | 235 | 255 | 267 | 250 | 218 | 214 | 220 | 232 | 254 | 258 | 215 | 761 | 733 | 666 | 727 | 2887 | |
| | Normal Births as % of births | >=60% | <55% | Nat Standard | 56.85% | 55.46% | 59.09% | 54.63% | 54.46% | 52.02% | 58.29% | 52.13% | 54.19% | 55.37% | 52.63% | 59.09% | 51.68% | 55.50% | 39.74% | 52.19% | 46.48% | 54.03% | 54.13% | 55.32% | 46.07% | 52.29% | |
| | % of Successful Planned Home Births | | | Births/month | 0.83% | 0.87% | 0.41% | 0.49% | 1.88% | 0.51% | 1.07% | 0.95% | 0.99% | 1.65% | 0.48% | 0.45% | 1.68% | 2.09% | 0.43% | 1.32% | 0.94% | 0.84% | 1.07% | 1.39% | 0.89% | 1.05% | |
| | Instrumental Deliveries as % of births | <12% | >15% | Nat Average | 12.03% | 11.35% | 7.85% | 13.17% | 10.80% | 11.11% | 10.16% | 9.48% | 12.32% | 8.68% | 10.05% | 9.09% | 14.29% | 8.38% | 12.39% | 7.46% | 7.04% | 10.23% | 10.24% | 10.79% | 9.04% | 10.06% | |
| | Total Caesarean Sections as % of births | <29% | ≥34% | GM Average | 31.12% | 33.19% | 33.06% | 29.76% | 34.27% | 36.36% | 31.55% | 38.39% | 33.50% | 36.36% | 37.80% | 31.82% | 33.61% | 38.22% | 47.44% | 39.91% | 46.01% | 35.57% | 35.93% | 34.36% | 44.44% | 37.68% | |
| | % Emergency Caesaean Sections | | | | 14.94% | 15.72% | 23.55% | 18.54% | 19.25% | 19.70% | 17.11% | 19.91% | 19.70% | 20.66% | 21.05% | 20.00% | 17.65% | 22.51% | 28.63% | 25.44% | 30.52% | 18.96% | 20.49% | 19.88% | 28.15% | 21.99% | |
| | % Elective Caesarean Sections | | | | 16.18% | 17.47% | 9.50% | 11.22% | 15.02% | 16.67% | 14.44% | 18.48% | 13.79% | 15.70% | 16.75% | 11.82% | 15.97% | 15.71% | 18.80% | 14.47% | 15.49% | 16.61% | 15.44% | 14.48% | 16.30% | 15.70% | |
| | Number of successful VBAC deliveries | | | Births/month | 6 | 7 | 5 | 4 | 4 | 4 | 3 | 5 | 3 | 4 | 5 | 3 | 5 | 3 | 6 | 5 | 4 | 12 | 12 | 11 | 15 | 50 | |
| | %of Caesarean Sections at Full Dilatation | | | Births/month | 2.67% | 5.26% | 8.75% | 11.48% | 4.11% | 6.94% | 8.47% | 3.70% | 1.47% | 4.55% | 2.53% | 7.14% | 1.25% | 4.11% | 3.60% | 7.69% | 6.12% | 6.13% | 2.98% | 4.04% | 5.67% | 4.74% | |
| | Induction of Labour as % of women delivered | <38% | >=42% | Births/month | 41.49% | 34.93% | 44.21% | 38.05% | 40.38% | 34.34% | 41.71% | 36.49% | 35.96% | 36.78% | 37.32% | 40.91% | 41.18% | 38.22% | 37.61% | 40.79% | 40.85% | 37.42% | 36.70% | 40.22% | 39.70% | 38.54% | |
| | % of women induced when RFM is the only indication <39 weeks | | | | 1.66% | 1.31% | 0.00% | 0.00% | 0.00% | 1.01% | 1.60% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.84% | 0.52% | 0.43% | 0.44% | 0.00% | 0.84% | 0.00% | 0.46% | 0.30% | 0.39% | |
| | % of women induced for Suspected SGA | | | | 6.64% | 12.23% | 11.16% | 11.22% | 7.04% | 9.60% | 9.63% | 9.00% | 5.42% | 5.79% | 3.35% | 10.00% | 7.14% | 8.90% | 4.27% | 4.39% | 7.51% | 9.40% | 4.89% | 8.63% | 5.33% | 6.99% | |
| | Average Postnatal Length of Stay | ≤1.5 | ≥1.8 | Births/month | 1.2 | 1.3 | 1.4 | 1.6 | 1.6 | 1.6 | 1.5 | 1.5 | 1.6 | 1.5 | 1.5 | 1.8 | 1.6 | 1.7 | 1.8 | 1.6 | 2 | 1.5 | 1.5 | 1.7 | 1.8 | 1.6 | |
| | Number of In-utero transfers in from other units | | | | 1 | 3 | 1 | 0 | 0 | 0 | 0 | 0 | 6 | 3 | 1 | 4 | 2 | 2 | 1 | 1 | 1 | | 10 | 8 | 3 | 21 | |
| | Number of In-utero transfers out to other units | | | | 0 | 0 | 2 | 0 | 0 | 1 | 0 | 0 | 2 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 5 | | | 6 | |
| | %of Women Smoking at Booking | | | 2020 Bookings = 17% | 14.00% | 13.83% | 13.02% | 13.93% | 12.90% | 13.65% | 13.61% | 12.50% | 16.47% | 14.34% | 14.81% | 16.43% | 17.72% | 12.10% | 12.20% | 14.30% | 11.62% | 13.25% | 15.21% | 15.42% | 12.71% | 14.15% | |
| | % of Women Smoking at Delivery | 14% | 17% | 2020 Births | 8.60% | 12.50% | 9.24% | 10.73% | 12.26% | 9.74% | 16.75% | 15.63% | 12.56% | 14.28% | 13.50% | 11.92% | 12.87% | 8.94% | 9.44% | 11.89% | 10.84% | 14.04% | 13.45% | 11.24% | 10.72% | 12.36% | |
| | Percentage of Babies in Skin-to-Skin within 1 hour of birth | ≥80% | ≤70% | Regional average | 80.00% | 74.24% | 75.62% | 72.55% | 78.67% | 80.30% | 79.14% | 80.09% | 82.76% | 84.00% | 77.03% | 82.27% | 77.64% | 73.82% | 76.09% | 75.77% | 75.94% | 79.87% | 81.04% | 78.09% | 75.93% | 78.69% | |
| | Percentage of Women Initiating Breastfeeding | ≥55% | ≤50% | 2020 Births | 47.50% | 48.03% | 55.37% | 50.49% | 49.29% | 55.05% | 46.52% | 51.18% | 52.22% | 52.07% | 50.72% | 56.82% | 57.38% | 61.78% | 54.35% | 47.14% | 57.08% | 51.01% | 51.68% | 58.49% | 52.77% | 53.53% | |
| | Percentage of Women booked by 12+6 weeks | ≥90% | ≤80% | Nat Standard | 89.19% | 94.21% | 90.75% | 88.11% | 92.27% | 84.87% | 88.12% | 88.63% | 87.27% | 95.20% | 95.37% | 93.46% | 90.45% | 88.79% | 92.91% | 93.80% | 95.81% | 86.86% | 92.36% | 90.84% | 94.09% | 90.99% | |
| Workforce | Prospective Consultant hours on Delivery Suite | 60 hours | < 60 hours | Nat Standard | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 180 | 180 | 180 | 180 | 720 | |
| | Midwife: Birth Ratio | ≤1:28 | ≥1:24 | WTE/Births | 1.28 | 1.28 | 1.28 | 1.28 | 1.28 | 1.28 | 1.28 | 1.28 | 1.28 | 1.28 | 1.28 | 1.28 | 1.28 | 1.28 | 1.28 | 1.28 | 1.28 | 1.84 | 1.84 | 1.84 | 1.84 | 4.36 | |
| | 1:1 Care in Labour | 100% | <100% | Nat Standard | 98.59% | 99.42% | 98.99% | 98.80% | 100.00% | 99.35% | 100.00% | 100.00% | 99.49% | 100.00% | 100.00% | 98.60% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 99.78% | 99.83% | 99.53% | ######## | 99.79% | |
| | Percentage of shifts where shift Co-ordinator able to remain supernumerary | 100% | <100% | Nat Standard | 95.16% | 93.33% | 95.16% | 100.00% | 100.00% | 98.38% | 100.00% | 100.00% | 98.33% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 98.30% | 99.44% | 99.44% | 100.00% | 99.43% | 99.58% | |
| | Diverts: Number of occasions unit unable to accept admissions | | | | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 1 | | 1 | 2 | 4 | |
| | Diverts: Number of women during period affected by unit closure | | | | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 | |
| | Attendance at Skills Drills/Mandatory Training | ≥8% | <8% | Training Database | 8.33% | 8.28% | | 0.00% | 11.72% | 0.00% | 10.94% | 10.94% | 10.94% | 13.47% | 13.85% | 11.72% | 0.00% | 6.77% | 8.40% | 9.16% | 9.16% | 7.27% | 13.18% | 6.17% | 8.91% | 8.88% | |
| Maternal Morbidity | 3rd/4th Degree Tear as % of births | <3% | ≥4% | 2020 Births | 1.24% | 1.79% | 2.10% | 3.90% | 3.30% | 2.05% | 0.54% | 0.97% | 1.51% | 3.36% | 3.00% | 0.46% | 2.94% | 2.11% | 1.72% | 1.32% | 2.36% | 1.19% | 2.67% | 1.87% | 1.79% | 1.89% | |
| | with unassisted births (normal) | | | 2020 Births | 0.83% | 0.45% | 1.26% | 3.41% | 2.36% | 1.54% | 0.54% | 0.48% | 1.51% | 2.94% | 2.50% | 0.46% | 2.52% | 1.58% | 0.86% | 1.32% | 1.42% | 0.85% | 2.35% | 1.56% | 1.19% | 1.50% | |
| | with assisted births (Instrumental) | | | 2020 Births | 0.41% | 1.34% | 0.84% | 0.49% | 0.94% | 0.51% | 0.00% | 0.48% | 0.00% | 0.42% | 0.50% | 0.00% | 0.42% | 0.53% | 0.86% | 0.00% | 0.94% | 0.34% | 0.31% | 0.31% | 0.60% | 0.39% | |
| | % of Episiotomies in Normal Birth | | | Births/month | 7.30% | 3.94% | 6.99% | 5.36% | 2.59% | 3.88% | 2.75% | 4.55% | 2.73% | 2.99% | 1.82% | 3.08% | 3.25% | 6.60% | 4.30% | 5.88% | 5.05% | 3.73% | 2.54% | 4.18% | 5.14% | 3.86% | |
| | Episiotomies with Episcissors | | | | 86.49% | 86.67% | 77.78% | 93.33% | 73.68% | 100.00% | 93.33% | 95.24% | 100.00% | 84.21% | 78.95% | 72.73% | 82.35% | 95.45% | 81.25% | 87.50% | 85.00% | 96.19% | 87.72% | 83.51% | 84.58% | 88.00% | |
| | PPH >2.5L as % of births | | | Births/month | 0.00% | 0.00% | 0.00% | 0.49% | 0.00% | 0.51% | 0.53% | 1.42% | 0.49% | 0.41% | 0.00% | 0.00% | 0.84% | 0.52% | 0.87% | 0.44% | 1.42% | 0.84% | 0.31% | 0.46% | 0.90% | 59.26% | |
| | Number of Blood Transfusions ≥ 4 Units | | | Births/month | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | | 1 | 2 | 1 | | 4 | |
| | Number of Women Requiring Level 2 Critical Care | | | Births/month | 4 | 0 | 1 | 1 | 2 | 3 | 1 | 2 | 1 | 0 | 1 | 2 | 3 | | 3 | 0 | 3 | 6 | 2 | 5 | 6 | 19 | |
| | Number of Women Requiring Level 3 Critical Care | | | Births/month | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | | | 0 | |
| | Maternal Deaths | | | Nat rate per 1000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 | |
| | Number of women re-admitted within 28 days of delivery | ≤1 | >4 | 16 in 2020 | 1 | 3 | 1 | 2 | 3 | 2 | 1 | 0 | 1 | 3 | 2 | 1 | 0 | 1 | 4 | 3 | 3 | 3 | 6 | 2 | 10 | 21 | |
| Neonatal Morbidity & Mortality | Stillbirths ** | | | Nat rate 3.5 per 1000 births | 1 | 0 | 0 | 0 | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 1 | 1 | 0 | 2 | 2 | 1 | |
| | Early Neonatal Deaths (before 7 days) | | | Nat rate per 1000 births | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 3 | 0 | 0 | 0 | 0 | 1 | 3 | 4 | |
| | Number of Neonates with Apgars <7 at 5 minutes (>37 weeks gestation) | ≤0 | >3 | GM av 10 per 1000 | 3 | 1 | 1 | 1 | 4 | 2 | 1 | 2 | 3 | 9 | 2 | 2 | 4 | 4 | 2 | 3 | 7 | 4 | 14 | 10 | 12 | 40 | |
| | HIE 2 &3 > 37 weeks (reported retrospectively) | | | GM av 1.95 per 1000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 2 | 0 | 2 | | 2 | 4 | |
| | Shoulder Dystocia as % of births | | | Births/month | 0.41% | 1.75% | 0.41% | 0.98% | 0.00% | 0.51% | 1.07% | 1.90% | 1.97% | 1.24% | 1.44% | 0.00% | 1.68% | 1.57% | 0.00% | 0.88% | 2.35% | 1.17% | 1.53% | 1.08% | 1.04% | 1.20% | |
| | Singleton Babies born <30 weeks gestation | | | Births/month | 1 | 0 | 0 | 2 | 0 | 0 | 2 | 2 | 1 | 0 | 2 | 0 | 0 | 0 | 1 | 0 | 0 | 4 | 3 | | 1 | 8 | |
| | % whose mother received magnesium sulphate | 100% | 90% | Rolling% of eligible babies | 100.00% | | 0.00% | 100.00% | N/A | N/A | 0.00% | 50.00% | 100.00% | N/A | 100.00% | N/A | N/A | N/A | 100.00% | N/A | N/A | 25.00% | 100.00% | | ######## | 70.00% | |
| | Singleton Babies born <34 weeks gestation | | | Births/month | 8 | 3 | 7 | 2 | 2 | 4 | 2 | 5 | 3 | 0 | 3 | 2 | 4 | 0 | 1 | 2 | 6 | 4 | 3 | | 1 | 8 | |
| | % whose mother received full course of steriods (1 week prior to delivery) | 100% | 90% | Rolling% of eligible babies | 60.00% | 66.67% | 66.67% | 33.33% | 25.00% | 50.00% | 33.33% | 80.00% | 66.67% | N/A | 66.67% | 0.00% | 50.00% | 100.00% | 100.00% | 0.00% | 83.33% | 58.33% | 66.67% | 50.00% | 70.00% | 61.11% | |
| | Mothers who did not receive full course and omissions in care noted | 0 | >1 | Eligible Mothers | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | 0 | |
| | Unexpected Term Admissions to NNU as % of births > 37 weeks gestation. | 3.50% | >4.5% | Births> 37 weeks /month | 4.48% | 4.74% | 5.61% | 0.56% | 3.16% | 2.34% | 1.16% | 1.63% | 2.11% | 8.51% | 3.74% | 3.61% | 1.82% | 9.26% | 3.81% | 8.45% | 8.16% | 1.70% | 5.07% | 4.51% | 6.79% | 4.62% | |
| Risk Management | Number of babies re-admitted with 28 days of birth | <16 | >20 | 194 in 2020 | 28 | 18 | 12 | 15 | 19 | 11 | 14 | 10 | 14 | 10 | 7 | 10 | 16 | 14 | 21 | 12 | 22 | 35 | 31 | 40 | 55 | 161 | |
| | Number of indicents reported | | | | 65 | 46 | 74 | 57 | 51 | 49 | 43 | 72 | 44 | 66 | 79 | 56 | 80 | 63 | 66 | 51 | 59 | 164 | 189 | 199 | 176 | 728 | |
| | Number of Concise Investigations | | | | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 2 | | 2 | 1 | 0 | 0 | 2 | 2 | 3 | 7 | |
| | Number of StEIS Reported Incidents | | | | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | | 2 | 0 | 0 | 0 | 1 | 1 | 2 | 4 | |
| | Number of Midwifery Red Flags Reported | | | | 3 | 4 | 3 | 3 | 0 | 4 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 2 | 1 | 2 | 5 | 4 | 1 | 2 | 8 | 15 | |
| | Number of Complaints | | | | 0 | 0 | 0 | 1 | 2 | 3 | 2 | 1 | 0 | 3 | 0 | 1 | 2 | 0 | 0 | 1 | 0 | 6 | 3 | 3 | 1 | 13 | |
| | Number of Letters of Claim Received | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | | | 0 | 1 | 0 | 1 | | 1 | 2 | |

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

| | | | 2021 Data | | | | | 2022 Data | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Indicator | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | YTD |
| DENOMINATOR Metrics | 1 | Number of Bookers | 222 | 242 | 227 | 244 | 233 | 271 | 235 | 255 | 267 | 250 | 216 | 214 | 220 | 232 | 254 | 258 | 215 | 2887 |
| | 2 | Number of Registrable Births | 241 | 229 | 242 | 205 | 213 | 198 | 187 | 211 | 203 | 242 | 209 | 220 | 238 | 191 | 234 | 228 | 213 | 2574 |
| | 3 | Number of Women Delivered | 241 | 224 | 238 | 205 | 212 | 195 | 184 | 207 | 199 | 238 | 200 | 218 | 234 | 190 | 233 | 227 | 212 | 2537 |
| | 4 | Number of Successful Planned Home Births | 2 | 2 | 1 | 1 | 4 | 1 | 2 | 2 | 2 | 4 | 1 | 1 | 4 | 4 | 1 | 3 | 2 | 27 |
| | 5 | Number of Midwifery Led Unit births | 241 | 224 | 238 | 205 | 212 | 195 | 184 | 207 | 199 | 238 | 200 | 218 | 234 | 190 | 233 | 227 | 212 | 2537 |
| | 6 | Number of Live Births at any gestation | 241 | 229 | 242 | 205 | 213 | 198 | 187 | 211 | 203 | 242 | 209 | 220 | 237 | 191 | 234 | 228 | 213 | 2573 |
| | 7 | Number of Live Births born ≥16 weeks to <24 weeks | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 2 |
| | 8 | Number of Live Births born ≥24 weeks to <37 weeks | 16 | 18 | 27 | 21 | 22 | 24 | 12 | 22 | 18 | 12 | 21 | 24 | 16 | 24 | 20 | 13 | 17 | 223 |
| | 9 | Number of Live Births born ≥24 weeks to <34 weeks | 5 | 3 | 6 | 3 | 4 | 6 | 3 | 7 | 5 | 4 | 3 | 5 | 9 | 4 | 2 | 2 | 5 | 55 |
| | 10 | Number of Live Births ≥37 weeks | 223 | 211 | 214 | 179 | 190 | 171 | 175 | 184 | 190 | 235 | 187 | 194 | 220 | 162 | 210 | 213 | 196 | 2337 |
| | 11 | Number of Live Births ≥38 weeks | 203 | 180 | 194 | 165 | 169 | 150 | 153 | 160 | 172 | 212 | 170 | 172 | 202 | 143 | 193 | 192 | 170 | 2089 |
| | 12 | Number of Live Births ≥39 weeks | 163 | 147 | 164 | 131 | 136 | 127 | 124 | 126 | 138 | 160 | 127 | 143 | 160 | 112 | 146 | 158 | 138 | 1659 |
| | 13 | Number of Episiotomies performed | 37 | 30 | 27 | 30 | 19 | 21 | 15 | 21 | 24 | 19 | 19 | 22 | 34 | 22 | 32 | 24 | 20 | 273 |
| | 14 | Episiotomies with Episcissors | 32 | 26 | 21 | 28 | 14 | 21 | 14 | 20 | 24 | 16 | 15 | 16 | 28 | 21 | 26 | 21 | 17 | 239 |
| | 15 | Number of babies born <3rd centile | 9 | 8 | 8 | 6 | 11 | 15 | 10 | 13 | 8 | 15 | 10 | 17 | 11 | 14 | 16 | 14 | 14 | 157 |
| MATERNAL Morbidity and Mortality Metrics | 16 | Number of Maternal Deaths | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 17 | Number of Blood Transfusions ≥ 4 Units | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | | 4 |
| | 18 | Number of Women Requiring Level 2 Critical Care | 4 | 0 | 1 | 1 | 2 | 3 | 1 | 2 | 1 | 0 | 1 | 2 | 3 | | 3 | 0 | 3 | 19 |
| | 19 | Number of Women Requiring Level 3 Critical Care | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 |
| | 20 | Number of Major Haemorrhages ≥ 2500mls | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 3 | 1 | 1 | 0 | 0 | 2 | 1 | 2 | 1 | 3 | 16 |
| | 21 | Number of Women readmitted to same Obstetric unit within 30 days of delivery | 1 | 3 | 1 | 2 | 3 | 2 | 1 | 0 | 1 | 3 | 2 | 1 | 0 | 1 | 4 | 3 | 3 | 21 |
| | 22 | Number of 3rd and 4th degree tears | 3 | 4 | 5 | 8 | 7 | 4 | 1 | 2 | 3 | 8 | 6 | 1 | 7 | 4 | 4 | 3 | 5 | 48 |
| | 23 | Number of Episiotomies in normal birth | 10 | 5 | 10 | 6 | 3 | 4 | 3 | 5 | 3 | 4 | 2 | 4 | 4 | 7 | 4 | 7 | 5 | 52 |
| | 24 | Number of Emergency LSCS | 36 | 36 | 57 | 38 | 41 | 39 | 32 | 42 | 40 | 50 | 44 | 44 | 42 | 43 | 67 | 58 | 65 | 566 |
| | 25 | Number of Elective LSCS | 39 | 40 | 23 | 23 | 32 | 33 | 27 | 39 | 28 | 38 | 35 | 26 | 38 | 30 | 44 | 33 | 33 | 404 |
| | 26 | Number of LSCS at Full Dilatation | 2 | 4 | 7 | 7 | 3 | 5 | 5 | 3 | 1 | 4 | 2 | 5 | 1 | 3 | 4 | 7 | 6 | 46 |
| | 27 | Number of Operative Vaginal Deliveries | 29 | 26 | 19 | 27 | 23 | 22 | 19 | 20 | 25 | 21 | 21 | 20 | 34 | 16 | 29 | 17 | 15 | 259 |
| | 28 | Number of Normal Vaginal Deliveries | 137 | 127 | 143 | 112 | 116 | 103 | 109 | 110 | 110 | 134 | 110 | 130 | 123 | 106 | 93 | 119 | 99 | 1346 |
| | 29 | Number of Inductions (excluding augmentations) | 100 | 80 | 107 | 78 | 86 | 68 | 78 | 77 | 73 | 89 | 78 | 90 | 98 | 73 | 88 | 93 | 87 | 992 |
| | 30 | Number of women induced only when RFM is the only indication < 39 weeks | 4 | 3 | 0 | 0 | 0 | 2 | 3 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 1 | 1 | 0 | 10 |
| PERINATAL Morbidity and Mortality Metrics | 31 | Number of Stillbirths | 1 | 0 | 0 | 0 | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 1 | 5 |
| | 32 | Number of Intrapartum Stillbirths | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 33 | Number of Early Neonatal Deaths 20+0 to 23+6 weeks | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 2 |
| | 34 | Number of Early Neonatal Deaths > 24 weeks | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 2 |
| | 35 | Number of Neonates with suspected HIE Grade 2 and 3, ≥ 37 Weeks | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | | 0 | 2 | 4 |
| | 36 | Number of Neonates with Apgars <7 at 5 Minutes, ≥ 37 Weeks | 3 | 1 | 1 | 1 | 4 | 2 | 1 | 2 | 3 | 9 | 2 | 2 | 4 | 4 | 2 | 3 | 7 | 41 |
| | 37 | Number of admissions to Neonatal Unit ≥ 37 Weeks | 10 | 10 | 12 | 1 | 6 | 4 | 2 | 3 | 4 | 20 | 7 | 7 | 4 | 15 | 8 | 18 | 16 | 108 |
| | 38 | Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received magnesium sulphate | 4 | 3 | 4 | 3 | 2 | 5 | 1 | 5 | 4 | | 3 | | 5 | 3 | 2 | | 4 | 32 |
| | 39 | Number of babies born ≥ 24+0 weeks to <34 weeks whose mother received steroids | 5 | 2 | 6 | 3 | 2 | 4 | 1 | 5 | 4 | 2 | 2 | | 5 | 4 | 2 | | 5 | 34 |
| | 40 | Number of babies less than 3rd centile delivered >38 weeks | 5 | 1 | 1 | 1 | 3 | 7 | 3 | 4 | 6 | 6 | 4 | 5 | 5 | 5 | 8 | 9 | 4 | 66 |
| PROCESS | 41 | Average Postnatal Length of Stay for Women | 1.2 | 1.3 | 1.4 | 1.6 | 1.6 | 1.6 | 1.5 | 1.5 | 1.6 | 1.5 | 1.5 | 1.8 | 1.6 | 1.7 | 1.8 | 1.6 | 2 | 19.7 |
| | 42 | Number of In-utero Transfers In | 1 | 3 | 1 | 0 | 0 | 0 | 0 | 0 | 6 | 3 | 1 | 4 | 2 | 2 | 1 | 1 | 1 | 21 |
| | 43 | Number of In-utero Transfers Out | 0 | 0 | 2 | 0 | 0 | 1 | 0 | 0 | 2 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 |
| | 44 | Diverts: Number of occasions the unit has been unable to accept admissions | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 4 |
| | 45 | Diverts: Number of women during the period affected by the units closures | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 46 | Number of women booked by 12 + 6 weeks | 198 | 228 | 206 | 215 | 215 | 230 | 205 | 226 | 233 | 238 | 206 | 200 | 199 | 206 | 236 | 242 | 206 | 2627 |
| | 47 | Number of women smoking at the time of booking | 27 | 31 | 31 | 34 | 30 | 37 | 32 | 32 | 44 | 36 | 32 | 35 | 39 | 27 | 31 | 37 | 25 | 407 |
| | 48 | Number of women smoking at delivery | 21 | 28 | 22 | 22 | 26 | 19 | 31 | 33 | 25 | 34 | 27 | 26 | 30 | 17 | 22 | 27 | 23 | 314 |
| | 49 | Number of women initiating breast feeding including attempted and expressed | 114 | 110 | 134 | 103 | 104 | 109 | 87 | 108 | 106 | 126 | 106 | 125 | 136 | 118 | 125 | 107 | 121 | 1374 |
| | 50 | Number of babies that received Skin to Skin contact within 1 hour of birth | 192 | 170 | 183 | 148 | 166 | 159 | 148 | 169 | 168 | 201 | 161 | 181 | 184 | 141 | 175 | 172 | 161 | 2020 |
| | 51 | Number of successful VBAC deliveries | 6 | 7 | 5 | 4 | 4 | 4 | 3 | 5 | 3 | 4 | 5 | 3 | 5 | 3 | 6 | 5 | 4 | 50 |
| Patient Experience | 52 | Friends & Family Test:Q2 Birth:Percentage returned complete | | | | | | | | | | | | | | | | | | 0 |
| | 53 | Friends & Family Test:Q2 Birth:Percentage of completed surveys returned as recommended | | | | | | | | | | | | | | | | | | 0 |
| Workforce | 54 | Number of women receiving 1:1 midwifery in labour | 200 | 184 | 215 | 204 | 180 | 165 | 152 | 168 | 170 | 200 | 165 | 189 | 195 | 160 | 189 | 194 | 179 | 2126 |
| | 55 | Midwife to Birth Ratio | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 336 |
| COVID -19 | 56 | Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were symptomatic | 2 | 2 | 2 | 2 | 22 | 54 | 4 | 11 | 5 | 2 | 4 | 5 | 2 | | 2 | | 3 | 92 |
| | 57 | Number of pregnant women positive for COVID-19 at some stage in their pregnancy who were asymptomatic | 5 | 2 | 1 | 2 | 2 | 9 | 1 | 2 | 2 | 1 | 1 | | | | | | | 16 |
| Safety | 58 | Number of babies born at Home Midwife NOT present | 1 | 1 | 0 | 0 | 4 | 1 | 1 | 1 | 0 | 0 | 1 | 2 | 2 | 1 | 0 | 0 | 1 | 10 |
| | 59 | Number of babies born in Other location Midwife NOT present | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 3 | 1 | 0 | 7 |

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

| | |
|---|---|
| **Title of report:** | Maternity Perinatal Quality Surveillance (Report incorporating Q3 Data) |
| **Presented to:** | Trust Board |
| **On:** | 01 February 2022 |
| **Presented by:** | Rabina Tindale Chief Nurse |
| **Prepared by:** | Cathy Stanford. Divisional Director of Midwifery and Neonates |
| **Contact details:** | T: 01942 773107 E: cathy.stanford@wwl.nhs.uk |

## Executive summary

The perinatal Quality Surveillance model incorporates 5 principles for increasing oversight and perinatal quality, integrating perinatal clinical quality into the ICS structures, and providing clear lines of responsibility and accountability in addressing quality concerns at each level of the system.

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

## Maternity Incentive scheme Compliance

The Maternity incentive scheme Year 4 has been effective from the 6 May 2022 following a 6 month pause in reporting.
The scheme's final submission date is **2 February 2023 by 12 noon**.

**Appendix 1** provides the power point presentation for the Maternity Incentive Scheme Safety Actions to assure the board that all safety actions are compliant in line with the standards guidance. Evidence that was required to be submitted to the Integrated Care Board (ICB) via the Local Maternity and Neonatal systems (LMNS) has been signed off.

**Appendix 2** is the completed Board Declaration Form with action plans against safety action 2,3 and 4 for approval and sign off prior to submission to the ICB and NHS Resolution.
Appendix 3 is the ATAIN action plan to support the compliance for Safety Action 3

**Ockenden Final Report**

Maternity services and the wider MDT team of Neonatal and Anaesthetic teams are making significant progress in implementing and providing assurance against the 15 IEA's. there are currently 22 sub actions that the service is not compliant with, with an additional 12 requiring National, regional or Trust support and development before they can be implemented within the service

Work continues at pace to achieve what is within the capabilities of the service and the detailed action plan is available for review upon the Boards/ sub committees request which provides the detail around each action and what plans are in place to achieve those not yet demonstrating compliance.

**Maternal perinatal and neonatal mortality and morbidity**

Q3 has seen an increase in the number of serious incident investigation undertaken, with increased Steis and HSIB referrals. There have been several extremely poor outcomes with 4 cases referred to HSIB as the babies underwent Therapeutic Hypothermic management (Cooling). (One case was rejected). There has also been 1 Stillbirths and 1 Neonatal Death during this reporting period (1 stillbirth is also included from Q2 as it wasn't included in previous report). Additionally, there have been 2 major post-Partum haemorrhages with mothers subsequently requiring ICU care and one requiring a hysterectomy following readmission.
Whilst WWL has historically demonstrated a low overall incidence of cases that meet the criteria for HSIB review or Steis referral there has been an increase in the last 3 quarters and these cases once completed will also undergo a thematic review to identify any themes or trends for learning. WWL continues to have the lowest stillbirth rate across GMEC.

**Maternity training compliance**

Full compliance against all CNST and SBLv2 training requirements has been demonstrated for Year 4 of the Maternity Incentive Scheme. This has been achieved by the concerted efforts of the Practice Education Teams with MDT support who have actively engaged each month to ensure that all staff groups reach compliance levels.

**Maternity service user feedback**

The number of complaints that are received for Maternity and Neonatal services remains low with the main themes identified as poor communication and staff attitudes and behaviours.

To note The Neonatal unit have received no complaints within the last 12 months, demonstrating the exceptional care and support that is offered to parents.

**Safe Staffing**
There are currently 12.94 vacancies which is likely to increase slightly in the coming weeks. Recruitment remains ongoing. There is a recruitment day planned for May which will capture the students who are completing their training in September 2023 from the GM and neighbouring universities. WWL has expressed an interest in recruiting 3 International Midwives from Cohort 3 of the Northwest recruitment programme. A workforce review is to be commenced alongside the analysis of the recently received Birth-rate Plus report which has identified an additional staffing shortfall. A full staffing review paper will be submitted to Board by the end of Q4, which will include the proposals for the development of enhanced Community Midwifery teams who will provide support for the most vulnerable and those living in deprivation within the Borough I order to improve outcomes for mothers and babies within this group.

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

**Contents**

NHS
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## Maternity Perinatal Quality Surveillance Report

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

| | Jan 22 | Feb 22 | Mar 22 | Apr 22 | May 22 | Jun e 22 | Jul 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Dec 22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| STEIS reportable incidents | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 0 |
| HSIB referrals | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 1 | 1 | 0 | 3 |

**Comments:**

The number of Serious Incidents which occur in any given quarter can vary considerably, due to SI data from Trusts not being published we are not able to benchmark this area.
Q3 has seen an increase in the number of serious incident investigation undertaken, with increased Steis and HSIB referrals. There have been several extremely poor outcomes with 4 cases referred to HSIB as the babies underwent Therapeutic Hypothermic management (Cooling). There has also been 1 Stillbirths and 1 Neonatal Death during this reporting period (1 stillbirth is also included from Q2 as it wasn't included in previous report). Additionally, there have been 2 major post-Partum haemorrhages with mothers subsequently requiring ICU care and one requiring a hysterectomy following readmission

It is important to note that WWL have a clear process for the identification and investigation of Serious Incidents and have an open and honest approach to this, however some cases may not be reported to StEIS until after the concise investigation has been completed. Duty of Candour has been initiated with all cases.

There has been 1 concise investigation completed in Q3 which is the case from Q2 This has highlighted several learning points for the management of Diabetic women and consideration of safeguarding needs. This will require a comprehensive action plan to address the issues, and it will be monitored via the SINE Panel.
all other investigations remain on-going with HSIB currently
Whilst WWL has historically demonstrated a low overall incidence of cases that meet the criteria for HSIB review there has been an increase in the last 3 quarters and these cases once completed will also undergo a thematic review to identify any themes or trends for learning.

The chart below indicates the overall number of cases that a have been referred to HSIB

**Maternity referrals: summary** HSIB

| | Cases to date | |
|---|---|---|
| January 2019-December 2023 Referrals | Total Number | 15 |
| | Referrals / cases rejected | 6 |
| | Total investigations to date | 9 |
| | Total investigations completed | 5 |
| | Current active cases | 4 |
| | Exception reporting | No cases currently have exceptions |

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

| Service | StEIS Ref/Datix | Reported in line with policy | Summary of completed concise investigations | Immediate Actions including level of harm/referral to HSIB |
|---|---|---|---|---|
| Maternity | WEB130767 Aug 22 | Yes | **Diabetic Keto-acidosis and Stillbirth**<br>Found unconscious at home with a 28+5 week delivered stillborn baby. Mother has no recollection of events. Safeguarding concerns have been raised.<br><br>High risk pregnancy due to maternal T1 Diabetes- poorly controlled, as evidenced by significantly raised HbA1C at booking (84) and multiple DNAs at Diabetic Antenatal clinic – repeated reminders and letters on HIS/EPR by Diabetes nurse, Obstetric Consultants and Diabetes Consultant stressing importance of optimising diabetic control to prevent adverse outcomes in pregnancy both foetal and maternal. | **Concise/ Steis/PMRT**<br>Immediate Lessons Learned<br>1. Missed opportunity for medical review when inpatient – unclear from documentation if took own discharge<br>2. Recurrent urine infections, treatment prescribed from ANC but delay in picking up.<br>3. Good practice notes regarding persistent DNA from appointments- diabetes nurse and midwife attempted to but unable to contact GK on several occasions by phone.<br>4. Prompt management by Diabetes/medical and ICU team – DKA Protocol commenced<br>Action plan to de developed incorporating safeguarding concerns and updating of DNA policy. |
| Maternity | WEB132239 Sep 22 | Yes | **Major Obstetric Haemorrhage** following Cat 2 EMCS for abnormal CTG and potential sepsis.<br><br>Subsequent Cardiac arrest following major Post-Partum Haemorrhage (PPH) (3.3L) in Maternity theatre. Transferred ICU<br><br>Readmission through ED with further PV loss EUA (examination under anaesthetic) Bakri Balloon inserted Total EBL 2000ml<br><br>Re-admission Attended ED by ambulance with fresh red loss 500mls uterus well contracted but abdomen extremely tender. | **Concise**<br>Immediate Lessons Learned<br>1. Ensure escalation to shift coordinator when major Haemorrhage occurring.<br>2. Clinicians to remain mindful of patient distress when regional anaesthesia in place as patient can see and hear all that is going on.<br>Investigation ongoing |

| | | | | |
|---|---|---|---|---|
| | | | Plan for emergency hysterectomy for ongoing bleeding. | |
| Maternity | WEB173782 Oct 22 | Yes | **Cooling**<br>39 +4, h/o Intra venous drug user - attended triage with? spontaneous Rupture of Membranes – abnormal Ante Natal CTG – Cat 1 C/S. Baby born in poor condition with low apgars, transferred for therapeutic cooling to Tertiary unit | **HSIB Accepted**<br>Immediate Lessons Learned<br>1. Category 1 LUSCS not undertaken within time frame of 30 minutes<br>2. Incorrect categorisation of antenatal CTG and not using Dawes Redman Criteria<br>3. Neonatal resuscitation and concerns with air entry<br>Investigation ongoing |
| Maternity | WEB133593 Oct 22 | Yes | **Neonatal death at 20+5**<br>G2PO Previous Late miscarriage at 18/40 Gestation Diabetic on metformin, history of Hypothyroidism on thyroxine. Seen by the diabetes team regularly attended at 20+2 with a history of PV bleeding<br>Inevitable miscarriage managed expectantly with a decision for Medical TOP following Spontaneous Rupture of Membranes. Baby born with signs of life and passed away soon after birth<br>Referred to Coroner | **Steis/PMRT**<br>Immediate Lessons Learned<br>1. Risk Assessment at booking identified 18/40 late fetal loss<br>2. Cervical length scans should have been requested at booking scan<br>3. Consultant review regarding Late fetal loss should have been booked<br>4. Plan of care for Cervical length scans from 16 weeks +/- cervical suture not performed.<br>Investigation ongoing |
| Maternity | WEB133159 Oct 22 | Yes | **Eclamptic Fit/ Neonatal Death 24+6**<br>Attended ED via ambulance with collapse and right shoulder pain<br>Possible Eclamptic fit at home. Raided blood pressure and marked proteinuria,<br>Transfer to Tertiary unit requested but was declined due to the concerns re Eclampsia and risk of further seizure<br>Required emergency cat 1 c/section due to Scan Umbilical Artery Doppler – Absent end diastolic flow and on one trace possible reversed flow (there is reduced and | **Steis/PMRT**<br>Immediate Lessons Learned<br>1. Diagnosis was? Eclamptic fit – there was clear signs that a collapse had occurred in view of clinical findings BP Proteinuria PLGF (placental growth factor in the blood) <12and PCR 56 with Fetal compromise.<br>2. Loss of awareness of condition of fetus following eclamptic fit and the chronic hypoxia which developed. |

| | | | | |
|---|---|---|---|---|
| | | | absent blood flow to the baby)<br>Fetal Bradycardia throughout examination No whole-body movements seen. Baby born in very poor condition<br>Full resuscitation given<br>HR <60bpm at 12mins for 3 mins only, thereafter absent<br>Withdrawal of active resus at 30mins of age<br>Weight 500g Centile 0.5 | 3. Review of baseline in relation to gestational age<br>4. Transfer to Tertiary declined – no further consideration given to transfer after initial rejection, even though stable<br>5. When fetal bradycardia present consideration should have been given to delivery<br>**6.** There was no documentation of open and honest discussion with the parents regarding the outcome for baby<br>Investigation ongoing |
| Maternity | WEB133998<br>Nov 22 | Yes | **Major Obstetric Haemorrhage**<br>Primigravida IVF pregnancy Admitted for an IOL at 39 weeks. Required cat 2 c/s as progress slow.<br>Very difficult extraction of baby and significant trauma to the uterus EBL 6000mls requiring admission to ICU (12hrs) and baby required a short stay on NNU Both discharged home. | **Concise.**<br>Immediate Lessons Learned<br>None identified<br>Investigation ongoing |
| Maternity | WEB135919<br>Dec 22 | Yes | **Shoulder Dystocia / Cooling**<br>Primip, spontaneous labour. Fetal tachycardia at full dilatation – NBFD in theatre - Shoulder dystocia confirmed. Brachial plexus injury and # humerus – transferred for therapeutic cooling to Tertiary unit | **HSIB Referral**<br>Immediate Lessons Learned<br>None identified<br>Investigation ongoing |
| Maternity | WEB136434<br>Dec 22 | Yes | **Placental Abruption/ NND**<br>Primip. 37+2. Abruption at home<br>Category 1 LUSCS within 20 minutes of arrival – Born in very poor condition and transferred for cooling – Subsequent Neonatal Death (NND) at Tertiary unit | **HSIB Rejected/PMRT**<br>Immediate Lessons Learned<br>None identified<br>PMRT commenced<br>Investigation ongoing |
| Maternity | WEB136351<br>Dec 22 | Yes | **Sepsis /mother and Baby**<br>G3P2, attended triage? labour. Sent home. | **HSIB Referral**<br>Immediate Lessons Learned |

| | | | | |
|---|---|---|---|---|
| | | | Returned? septic and category 1 C/S performed | 1. Antenatal CTG did not meet criteria prior to discharge, this should have been repeated<br>2. Discussion regarding antibiotics for Group BStrep on HVS should have been discussed<br>Investigation ongoing |
| Maternity | WEB136240<br>Dec 22 | Yes | **Stillbirth**<br>Primigravida. Intrauterine death at 38-weeks' gestation<br><br>Attended Triage with history of no fetal movements for 24 hours.<br>Fetal death in utero (FDIU) confirmed. | **Concise/ PMRT**<br><u>Immediate Lessons Learned</u><br>1. No documented evidence that Reduced Fetal Movements (RFM) leaflet given during the antenatal period<br>2. Lack of continuity of care.<br>3. Six Consultant clinic appointments seeing 3 different consultants and a registrar<br>4. Consultant clinic review not documented in handheld notes after 31/40<br>5. No follow up arranged following raised PI (pulsatility index) noted at 36+5. PI documented on scan report as on 97th centile.<br>**6.** No documented evidence of endocrinology review after 28/40<br>Investigation ongoing |

| | |
|---|---|
| **MVP/ Patient Feedback.** | **. A 15 Steps walk about was undertaken by the MVP in November which was overall very positive. See attached appendix 3** |

## MVP Feedback October 2022
## General Themes

In October we visited Higher Folds Community Centre in Leigh and we have continued to receive feedback in the usual way via facebook and email. Below is a summary of the general themes that families communicated with us:

- Comments received around the fact that lots of staff were helpful, supportive and friendly staff (despite being overworked).
- However, service users reported that not all staff were approachable and there were variations in quality of their experience depending on who was looking after them (as an example, 1 service user said that she felt that the night team were not as helpful as the staff during the day)
- Continuity of Carer teams continue to be singled out for praise by service users. All service users spoken to reported that they liked being able to see the same person throughout their pregnancy
- Issues raised around suitability of appointment times/locations for ante-natal care. People living in more deprived areas struggle to move around the borough
- Service users again reported that when they had contact with the Infant Feeding Team it was really good, but they would have liked more support earlier (1 service user said that if she had had more support she would have liked to have breastfed her baby but by the time she received a text she had already started bottle feeding)


WIGAN BOROUGH Maternity Voices
Working in partnership to improve maternity services

NHS

Healthier Wigan
better care for you and your family

| Formal Complaints | Jan 22 | Feb 22 | Mar 22 | Apr 22 | May 22 | Jun 22 | Jul 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Dec 22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 1 | 0 | 1 | 2 | 0 | 1 | 1 | 0 | 3 | 2 | 0 |
| NNU | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

**Comments:**
In Q3, 3 formal complaints have been received for maternity services with the maternity matrons and managers continuing to meet with women and their families before discharge to deal with any immediate concerns. The maternity service offers a debrief service which women can access to discuss their care. No complaints have been received for NNU.
The main themes identified within the complaints are

- Poor communication
- Staff attitudes and behaviours
- Clinical treatment

| Risk Register | Corporate | Divisional | Local |
|---|---|---|---|
| | 0 | 8 | 3 |

**Comments:**
There are no Maternity risks scoring 15 or above and there are currently 6 Maternity Risks on the divisional risk register which are all being proactively managed within the service.

- CNST year 4 compliance risk (12)
- Midwifery Staffing Shortages (12)
- CTG Misinterpretation (10)
- Screening for GBS at 36 weeks gestation in women with a history of GBS (group B beta-haemolytic streptococcus) infection (9)
- Out of area women cared for under different SGA/FGR guidance (8)
- Sustainability of Maternity Services (8)

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

There are 4 neonatal risks managed within division.

- Staff who do not have current accreditation for NLS course (12)
- BAPM staffing – staff shortage on the Neonatal Unit (9). Due for review
- Access to a Neonatal Dietician competent in Neonatal nutrition (4)
- Specialise neonatal Physiotherapy Services (4)

**New Risk for consideration**

- Escalation process and risk of competing workloads due to their being no separate Consultant on call rota for Maternity/ Obstetric services and Gynaecology services. (15)
- NWAS strike action risk (12)
- Obstetrics and Gynaecology Medical Compensatory Rest (9)
- New-born Resuscitaire Risk (8)

| | |
|---|---|
| **Ockenden 2 Update** | **Within the 15 Immediate and Essential actions there are 92 sub actions.**<br>8 IEAs are directly related to workforce and training, and it is acknowledged that there is a requirement for significant investment in the maternity workforce and multi-professional training to be able to achieve all these actions. However good progress is being made against these actions as workforce planning utilising the Birth-rate Plus Maternity staffing tool has been completed and the final report is awaited which will provide an updated baseline staffing requirement based on accurate acuity and activity data which incorporates increased training requirements for the maternity workforce.<br>There is a significant emphasis on strengthened accountability for improvements in care among senior maternity staff, with timely implementation of changes in practice and improved investigations involving families.<br>Several IEAs relate to governance arrangements and leadership within the governance teams and training for staff who undertake governance activities, in order that families are informed of adverse events and involved in the investigation process and that services remain open and honest and learn from when things go wrong.<br>Maternity services and the wider MDT team of Neonatal and Anaesthetic teams are making significant progress in implementing and providing assurance against the 15 IEA's and the table below outlines progress to date.<br>Work continues at pace to achieve what is within the capabilities of the service and the detailed action plan is available for review upon the Boards/ sub committees request which provides the detail around each action and what plan are in place to achieve those not yet demonstrating compliance. |

| **Q3 Update** | | Local Actions | | | N/A | Trust Corp Action | National/ regional Action |
|---|---|---|---|---|---|---|---|
| | | Red | Amber | Green | | | |
| EA1 | Workforce planning and sustainability | 0 | 2 | 5 | | | 4 |
| EA2 | Safe staffing | 0 | 2 | 7 | | | 1 |
| EA3 | Escalation and accountability | 0 | 3 | 1 | | | 1 |
| EA4 | Clinical governance-leadership | 0 | 2 | 4 | | 1 | |
| EA5 | Clinical governance – incident investigation and complaints | 0 | 1 | 6 | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| EA6 | Learning from maternal deaths | 0 | 0 | 2 | | | 1 |
| EA7 | Multidisciplinary training | 0 | 2 | 5 | | | |
| EA8 | Complex antenatal care | 0 | 2 | 3 | | | |
| EA9 | Preterm birth | 0 | 0 | 4 | | | |
| EA10 | Labour and birth | 0 | 1 | 3 | 2 | | |
| EA11 | Obstetric anaesthesia | 0 | 1 | 6 | | | 1 |
| EA12 | Postnatal care | 0 | 1 | 3 | | | |
| EA13 | Bereavement care | 0 | 0 | 4 | | | |
| EA14 | Neonatal care | 0 | 3 | 4 | | | 1 |
| EA15 | Supporting families | 0 | 2 | 1 | | | |
| | Total | 0 | 22 | 58 | 2 | 1 | 9 |

| | |
|---|---|
| **Maternity Incentive Scheme Year 4. Progress** | The Trust Board must submit their completed Board declaration form the NHS Resolution by **12 Noon on 2 February 2023. After sign of by the designated Officer within the ICB** If the Trust confirm compliance with all the ten safety actions, then the evidence submitted to Trust Board can be requested by NHS Resolution for review.<br>**The January 2023 update included as Appendix 1 (Power Point Presentation TO Board by Divisional Director of Midwifery and Child Health and Clinical Director for Obstetrics and Gynaecology) and 2 (Board Declaration Form) demonstrate compliance alongside mitigating action plans with all the Maternity Incentive Scheme Safety Standards.** |

| | |
|---|---|
| **Q2 Avoiding Term Admissions into Neonatal Unit (ATAIN) Report** | **Maternity Incentive Scheme Safety Action 3**<br>ATAIN, (Avoiding Term Admissions into Neonatal units), is a programme of work to reduce maternal and new-born separation from avoidable admissions to a neonatal unit (NNU) for infants born at term, i.e., ≥ 37 +0 weeks **gestation**.<br>**Why is this so important?**<br>There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. |

This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

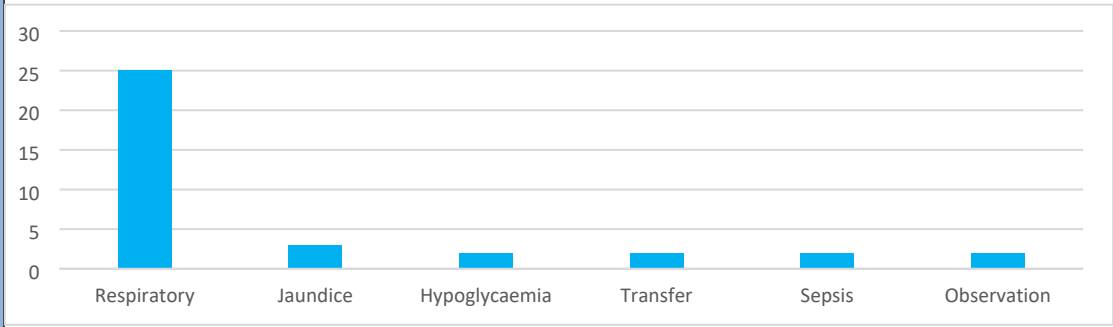
The maternity and neonatal services undertake the ATAIN audit and findings of the audit are shared at the Clinical Cabinet, audit meetings and learning shared with staff.

**ATAIN audit from April – June 2022 (Q2)** assessed if transfers to the NNU were appropriate or avoidable, and if transitional care could have been undertaken to avoid the admission to the NNU.

There were N = 35 term babies were admitted to the NNU at term (excluding babies who were admitted at term with medical problems)

**Reason For Admission**

The main reasons for admission were
25 babies were admitted for respiratory problems
3 babies were admitted for Jaundice
2 babies were admitted with hypoglycaemia




Of the 35 babies admitted 2 could have been cared for on a transitional care unit

Observation

2 babies were admitted for observation and required no further treatment other than observation and double phototherapy which is not available on the postnatal ward

Work continues to ensure babies are not admitted to the NNU unless necessary for their ongoing care and management.no actions identified for escalation or inclusion in action plan.

**Conclusion**

In Q2, 94% of babies were appropriately admitted to the NNU, with 6% (2) babies could have been cared for on the transitional care unit. The transitional care unit has been re-established after Covid in Q2 where the service was suspended, and staffing levels have now improved

These babies could have been managed with close observation, sepsis screen and prophylactic antibiotics if required which does not require infant and maternal separation and supports parental bonding

The audit continues monthly with input from the maternity and neonatal teams with the results and action plan shared at Maternity Safety Champions, Clinical Audit Meetings and Clinical cabinet and quarterly through Quality Safety Committee,

**PMRT/ Stillbirth Data**
**Jan 2022- Dec 2022**.

| Stillbirths | Jan 22 | Feb 22 | Mar 22 | April 22 | May 22 | June 22 | July 22 | Aug 22 | Sept 22 | Oct 22 | Nov 22 | Dec 22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Q4 21-22 | | | Q1 22-23 | | | Q2 22-23 | | | Q3 22-23 | | |
| Total Stillbirths | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 1 |
| MTOP | 0 | 0 | 1 | 1 | 3 | 1 | 1 | 1 | 1 | 2 | 0 | 0 |
| ENND | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 3 | 1 | 1 |
| Total births | 198 | 187 | 211 | 203 | 242 | 209 | 220 | 238 | 191 | 234 | 228 | 213 |
| Rate / 1000 births including MTOP | 0 | 0 | 4.73 | 4.92 | 12.39 | 4.78 | 4.54 | 12.6 | 10.47 | 8.54 | 4.38 | 4.69 |
| Rate / 1000 births excluding MTOP | 0 | 0 | 4.73 | 0 | 0 | 0 | 0 | 8.4 | 5.23 | 0 | 4.38 | 4.69 |
| Quarterly Rate / 1000 births excluding MTOP | 1.67 | | | 0 | | | 4.62 | | | 2.96 | | |

Table 1 Stillbirth rates for 2022

The NHS Long Term plan has set a target of reducing stillbirths by 50% by 2025. That would require England to reduce its stillbirth rate to 2.6 stillbirths per 1,000 births. The most recent ONS data from 2020 records the still birth rate for England and Wales to be 3.8/1000 births. There has been a slow decline in the national stillbirth rate in the years prior to this.

There have been worldwide reports of an increased stillbirth rate during the covid pandemic. UK data from a single centre in London demonstrated a fourfold increase in the stillbirth rate during the first lockdown of 2020. The CNS data for the full year of 2020 however showed a still birth rate of 3.8/1000 births, a decrease from 3.9/1000 in the previous year. Posted 9 August 2022 Data released by the Office for National Statistics (ONS) has confirmed that rates of stillbirth in England and Wales increased from 3.8/1000 births in 2020 to **4.1/1000** in 2021. The data also shows that there continues to be significant variation in stillbirth rates across different parts of England and Wales.

Data for Greater Manchester (GM) is available on charts 1 & 2 below. The stillbirth rates up to the end of 2021 for Wrightington Wigan & Leigh is below the GM average, this data will be reviewed at the end of 2022, the current trajectory suggests the rates will remain below GM average.

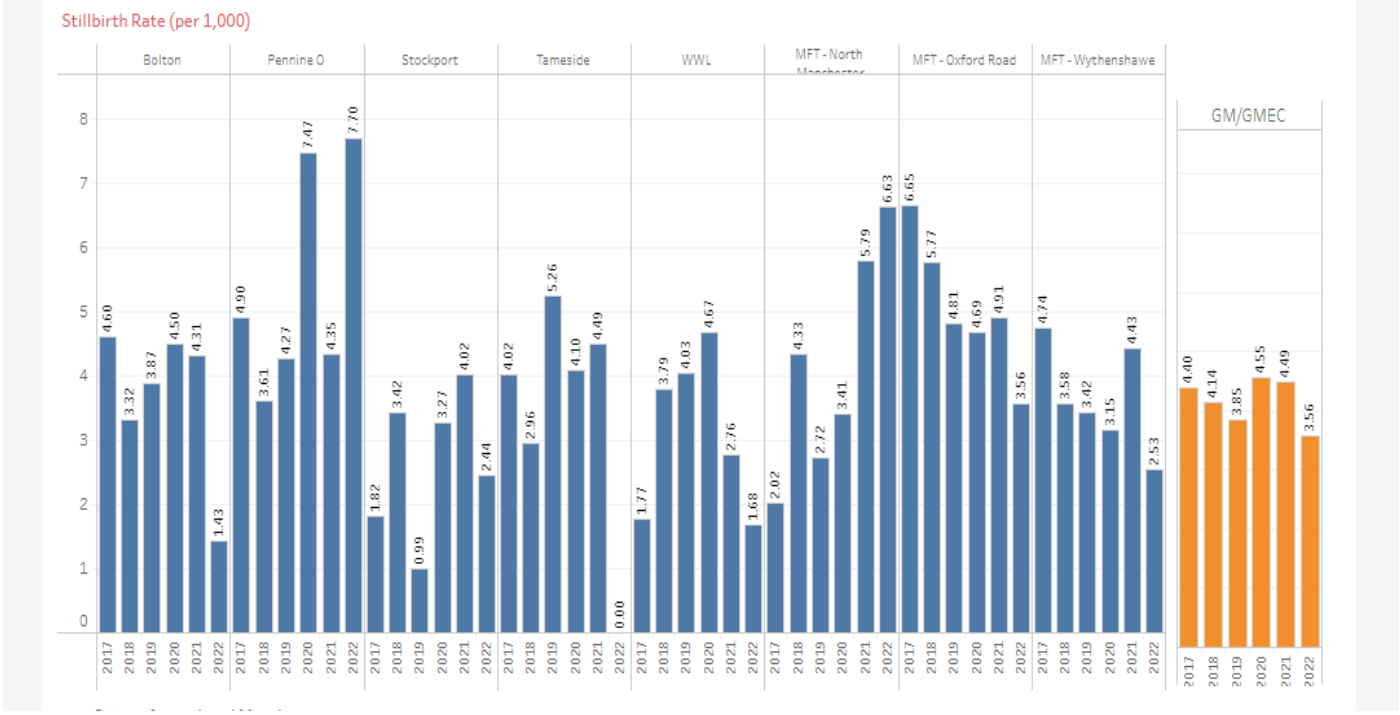



Chart 2 – Stillbirths across GM

## 1.2 Multiple Pregnancy

There was one multiple pregnancy within this report. Twin 2 demised at 28+5 and delivered at 35+ weeks by Elective Caesarean.

## 1.3 Social Deprivation

The quintile of deprivation for the women who suffered a stillbirth in November and December 2022 (Q3 2022), is unable to be presented as per Quintile chart due to both being new housing estates.

### 1.4 Stillbirth Case Reviews

All eligible cases undergo a full PMRT review, with care from across the antenatal and intrapartum period being subject to clinical and managerial scrutiny. The care that the mother receives is subject to a grade which aligns with the MBRRACE-UK grading system. Postnatal care is reviewed, typically with a focus on the bereavement care the family receive. Any complications of labour and within the postnatal period are subject to the same grading system.

The two stillbirths in quarter 3 (not including pregnancy losses at 22-24 weeks) are currently awaiting investigations.

## 1.5 Learning from Stillbirths

The two stillbirths at Wrightington Wigan & Leigh in Q3 (2022)

- Awaiting placental histology and cytogenetics investigations
- MBRACE reportable, awaiting PMRT final review.

**WWL have again been identified as in the top 10 Trusts for detection rates of SGA babies for Quarter 4 (October - December 2022), which is a major contributing factor to stillbirth.**

| Trust Q4 Detection Rate | GAP User Average Q4 Detection Rate |
|---|---|
| 61.4% | 42.6% |

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# SBLCB v2 Jan 2023

**Element 1: Reducing Smoking in Pregnancy**

CO @ booking — 96%

CO @ 36 weeks — 96%

**Element 2: SGA detection**

Risk @ Booking — 100%

Babies born <3rd centile >37+6 — 96%

**Element 3: RFM**

Women attending for RFM receiving computerised CTG — 100%

**Element 4: Effective Foetal Monitoring in Labour**

Overall Staff received foetal monitoring training — 100%

**Element 5: Reducing Preterm Births Singleton <34/40**

Antenatal Steroids — 96%

MgSo4 — 96%

Correct Birthplace — 96%

| Element | Rating | Compliancy/Improvement Plan |
|---|---|---|
| **Element 1 –** Reducing smoking in pregnancy | | Compliant. Co @ booking 96% for quarter 3. Co @ 36 weeks 96%. Smoking cessation midwife and Saving Babies Lives Lead have addressed the data input and collation from antenatal staff and delivery suite staff. Correct input of data and regular teaching sessions of CO monitors are undertaken. Some stock issues for disposable equipment rectified. Audit regularly undertaken. |
| **Element 2 –** Risk assessment and surveillance for fetal growth restriction | | Audit completed and 100% compliant. |
| **Element 3 –** Raising awareness of reduced foetal movements. | | Audit completed and 100% complaint. |
| **Element 4 –** Effective foetal monitoring during labour | | Foetal surveillance lead midwife responsible for data. |
| **Element 5 –** Preterm Births. | | Preterm birth lead obstetrician in place. Funding for preterm birth midwife to be secured. Exploration of a dedicated preterm birth clinic ongoing. Women are identified of risk status at booking and placed into low, intermediate, or high-risk categories. Transvaginal scanning is available within WWL USS departments. Trends are identified in audit and highlighted issues are addressed. |
| Additional ELearning for SBL training Elements 1, 2, 3, and 5. (Not a CNST requirement for Year 4) | | 88% doctors and midwives compliant with ELearning element modules. 12% non-compliant all contacted via e mail and face to face to address any ongoing issues with access, time allocation or learning challenges. |

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**Mandatory Training compliance for Q3**

## NLS Compliance Paediatrics 2022

| | |
|---|---|
| Consultants | 93.33% |
| Middle Grades | 100% |
| Nurses | 100% |
| Tier 1 ( on induction) | 100% |

Both PROMPT and fetal physiology training is multidisciplinary with compulsory attendance from Midwives and Obstetricians. PROMPT is also compulsory for all Maternity support workers and Obstetric anaesthetists.

## Mandatory Training compliance Midwifery

| | Number attended | Percentage of staff | Rolling percent |
|---|---|---|---|
| BLS | 26 | 17% | 93% |
| NLS | 26 | 17% | 93% |
| PROMPT | 37 | 25% | 91% |
| Fetal Physiology | 24 | 16% | 93% |
| Fetal Physiology 2 | 73 | 48% | 91% |

All Maternity mandatory training achieved 90% compliance throughout December to achieve CNST compliance.

## Mandatory training compliance other specialities

| | PROMPT | |
|---|---|---|
| | Number attended | Rolling percentage |
| Consultant Obstetrician | 1 | 91% |
| Obstetric registrar | 5 | 91% |
| Anaesthetist | 9 | 100% |
| MSW | 14 | 94% |

All specialities achieved 100% compliance by December.

## Fetal Physiology

| | Oct 22 | Rolling % | Nov 22 | Rolling % | Dec 22 | Rolling % |
|---|---|---|---|---|---|---|
| **Midwives** | **9** | **96%** | **13** | **96%** | **57*** | **91%** |
| **Obstetric Consultants** | **0** | **100%** | **0** | **90%** | **0** | **100%** |
| **Obstetric Registrars** | **1** | **90%** | **1** | **90%** | **3** | **90%** |

*Due to standards for fetal physiology requiring all staff to attend full day training – additional sessions put on to meet 90% compliance of staf

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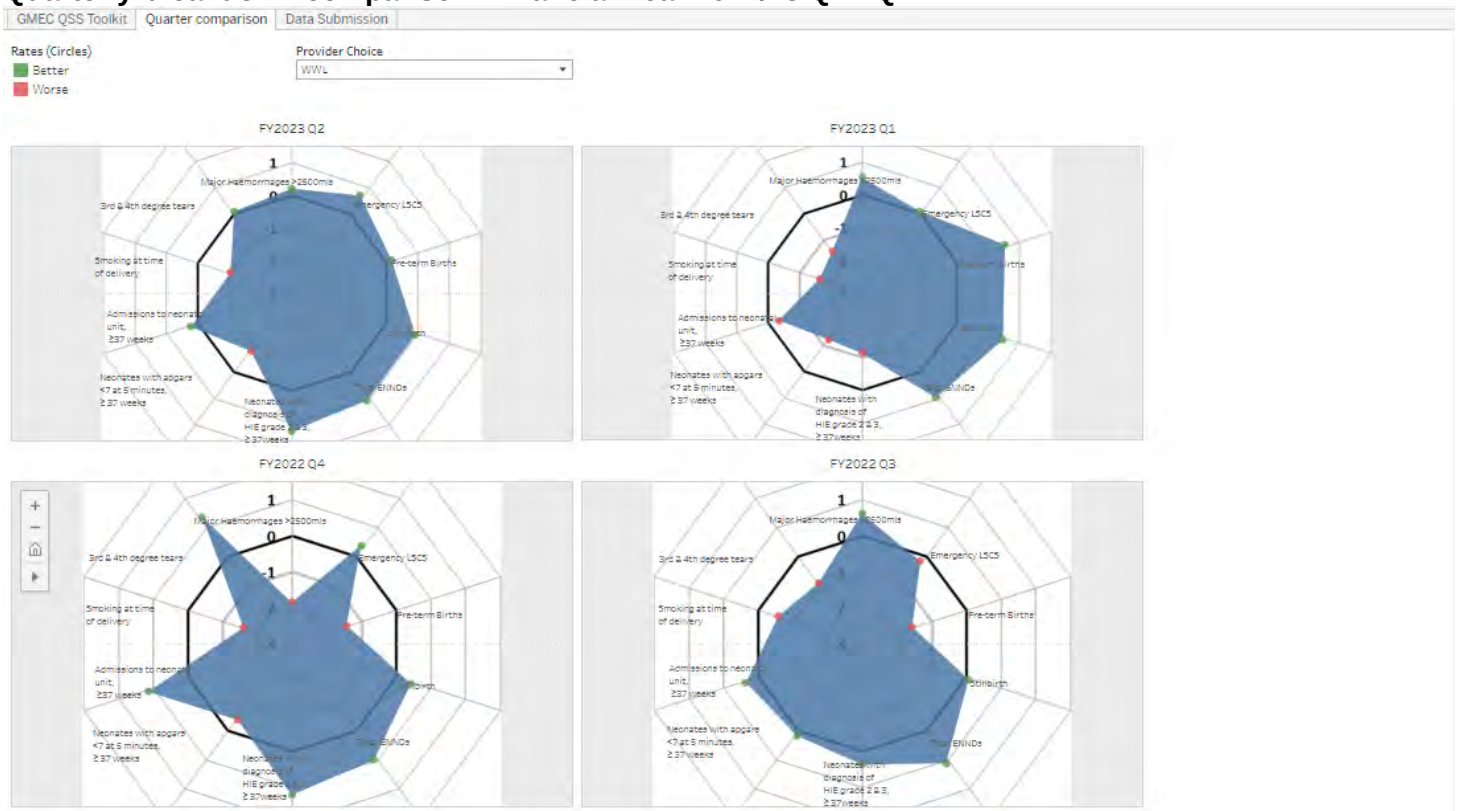
## GMEC Maternity Quality Surveillance Dashboard

## Quarterly breakdown comparison. Financial Year 2022/23 Q1 - Q4




**The GMEC data looks at 10 metrics for all GM an Eastern Cheshire Trusts**

## WWL Data compared to GMEC average

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**Local Maternity Dashboard. Key metrics.**

| | Metric | Standard | Apr 22 | May 22 | Jun 22 | July 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Dec 22 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Workforce | 1:1 care in labour | 100% | 99.49 % | 100% | 100% | 99.47 % | 100% | 100% | 100% | 100% | 100% |
| | Supernumerary Shift Coordinator | 100% | 98.33 % | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 98.3 % |
| | Midwifery Sickness | In development | | | | | | | | | |
| | Midwifery Vacancies | | 20.21 | 20.21 | 15.98 | 16.76 | 20.15 | 17.75 | 14.62 | 12.71 | 12.94 |
| | Midwifery Red Flags | | 1 | 0 | 0 | 0 | 0 | 2 | 1 | 2 | 5 |
| Activity | Number of bookings | >240 <200 | 267 | 250 | 216 | 214 | 220 | 232 | 254 | 258 | 215 |
| | Registerable births | >200 <180 | 203 | 242 | 209 | 220 | 238 | 191 | 234 | 228 | 213 |
| | Induction of Labour as % births | <38% >=42 % | 35.96 % | 36.78 % | 37.32 % | 40.91 % | 41.18 % | 38.22 % | 37.61 % | 40.79 % | 40.85 % |
| | Instrumental deliveries | 10.8% | 12.32 % | 8.68 % | 10.05 % | 9.09 % | 14.29 % | 8.38 % | 12.39 % | 7.46 % | 7.04 % |
| | Total C/S | 34.27 % | 33.5 % | 36.36 % | 37.80 % | 31.82 % | 33.61 % | 38.22 % | 47.44 % | 39.91 % | 46.01 % |
| | Robson Criteria Remains under development. Awaiting upgrade to MIS. | | | | | | | | | | |
| | 3rd/4th degree tear as % of births | <3 >4 | 1.51 % | 3.36 % | 3% | 0.46 % | 2.94 % | 2.11 % | 1.72 % | 1.32 % | 2.36 % |
| | PPH >2500 as % of births | | 0.49 % | 0.41 % | 0% | 0% | 0.84 % | 0.52 % | 0.87 % | 0.44 % | 1.42 % |
| Neonatal | Metric | Standard | Apr 22 | May 22 | Jun 22 | Jul 22 | Aug22 | Sep22 | Oct 22 | Nov 22 | Dec 22 |
| | Apgar's <7 at 5 minutes | <4 | 3 | 9 | 2 | 2 | 4 | 4 | 2 | 3 | 7 |
| | Unexpected term admissions to NNU (%) | 3.5% >4.5% | 2.11 % | 8.51 % | 3.74 % | 3.61 % | 1.82 % | 9.26 % | 3.81 % | 8.45 % | 8.16 % |
| | Babies readmitted within 28 days of birth | <16 >20 | 14 | 10 | 7 | 10 | 16 | 14 | 21 | 12 | 22 |
| | Shoulder dystocia as % of births | | 1.97 % | 1.24 % | 1.44 % | 0% | 1.68 % | 1.57 % | 0.00 % | 0.88 % | 2.35 % |
| | HIE 2 & 3 >27 weeks | | 0 | 1 | 1 | 0 | 0 | 1 | 1 | 0 | 2 |
| | Stillbirths | | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 1 | 1 |
| | Early NND | | 0 | 0 | 0 | 0 | 1 | 0 | 3 | 0 | 0 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Singleton babies born <30 weeks | | 1 | 0 | 2 | 0 | 0 | 0 | 1 | 0 | 0 |
| | % Whose mother received MgSO4 | 100% | 100% | 0 | 100% | N/A | N/A | N/A | 100% | N/A | N/A |
| | Singleton babies born <34 weeks | | 3 | 0 | 2 | 2 | 4 | 2 | 1 | 2 | 6 |
| | % Whose mother received full course steroids | 100% | 66.67 % | 0 | 100% | 0% | 50% | 100% | 100% | 0.00 % | 83.33 % |
| | omissions in care noted | | 0 | N/A | 0 | 0 | 0 | N/A | N/A | 0 | 0 |
| | **Neonatal Dashboard Summary**<br>The figures above show a spike in term admissions to NNU in September of Q2 22-23. These cases have all been investigated and no patterns or omissions in care were noted. However, when compared against the GMEC average WWL are not an outlier and have remained persistently lower than the GMEC average.<br><br>All term admissions to NNU are looked at in detail as part on the ongoing ATAIN audit and any actions noted and added to the overarching action plan.<br><br>There was also a spike in Apgar <7 at 5 minutes in August and September. Cases have been investigated and no omissions in care have been noted. The comparison charts do identify an upward trend but Q3 2022/23 showed an improving picture.<br>There were 8 Mothers who were eligible for steroids within Q2 22-23. Of these 4 received a full course of steroids in the week before delivery. The other Mothers were unable to receive a complete course as delivery needed to be expedited. There were no omissions in care noted. It can be seen above that the figures for September are 100%. | | | | | | | | | | |

**Summary**

Quarter 3 has seen an increase in activity and clinical incidents, with 4 cases referred to HSIB due to infants requiring Therapeutic Cooling and 2 cases referred to Steis. All cases are being fully reviewed and monitored with any immediate learning shared with staff. Any themes or trends from these cases will be identified, however it should be noted that HSIB investigations typically take longer to receive the final report. On internal review there are no themes or trends identified at this stage.

Good progress has been made with the Ockenden Immediate and Essential actions and work is ongoing at pace to achieve full compliance.

The service will be declaring full compliance against the 10 safety actions for the Maternity Incentive Scheme Year 4, although 3 action plans are in place against safety Actions 2, 3 and 4 as I element in each has not met the full compliance. If the action plans are approved by NHSR then full compliance will be achieved for Year 4 as in previous years.

Exceptional compliance in multidisciplinary training has been achieved and should be noted despite operational pressures and staffing challenges.

Wrightington, Wigan And Leigh NHS Foundation Trust

## 2022 - 2023

| | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct 22 | Nov-22 | Dec-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Training compliance for all staff groups in maternity as per CNST requirments (need 90% compliance rate for all staff groups)**<br>**Attendance = Midwives = 10-15 per month Consultant = 1 per month Registrars = 2 per month To maintain % over 95%** | | | | | | | | | | | |
| **Cardiotocograph (CTG) training and competency assessment** | Total Midwifery staff = 81% compliant end of February<br><br>Registrars =87.5%<br>Consultant = 73% (x2 attending next week = 90%) | Midwives 12% *90%<br>Consultant 16% *91%<br>Registrars 11% *89% | Midwives rolling percentage is 85%<br>Consultant/Registrars 1 91% | Consultants – 2 (100% rolling compliance)<br><br>Registrars – 2 (100% rolling compliance)<br><br>Midwives – 18 (87% rolling) | Consultants – 1 (100% rolling compliance)<br><br>Registrars – 0 (100% rolling compliance)<br><br>Midwives – 18 (94.3% rolling) | Midwives = 16 (99% rolling compliance)<br><br>Consultant= 1 (100% rolling compliance)<br><br>Registrar = 0 (100% rolling compliance) | No training in August | Midwives = 14 (96% rolling compliance)<br><br>Consultant = 1 (100% rolling compliance)<br><br>Registrars = 4 (90% rolling compliance) | Midwives = (96% rolling compliance)<br><br>Consultant = (100% rolling compliance)<br><br>Registrars = (90% rolling compliance) | Midwives = 13 (96% rolling compliance)<br><br>Consultant = (100% rolling compliance)<br><br>Registrars = 1 (90% rolling compliance) | Midwives = 57 (91% rolling compliance)<br><br>Consultant = (100% rolling compliance)<br><br>Registrars = 3 (90% rolling compliance) |
| **Practical Obstetric Multi-Professional Training (PROMPT) (emergency Skills Drills Training)** | Midwives 7.2% rolling percentage 78% Consultants 9% rolling percentage 36.36%<br>Registrars 9% rolling percentage 63.63%<br>Anaesthetist's 0% rolling percentage 26.66%<br>MSW's 6% rolling percentage 48.48% | Midwives 10.14% rolling percentage 70%<br>Consultants 9% rolling percentage 45.45%<br>Registrars 9% rolling percentage 72.72%<br>Anaesthetists 0% rolling percentage 26.66%<br>MSW 9% rolling percentage 57.57% | Midwives 14/138 attended 10.14% rolling percentage 73%<br>Consultants /11 attended 0% rolling percentage 45.45%<br>Registrars 1/11 attended 9% rolling percentage 81.81%<br>Anaesthetist's 3/21 attended 14% rolling percentage 33.33%<br>MSW's 2/33 attended 6% rolling percentage 63.63% | Midwives 19/141 attended, rolling % 81%<br>Consultants 1/11 attended, rolling % 55%<br>Registrars 0/11 attended, rolling% 90%<br>Anaesthetists 3/21 attended, rolling% 43%<br>MSW 3/30 attended, rolling% 57% | Midwives 10/144 attended, rolling% 83%<br>Consultants 1/11 attended, rolling % 64%<br>Registrars 0/11 attended, rolling% 82%<br>Anaesthetists 2/19 attended, rolling % 58%<br>MSW 2/30 attended, rolling % 64% | Midwives 15 attended (10.4%) rolling % 87.5%<br>Obstetric consultants 1 attended (9%), rolling % 82%<br>Obstetric registrars 0 attended, rolling% 82%<br>Anaesthetists 0 attended, rolling% 58%<br>MSW 4 attended, rolling% 64% | no Training in August | Midwives rolling % 87.4%<br>Obstetric consultants rolling % 91%<br>Obstetric registrars rolling% 67%<br>Anaesthetists rolling% 63%<br>MSW rolling% 78% | Midwives 11 attended (7%) rolling% 82%<br>Obstetric consultants 1 attended (9%) rolling% 91%<br>Obstetric registrars 1 attended (9%) rolling% 82%<br>Anaesthetists 3 attended (16%) rolling% 74%<br>MSW's 5 attended (14%) rolling% 81% | Midwives 12 attended (8%) rolling % 88%<br>Obstetric consultants 0 attended (0%), rolling % 91%<br>Obstetric registrars 2 attended (18%), rolling% 82%<br>Anaesthetists 1 attended (5%) rolling% 79%<br>MSW's 4 attended (11%) rolling % 86% | Midwives 12 attended (8%) rolling % 91%<br>Obstetric consultants 0 attended (0%), rolling % 91%<br>Obstetric registrars 2 attended (18%), rolling% 91%<br>Anaesthetists 6 attended rolling% 100%<br>MSW's 4 attended (11%) rolling % 94% |
| **Prospective Consultant Delivery Suite Cover ( 60 as standard for WWL)** | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 |
| **1:1 care in labour** | 100% | 100% | 99.49% | 100% | 100% | 99% | 100% | 100% | 100% | 100% | 100% |
| **Maternity Red Flags reported (>3)** | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 2 | 1 | 2 | 5 |
| **Diverts: Number of occasions unit unable to accept admissions(>1)** | 0 | 0 | 0 | 0 | 0 | 0 | | 1 | 1 | 1 | 0 |
| **Supernumeray Shift Co-ordinator** | 100.00% | 100% | 98.30% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 98% |
| **The number of incidents logged graded as moderate or above ( >5)** | 2 | 4 | 4 | 1 | 4 | 0 | 4 | 1 | 5 | 1 | 4 |
| **All cases eligible for referral to HSIB.** | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 1 | 1 | 0 | 3 |
| **Number of Datix submitted when shift co-ordinator not supernumerary** | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| **Service User Voice feedback** | **Maternity Voice Partnership Feedback** Have provided Thank You Thursdays Infographs with details of areas where families have reported excellent care provision, including; continuity teams; infant feeding support; community teams; in-hospital care | **Maternity Voice Partnership Feedback** Service user provided details of their care at the MVP meeting. Expressed that she had received excellent postnatal care from her community midwives but also reflected that she had experienced lack of compassion with her dating scan which led to her booking the rest of her antenatal and birth care at a neighbouring unit. | **Feedback from Patient** "I would like to thank the amazing midwives in particular Lois, Tracey and Sheryl (I don't know there last names to personally thank them) who took care of me Friday night and helped welcome our amazing daughter, into the world. I couldn't of done it without them from stepping onto the ward to leaving. Thank you all so much once again." | **Feedback from Patient** "Wigans antenatal services based at Leigh Infirmary. Every single member of staff from midwives to admin have been lovely, approachable and very informative.I am looking forward to the rest of my pregnancy under the care of Wigan and Leigh" | **Feedback from Patient** "we have had additional growth scans with both our preganacies due to both our boys measuring small. We have felt fully informed and supported throughout this process; the midwives and consultants always explained things to us in detail putting our minds at ease" | **Maternity Voice Partnership Feedback** Really positive comments from service user who is a WWL employee. She found continuity with her Antenatal Care as she saw the same midwife throughout, and the postnatal staff were amazing. Parentcraft was highlighted as an area which she felt could be developed and we were able to share the improvements we have made to our antenatal education | **Feedback from Patient** Concerned about lack of movement during my pregnancy the student I spoke to at RAEI was calm and reassuring and avoided making me feel any kind of anxiety or worry with how she handled the call. Without her I would have become even more distressed | **Maternity Voice Partnership Feedback** *Woman shared her journey with her struggles with mental health during her pregnancy and reflected on how she has had a positive experience this pregancy with support from Perinatal Mental Health *New mum shared her experience around birth and postnatal care and felt that we should have talked about colostrum harvesting We were able to reassure her we would learn from her expereince and offered her Birth Afterthoughts service | **Feedback from Patient** "We received excellent, personalised care from the team at the Maternity Ward. We were admitted with our newborn son to treat his jaundice; this is a common but worrying complaint in newborn children depending on the cause. The maternity team were excellent in their reassurance, support and advice. " | **Feedback from Patient** Thank you to all staff at the Maternity Ward; you are an excellent team and we would not hesitate to return should it ever be required. | **Feedback from Patient** Woman shared her experience with her community midwife ..... came to see as a friend and you did and said so much to put my anxiety at ease. Having continuity with you was the best gift and you were amazing at your job and felt blessed to have had you as her midwife. |
| **Staff feedback from frontline champions and walk-abouts** | **Chief Nurse and CEO Walkabout in Feb Chief Nurse and Board Chair walkabout in Feb No Issues Raised** | **No Formal walkabout took place** | **NED Dr S Elliott unbdertook walkabout across Maternity and NNU. No safety issues identified. Staff reported no concerns in either area** | **Chief Nurse attended maternity unit for walkabout. No issues identified** | **Ockenden Assurance visit and walkabout July 15.** | **Ockenden Insight visit 18/07/2022** The team heard positive feedback around Quality Champions and the Midwifery Preceptorship programme. The visit also highlighted challenges with the reporting structure for the Director of Midwifery, process for compensatory rest and review of PA's allocated. There was concern to the lack of midwifery led care rooms which was addressed immediately. | **No Formal walkabout took place** | **CQC Sharing Success** Maternity Birthing Pool Evacuation Skills Drill performed from which learning points were identified and shared with the maternity and obsteteric staff | **Formal walkabout** Non Executive Director Steven Elliott undertook a walkabout across Maternity and No safety issues identified. Staff reported no concerns and positive feedback to the staff being really friendly | **Formal walkabout** Non Executive Director Steven Elliott undertook a walkabout across Maternity. Maternity staff were able to discuss any issues that concerned them and were provided with information about the Freedom to Speak Up guardian | **No Formal walkabout took place** |
| **Healthcare Safety Investigation Branch (HSIB)/NHS Resolution (NHSR)/CQC or other organisation with a concern or request for action made directly with Trust** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Coroner Reg 28 made directly to Trust** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Progress in achievement of CNST 10** | | All standards remain on Track | | | All standards remain on Track | Work ongoing with Year 4 All standards remain on Track | Work ongoing with Year 4 All standards remain on Track | Work ongoing with Year 4 All standards remain on Track | Work ongoing with Year 4 All standards remain on Track | Work ongoing with Year 4 All standards remain on Track | Work ongoing with Year 4 All standards remain on Track |
| **Number of StEIS Reportable Incidents** | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 1 | 2 | 0 | 0 |
| **Number of Stillbirths** | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 1 |
| **Number of Neonatal Deaths** | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 2 | 0 | 0 |
| **Number of Maternal Deaths** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

| | |
|---|---|
| **Title of report:** | Risk Appetite 2023/24 Review |
| **Presented to:** | Board of Directors |
| **On:** | 1 February 2023 |
| **Presented / Prepared by:** | Director of Corporate Affairs<br>Head of Risk |
| **Contact details:** | E: paul.howard@wwl.nhs.uk |

**Executive summary**

This paper proposes our risk appetite statement for 2023/24 and recommends that we continue with the same risk appetite matrix approach which was devised and approved by the Board in June 2022. However, the paper notes that average (mean) current risk scores for Board Assurance Framework (BAF) and Corporate Risk Register (CRR) risks have been consistently outside the risk appetite tolerance range for the past twelve months. The paper recommends increasing the risk appetite scoring range to reflect the level of risk which we are facing as a Trust in the current climate.

**Link to strategy**

The risks identified within this report relate to the achievement of the trust's objectives.

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

Risk appetite statements may influence the amount of risk which the trust is willing to pursue and tolerate when considering the trust's risks.

**Financial & Legal implications**

There are no financial or legal implications associated with this report.

**People implications**

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

**Wider implications**

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

**Recommendation(s)**

The Board are asked to approve on the trust's risk appetite statement for 2023/24 for implementation from April 2023.

## 1. Background

1.1 NHS well led guidance (2017) requires the trust to have clear and effective processes for managing risks, issues and performance including a clear understanding of the Board's risk appetite and tolerance, which is reviewed regularly (at least annually) and appropriately communicated to staff.

1.2 In addition, we are required to describe the key elements of our risk management strategy as part of the annual report, including a narrative on how risk appetites are determined.

1.3 The MIAA Risk Management Assignment Report 2020/21 identified control design issues with the risk strategy, processes and the risk appetite statement. In 2021/22, the risk strategy, processes and risk appetite statement were reviewed and updated by the RMG, ETM and the Board. A risk appetite matrix was devised, rather than a series of statements, and this was approved by the Board in June 2022. The MIAA Risk Management - Core Controls Review Assignment Report, November 2022, identified the new risk appetite statement as an area of good practice with High Assurance achieved. It is recommended that we continue with the same risk appetite matrix approach in 2023/24.

## 2. Definitions

**Risk Appetite** = the level of risk with which an organisation **aims** to operate (the optimal risk position).

**Risk Tolerance** = the level of risk with which an organisation is **willing** to operate (the tolerable risk position).

## 3. Risk Appetite and Risk Scoring

3.1 Charts 1 and 2 below display the average (mean) current and target risk scores over the last 12 months for the BAF and the CRR. These scores are plotted together with the average (mean) optimal and tolerable risk appetite ranges, ≤4.8 and ≤7.2. As the risk appetite scoring chart was first introduced in 2022/23, we do not have comparable data for 2021/22.

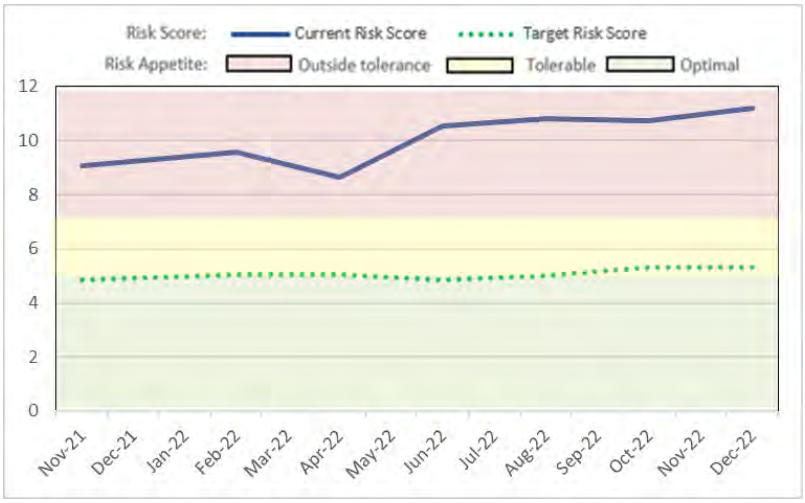
3.2 Charts 1 and 2 highlight that the average (mean) current risk score has been consistently outside the tolerance range for both the BAF and Corporate Risk Register for the past 12 months. This indicates that the current risk tolerance ranges require review as they may be set too low for the level of risk which we are facing as a Trust in the current climate.

3.3 The average (mean) target risk score is within tolerance and just above the optimal risk range. This suggests that no amendments are currently required to the optimal risk range as it is reflective of our target risk scores.

3.4 It is recommended that there is a focus on closing outstanding actions for both BAF and CRR risks to achieve our target scores and bring risks within the tolerable risk range.

3.5 It is noted that the BAF and CRR do not currently identify any risks as opportunities. It is recommended that consideration is given to identifying risk opportunities and reframing threats as opportunities where appropriate in 2023/24.

BAF average (mean) current and target risk scores Nov 2021 to Dec 2022




Current risk score consistently outside tolerance.

Tolerable range is currently ≤ 7.2

Target risk score is within tolerance and can be achieved if outstanding risk actions are completed.

Chart 1

CRR average (mean) current and target risk scores Nov 2021 to Dec 2022

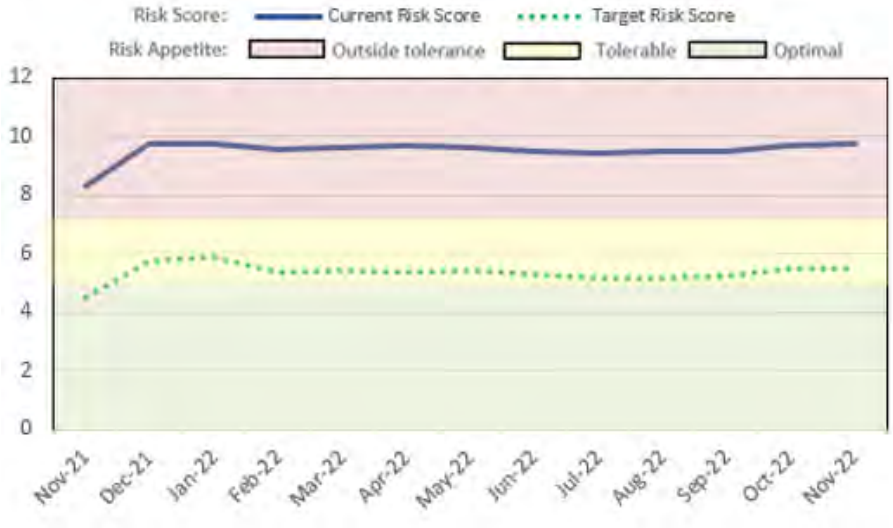



Chart 2

## 4. Risk Appetite Summary Table

4.1 It is recommended that the risk score ranges are adjusted to slightly increase the tolerance score for a cautious risk appetite. The open and eager risk appetites also require minor adjustments to facilitate a change to the cautious risk appetite as shown in table 1.

| Risk Appetite | Adverse | Minimal | Cautious | Open | Eager |
|---|---|---|---|---|---|
| **Optimal risk score** | =1 Very Low | ≤3 Low | ≤6 Moderate | ≤8 High | Decrease to ≤15 Significant (currently 16 Significant) |
| **Tolerable risk score** | 2-3 Low | 4-6 Moderate | Increase to 8-10 High (currently ≤8 High) | Increase to ≤12 High (currently 10 - 12 High) | Increase to ≤15 Significant (currently ≤12 Significant) |

Table 1.

4.2 Our proposed risk appetite position for 2023/24 is summarised in the following table:

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

4.3 For each risk category, a risk appetite has been set based on whether the risk poses a threat or an opportunity. Detail on the optimal and tolerable risk scores is also provided to guide risk owners in their decision-making.

4.4 The scores shown in the matrix above provide guidance to risk owners as to the optimum and tolerable score for each individual risk. More specific definitions for each of these is included in appendices 1 and 2.

4.5 In line with recommended practice, a one-word description of our risk appetite has also been provided using the scale below:

| Least risk | | ← → | | Most risk |
|---|---|---|---|---|
| Averse | Minimal | Cautious | Open | Eager |

## 5.0 Recommendations for risk appetite scoring

5.1 The Board are asked to approve on the trust's risk appetite statement for 2023/24 for implementation from April 2023.

5.2 It is recommended that we:

- Continue with the same risk appetite matrix approach which was devised and approved by the Board in June 2022.

- Increase the risk tolerance score ranges for risk appetite to reflect the current level of risk which we are tolerating as a Trust in the current climate.

- Incorporate the revised risk appetite statement into our BAF and CRR, ensuring risks are aligned to the most appropriate risk category and closing actions to bring risks within the tolerable risk range.

## Appendix 1: Risk Appetite Statements 2023/24

| **Patients** | Our ambition is to be widely recognised for delivering safe, personalised, and compassionate care, leading to excellent outcomes and patient experience | | | | |
|---|---|---|---|---|---|
| **Risk Appetite**<br><br>**Risk Category** | **Adverse** | **Minimal**<br>Threat | **Cautious**<br>Opportunity | **Open** | **Eager** |
| Safety, Quality of Services & Patient Experience | We will avoid anything that may impact on quality outcomes unless essential. Defensive approach to operational delivery – aim to maintain/protect, rather than create or innovate. Priority for close management controls and oversight with limited devolved authority. | Our preference is for risk avoidance. However, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. Innovations largely avoided unless essential. Decision making authority held by senior management. | We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer term rewards. Tendency to stick to the status quo, innovations generally avoided unless necessary. Decision making authority generally held by senior management. Management through leading indicators. | We will pursue innovation wherever appropriate, with clear demonstration of benefit / improvement in management control. Responsibility for non-critical decisions may be devolved. | We seek to lead the way and will prioritize new innovations, even in emerging fields. Desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust / lagging indicators rather than close control. |
| Data & Information Management | We lock down data & information. Access tightly controlled, high levels of monitoring. | We minimise the level of risk due to potential damage from disclosure. | We accept the need for operational effectiveness with risk mitigated through careful management limiting distribution. | We accept the need for operational effectiveness in distribution and information sharing. | We minimise the level of controls with data and information openly shared. |

| | | | | | |
|---|---|---|---|---|---|
| Governance | We will avoid actions with associated risk. No decisions are taken outside of processes and oversight / monitoring arrangements. Trust controls minimise risk of fraud, with significant levels of resource focused on detection and prevention. | We are willing to consider low risk actions which support delivery of priorities and objectives. Processes, and oversight / monitoring arrangements enable limited risk taking. Trust controls maximise fraud prevention, detection and deterrence through robust controls and sanctions. | We are willing to consider actions where benefits outweigh risks. Processes, and oversight / monitoring arrangements enable cautious risk taking. Controls enable fraud prevention, detection, and deterrence by maintaining appropriate controls and sanctions. | We are receptive to taking difficult decisions when benefits outweigh risks. Processes, and oversight / monitoring arrangements enable considered risk taking. Levels of fraud controls are varied to reflect scale of risks with costs. | We are ready to take difficult decisions when benefits outweigh risks. Processes, and oversight / monitoring arrangements support informed risk taking. Levels of fraud controls are varied to reflect scale of risk with costs. |
| Regulatory Standards | We will avoid any decisions that may result in heightened regulatory challenge unless essential. Play safe and avoid anything which could be challenged, even unsuccessfully. | We are prepared to accept the possibility of limited regulatory challenge. Want to be very sure we would win any challenge. | We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably sure we would win any challenge. | We are willing to take decisions that will likely result in regulatory intervention if we are likely to win, and the gain will outweigh the adverse impact. | We are comfortable challenging regulatory practice. Chances of losing are high but exceptional benefits could be realised. |

# People

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

| Risk Appetite<br><br>Risk Category | Adverse | Minimal | Cautious<br>Threat | Open | Eager<br>Opportunity |
|---|---|---|---|---|---|
| Staff Capacity & Capability | We will avoid all risk relating to our workforce unless essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere. | We are prepared to take limited risks with regards our workforce. Where attempting to innovate, we would seek to understand where similar action had been successful elsewhere before taking any decision. | We are prepared to accept the possibility of some workforce risk, as a direct result of from innovation as long as there is the potential for improved recruitment and retention, and development opportunities for staff. | We will pursue workforce innovation. We are willing to take risk which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognise that innovation is likely to be disruptive in the short term but with the possibility of long-term gains. | We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change. |
| Staff Experience | Our priority is to maintain close management control & oversight. Limited devolved authority. Limited flexibility in relation to working practices. Development investment in standard practices only. | Our decision-making authority is held by senior management. Development investment generally in standard practices. | We seek safe and standard people policy. Decision making authority generally held by senior management. | We are prepared to invest in our people to create innovative mix of skills environment. Responsibility for noncritical decisions may be devolved. | We pursue innovation – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control. |

| | | | | | |
|---|---|---|---|---|---|
| Staff Wellbeing | Well-being is a minor consideration in our decision making | We recognise the importance of well-being and seek opportunities to enhance it, but this is not our major consideration | We look for opportunities to improve well-being but we prefer to use methodology which is tried and tested and there is a strong expectation that productivity efficiencies will be demonstrable in the short term | We actively prioritise well-being and are willing to be a front runner in new or novel approaches, where there is a strong underpinning evidence base that would predict successful delivery in the medium term | Well-being is our primary consideration and we are willing to innovate or collaborate where there is no current established evidence base and take a longer term view of achieving productivity benefits |

# Performance

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

| Risk Appetite<br><br>Risk Category | Adverse | Minimal | Cautious<br>Threat | Open<br>Opportunity | Eager |
|---|---|---|---|---|---|
| Estates | We are obliged to comply with strict policies for purchase, rental, disposal, construction, and refurbishment that ensures producing good value for money. | We will follow strict policies for purchase, rental, disposal, construction, and refurbishment that ensures producing good value for money. | We will adopt a range of agreed solutions for purchase, rental, disposal, construction, and refurbishment that ensures producing good value for money. | We will consider the benefits of agreed solutions for purchase, rental, disposal, construction, and refurbishment that meeting organisational requirements. | We will apply dynamic solutions for purchase, rental, disposal, construction, and refurbishment that ensures meeting organisational requirements. |
| Financial Duties | We are only willing to accept the possibility of limited financial risk. Avoidance of any financial impact or loss, is a key objective. | We are only willing to accept the possibility of limited financial risk if essential to delivery. | We are prepared to accept the possibility of some financial risk as long as appropriate controls are in place. Seek safe delivery options with little residual financial loss only if it could yield upside opportunities. | We will invest for the best possible return and accept the possibility of increased financial risk. We will minimise the possibility of financial loss by managing the risks to tolerable levels. | We will consistently invest for best possible benefit and accept possibility of financial loss (controls must be in place). |

| | | | | | |
|---|---|---|---|---|---|
| Performance Targets | We will avoid anything that may impact on performance targets unless essential. Defensive approach to operational delivery – aim to maintain/protect, rather than create or innovate. Priority for close management controls and oversight with limited devolved authority. | Our preference is for risk avoidance. However, if necessary, we will take decisions on performance targets where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. Innovations largely avoided unless essential. Decision making authority held by senior management. | We are prepared to accept the possibility of a short-term impact on performance targets with potential for longer term rewards. Tendency to stick to the status quo, innovations generally avoided unless necessary. Decision making authority generally held by senior management. Management through leading indicators. | We will pursue innovation wherever appropriate, with clear demonstration of benefit / improvement in management control. Responsibility for non-critical decisions may be devolved. | We seek to lead the way and will prioritize new innovations, even in emerging fields. Desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust / lagging indicators rather than close control. |
| Sustainability / Net Zero | Net zero is a minor consideration in our decision making | | We look for opportunities to reduce our carbon footprint, but we prefer to use methodology which is tried and tested and there is a strong expectation that improvements will be demonstrable in the short term | We actively prioritise reducing or carbon footprint and are willing to be a front runner in new or novel approaches, where there is a strong underpinning evidence base that would predict successful delivery in the medium term | Reducing our carbon footprint is our primary consideration and we are willing to innovate or collaborate where there is no current established evidence base and take a longer term view of achieving sustainability benefits |
| Technology | We generally avoid systems / technology developments. | We are prepared to take only essential systems / technology developments to protect current operations. | We will consider the adoption of established / mature systems and technology improvements. Agile principles are considered. | We will consider systems / technology developments to enable improved delivery. Agile principles may be followed. | We view new technologies as a key enabler of operational delivery. Agile principles are embraced. |

# Partnerships

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

| Risk Appetite<br><br>Risk Category | Adverse | Minimal | Cautious<br>Threat | Open<br>Opportunity | Eager |
|---|---|---|---|---|---|
| Adverse Publicity | We have zero appetite for any decisions with high chance of repercussion for trust's reputation. | We have an appetite for risk taking limited to those events where there is no chance of any significant repercussion for the trust. | We have an appetite for risk taking limited to those events where there is little chance of any significant repercussion for the trust. | We have an appetite to take decisions with potential to expose the trust to additional scrutiny, but only where appropriate steps are taken to minimise exposure. | We have an appetite to take decisions which are likely to bring additional scrutiny only where potential benefits outweigh risks. |
| Contracts & demands | We have zero appetite for untested commercial agreements. Priority for close management controls and oversight with limited devolved authority. | We have an appetite for risk taking limited to low scale procurement activity. Decision making authority held by senior management. | We have a tendency to stick to the status quo, innovations generally avoided unless necessary. Decision making authority generally held by senior management. Management through leading indicators. | We support Innovation, with demonstration of benefit / improvement in service delivery. Responsibility for non-critical decisions may be devolved. | We pursue innovation – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust / lagging indicators rather than close control. |

| | | | | | |
|---|---|---|---|---|---|
| Strategy | We will follow guiding principles or rules that limit risk in the trust's actions and the pursuit of priorities. Trust strategy is refreshed at 5+ year intervals | We will follow guiding principles or rules that minimise risk in the trust's actions and the pursuit of priorities. Trust strategy is refreshed at 4–5-year intervals | We will follow guiding principles or rules that allow considered risk taking in the trust's actions and the pursuit of priorities. Trust strategy is refreshed at 3–4-year intervals | We will follow guiding principles or rules that are receptive to considered risk taking in the trust's actions and the pursuit of priorities. Trust strategy is refreshed at 2–3-year intervals | We will follow guiding principles or rules that welcome considered risk taking in the trust's actions and the pursuit of priorities. Trust strategy is refreshed at 1–2-year intervals |
| Transformation | We have a defensive approach to transformational activity. We aim to maintain/protect, rather than create or innovate. Priority for close management controls and oversight with limited devolved authority. Benefits led plans fully aligned with strategic priorities, functional standards. | We aim to avoid innovations unless essential. Decision making authority held by senior management. Benefits led plans aligned with strategic priorities, functional standards. | We tend to stick to the status quo, innovations generally avoided unless necessary. Decision making authority generally held by senior management. Plans aligned with strategic priorities, functional standards. | We support innovation with demonstration of commensurate improvements in management control. Responsibility for noncritical decisions may be devolved. Plans aligned with functional standards and organisational governance. | We pursue innovation– desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust rather than close control. Plans aligned with organisational governance. |

## Appendix 2: Risk Appetite Statement 2023/24

| Principle Objective | Risk Appetite<br>Adverse, Minimal, Cautious, Open, Eager<br>Opportunity → Threat | Risk Statement | Optimal Risk Position | Tolerable Risk Position |
|---|---|---|---|---|
| **Patient** | A M **C** O E | We have a **CAUTIOUS** appetite for risks that present an opportunity relating to safety, quality of services and patient experience. | **= < 6 Moderate** | **8 - 10 High** |
| | | We have a **CAUTIOUS** appetite for risks that present an opportunity relating to data and information management. | **<=6 Moderate** | **8 - 10 High** |
| | | We have a **CAUTIOUS** appetite for risks that present an opportunity relating to governance and regulatory standards. | **<=6 Moderate** | **8 - 10 High** |
| | A **M** C O E | We have a **MINIMAL** appetite for risks that present a threat to safety, quality of services and patient experience. | **<=3 Low** | **4 - 6 Moderate** |
| | | We have a **MINIMAL** appetite for risks that present a threat to data and information management. | **<=3 Low** | **4 - 6 Moderate** |
| | | We have a **MINIMAL** appetite for risks that present a threat to governance and regulatory standards. | **<=3 Low** | **4 - 6 Moderate** |
| **People** | A M C **O** E | We have an **OPEN** appetite for risks that present an opportunity relating to staff capacity and capability | **= < 8 High** | **=<12 High** |
| | | We have an **EAGER** appetite for risks that present an opportunity relating to experience. | **= < 15 Significant** | **= < 15 Significant** |
| | | We have an **EAGER** appetite for risks that present an opportunity relating to staff wellbeing. | **= < 15 Significant** | **= < 15 Significant** |

| Principle Objective | Risk Appetite<br>**A**dverse, **M**inimal, **C**autious, **O**pen, **E**ager<br>  | Risk Statement | Optimal Risk Position | Tolerable Risk Position |
|---|---|---|---|---|
| **People** |  | We have a **CAUTIOUS** appetite for risks that present a threat to staff capacity and capability.<br><br>We have a **CAUTIOUS** appetite for risks that present a threat to staff engagement.<br><br>We have a **CAUTIOUS** appetite for risks that present a threat to staff wellbeing. | **= < 6 Moderate**<br><br>**= < 6 Moderate**<br><br>**= < 6 Moderate** | **8 - 10 High**<br><br>**8 - 10 High**<br><br>**8 - 10 High** |
| **Performance** |  | We have an **OPEN** appetite for risks that present an opportunity relating to estates management.<br><br>We have a **CAUTIOUS** appetite for risks that present an opportunity relating to financial duties.<br><br>We have an **OPEN** appetite for risks that present an opportunity relating to performance targets.<br><br>We have an **OPEN** appetite for risks that present an opportunity relating to sustainability and net zero.<br><br>We have an **OPEN** appetite for risks that present an opportunity relating to technology. | **= < 8 High**<br><br>**= < 6 Moderate**<br><br>**= < 8 High**<br><br>**= < 8 High**<br><br>**= < 8 High** | **=<12 High Risk**<br><br>**8 - 10 High**<br><br>**=<12 High Risk**<br><br>**=<12 High Risk**<br><br>**=<12 High Risk** |

| Principle Objective | Risk Appetite<br>**A**dverse, **M**inimal, **C**autious, **O**pen, **E**ager<br>  | Risk Statement | Optimal Risk Position | Tolerable Risk Position |
|---|---|---|---|---|
| **Performance** |  | We have a **CAUTIOUS** appetite for risks that present a threat to estates management. | **= < 6 Moderate** | **8 - 10 High** |
| | | We have a **CAUTIOUS** appetite for risks that present a threat to performance targets. | **= < 6 Moderate** | **8 - 10 High** |
| | | We have a **MINIMAL** appetite for risks that present a threat to financial duties. | **<=3 Low** | **4 - 6 Moderate** |
| | | We have a **CAUTIOUS** appetite for risks that present a threat to sustainability and net zero. | **= < 6 Moderate** | **8 - 10 High** |
| | | We have a **CAUTIOUS** appetite for risks that present a threat to technology. | **= < 6 Moderate** | **8 - 10 High** |
| Partnerships |  | We have a **CAUTIOUS** appetite for risks that present an opportunity relating to potential adverse publicity. | **= < 6 Moderate** | **8 - 10 High** |
| | | We have a **CAUTIOUS** appetite for risks that present an opportunity relating to contracts and demands. | **= < 6 Moderate** | **8 - 10 High** |
| | | We have an **OPEN** appetite for risks that present an opportunity relating to strategy. | **= < 8 High** | **=<12 High Risk** |
| | | We have an **EAGER** appetite for risks that present an opportunity relating to transformation. | **= < 15 Significant** | **= < 15 Significant** |

| Principle Objective | Risk Appetite<br>**A**dverse, **M**inimal, **C**autious, **O**pen, **E**ager<br>  | Risk Statement | Optimal Risk Position | Tolerable Risk Position |
|---|---|---|---|---|
| Partnerships |  | We have a **MINIMAL** appetite for risks that present a threat of adverse publicity. | **<=3 Low** | **4 - 6 Moderate** |
| | | We have a **MINIMAL** appetite for risks that present a threat to contracts and demands. | **<=3 Low** | **4 - 6 Moderate** |
| | | We have a **CAUTIOUS** appetite for risks that present a threat to strategy. | **= < 6 Moderate** | **8 - 10 High** |
| | | We have a **CAUTIOUS** appetite for risks that present a threat to transformation. | **= < 6 Moderate** | **8 - 10 High** |

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|---|---|
| **Title of report:** | Well-led action plan |
| **Presented to:** | Board of Directors |
| **On:** | 1 February 2023 |
| **Presented by:** | Director of Corporate Affairs |
| **Prepared by:** | Paul Howard, Director of Corporate Affairs |
| **Contact details:** | E: paul.howard@wwl.nhs.uk |

**Executive summary**

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

The attached action plan for each of the recommendations has been approved by the board and the executive team has updated each of the open items with progress to date. Updates will continue to be provided to each board meeting until all recommendations have been fully implemented.

At today's meeting, the board is asked to close the action plans associated with three recommendations and to extend the timescales associated with two of the recommendations.

**Link to strategy**

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

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

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

**Financial implications**

There are no financial implications associated with this report.

**Legal implications**

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

**People implications**

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

**Wider implications**

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

**Recommendation(s)**

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

- Approve the closure of the actions associated with recommendations 1, 13 and 14
- Approve the extension of timescales associated with recommendations 4 and 5

**Well-led review of leadership and governance**
**Action plan as at 24 January 2023**

**Open actions**

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

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

| № and priority | Recommendation | Action plan and milestones | Lead director | Update | RAG |
|---|---|---|---|---|---|
| 4<br>High | The CEO should consider including senior divisional leaders in some executive team development activities to help further build cohesion between the executive and divisional leadership levels, as well as exploring ways in which leaders can further demonstrate the values and behaviours expected within the organisation. | As part of the executive development programme referenced at recommendation 1 above, divisional leaders will be invited to participate in at least 2 sessions in H2 2022/23.*<br>*(Original intention to provide 1 session in H1 2022/23 and a second session in H2 2022/23 was amended by the Board in August 2022 to reflect the narrative above).* | Chief Executive | Initially, this had been scheduled to take place on 22 December 2022 but this was cancelled due to operational pressures. It has been rescheduled to take place on 9 February 2022.<br>A further joint session is planned for April 2023.<br>As it will not be possible to achieve the intention of delivering two joint sessions in H2 2022/23, this action has been red rated and a **revised deadline of June 2023 is proposed**. | |
| 5<br>High | The Trust should consider the development of a refreshed accountability and performance framework, in collaboration with divisional leaders, to formalise responsibilities and accountabilities for divisional and directorate leaders at different levels of the organisation. | By the end of Q3 2022/23,* we will have developed an 'Accountability Framework' incorporating the existing trust behaviours and we will have implemented this by the end of Q3 2022/23.<br>*(Original intention to complete by end of Q2 2022/23 was amended by the Board in October 2022).* | Deputy Chief Executive | As previously noted, the divisional assurance framework has been developed and is in place.<br>Development of the accountability framework has been delayed due to operational pressures as it was felt important to involve a range of stakeholders in the design. An **extension to the end of the financial year is requested**, although this may further slip given continuing pressures. | |

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

| № and priority | Recommendation | Action plan and milestones | Lead director | Update | RAG |
|---|---|---|---|---|---|
| 10<br>High | The Board should consider more detailed oversight of the digital agenda through the introduction of tailored board seminars in this area and by building this agenda item into the board and committee annual plans. This could involve assigning responsibility for the digital strategy to one of the existing committees, for example the Finance and Performance Committee, which is already responsible for the oversight of material business cases. | By the end of Q4 2021/22, we will have agreed where oversight of the digital agenda will take place.<br>At least one board seminar session in H2 2021/22 as well as H1 and H2 2022/23 will include an aspect of the digital agenda. | Chair | The board has agreed that oversight of the digital agenda will take place via the Finance and Performance Committee and this has been incorporated into the revised terms of reference.<br>The H2 2021/22 board seminar session was held on 23 Feb 2022 and focused on cybersecurity. The H1 2022/23 seminar session took place on 20 July 2022 and focused on the digital strategy in action.<br>The H2 2022/23 session was scheduled to take place on 18 Jan 2023 around the data strategy but this was cancelled due to national industrial action affecting WWL. This is in the process of being rescheduled to March 2023. | |

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

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

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

| № and priority | Recommendation | Action plan and milestones | Lead director | Update | RAG |
|---|---|---|---|---|---|
| 14<br>High | The board should formulate a more detailed plan aimed at embedding a more structured approach to QI within the organisation. This should include clarity over how the approach will be implemented, how the impact will be tracked and shared as well as identifying opportunities for increased system working in this area. This should include consideration of how QI can be utilised within a system context. | By the end of Q4 2021/22, the Continuous Improvement (CI) Building Capability Plan will have been approved by the Continuous Improvement Group (CIG), setting out a systematic approach and plan to building CI capacity and capability over the next two years based on the 'dosing formula' and setting SMART goals to be achieved and monitored through the CIG.<br>The Trust will continue to participate in and steer ongoing discussions with partners within the HWP in the shared objective of developing a shared approach to improvement, using the Trust's 5D Model for Improvement as the basis for this, and then ensuring this is used for transformation priorities within the 2022/23 Locality Plan. | Director of Strategy and Planning | Approval of the Continuous Improvement Building Capacity Plan is complete as at the end of Q4 2021/22. There was a further soft launch of the CI programme in Q3 2022/23 in order to target the continuous improvement capability to wider organisational challenges and work collaboratively with system partners.<br>Work on the second part of the action plan is ongoing as part of the new place-based operating model currently being developed.<br>The board is recommended to close this action. | |

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

| № and priority | Recommendation | Action plan and milestones | Lead director | Update | RAG |
|---|---|---|---|---|---|
| 15<br>High | At the time of fieldwork, a number of changes were underway to strengthen leadership development, including identifying and supporting future talent. This should take into account opportunities for a multidisciplinary approach (both within the trust and across system partners where appropriate) and should also consider the skills required both as a leader within the trust as well as those which will be needed as a result of greater levels of integrated system working. | By the end of April 2022, we will have relaunched the Leadership Development Framework within the organisation.<br>The talent programme will be prioritised for development from April 2022, which will include identification of talent, assessment of potential, talent pathways and development programmes. The design element of the programme will be completed by the end of Q1 2022/23 and phased implementation for organisational tiers will commence from Q2 2022/23. | Chief People Officer | The Leadership Development Framework has been agreed and relaunch took place during March and April 2022.<br>Work is underway to scope and develop the talent programme. Feedback has been obtained from key stakeholders and a survey has been distributed to leaders to gain insight on talent identification and talent management, coupled with the skills required for future leaders. The initial draft of the programme is being shared in August for consultation, input and feedback.<br>The design element of the programme is in final stage of review and subject to ETM approval, pilot launch will commence Q4 2022/23. | |

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

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

| № and priority | Recommendation | Action plan and milestones | Lead director | Update | RAG |
|---|---|---|---|---|---|
| 2<br>High | The board should consider a board seminar session that takes stock of where WWL is with regard to enabling strategies and implementation of the corporate strategy. This should explicitly review the opportunity for accelerating the pace of strategy implementation, for enhancing board oversight of the process and in using a range of different communication methods to increase awareness within the organisation. | A board seminar will be scheduled during Q1 2022/23 to provide the board with dedicated time to review its enabling strategies and overall implementation of the corporate strategy.<br>Any necessary actions to accelerate the pace of strategy implementation, enhance board oversight or increase awareness will be agreed and appropriate timescales and milestones developed. | Chair | The objectives that drive the strategy were challenged and updated at a Board away day on 23 February 2022 and at a workshop on 2 March 2022. They were approved in April 2022.<br>A seminar which reviewed the strategy through the lens of place-based leadership took place on 4 May 2022.<br>A Healthier Wigan Partnership session took place on 23 Mar 2022.<br>Future work is planned in relation to reviewing the enabling strategies. | |
| 3<br>High | The board should set aside time in a board seminar to review progress against the various initiatives aimed at positively influencing culture, to ensure it is appropriately apprised of activities and that suitable mechanisms are in place for it to monitor progress against plan over time. | By the end of Q1 2022/23, the board will have undertaken a dedicated session as part of a seminar or away day to review progress against the *Our Family, Our Future, Our Focus* programme and will have considered whether it is appropriately apprised of activities and whether it has appropriate mechanisms in place to monitor progress. | Chair | This session took place on 20 April 2022. | |

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

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

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

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

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

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

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

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

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

| № and priority | Recommendation | Action plan and milestones | Lead director | Update | RAG |
|---|---|---|---|---|---|
| 11<br>High | In addition to the ongoing work to develop the Integrated Performance Report, the board and committees should make an effort to instil a culture where papers are more concise, focused and exception-based, with a view to facilitating presentations by executive directors, guiding debate and enhancing the quality of scrutiny. This process should also give due consideration to reporting around themes and trends in order to further refine debate and in the development of more bespoke, targeted action plans. | By the end of Q2 2022/23, we will have a new balanced scorecard which will facilitate more holistic discussion around performance and provide clear line of sight from board to ward. The narrative will aim to identify relevant trends and themes and metrics will include more SPC presentations rather than just threshold metrics where these enable a more appropriate discussion.<br>By the end of Q2 2022/23, we will have delivered at least two report writing training sessions for report authors.<br>During the year, executive directors will be invited to attend NED meetings to socialise complex issues before meetings as needed. | Director of Strategy and Planning | The balanced scorecard is now in use at board and committee meetings, and further refinement will take place as additional metrics are automated, although this is anticipated to take up to 2 years in line with the timescales associated with the migration of the data warehouse into the cloud.<br>All directors have access to the interactive version in addition to the static report presented.<br>Three report writing training sessions for authors have been delivered (on 26 May 2022, 7 Jun 2022 and 26 Jul 2022). Around 30 report authors have taken part in the training so far, as well as members of the executive team.<br>Executive directors have attended NED meetings to socialise topics, such as the BAF and the Shadow Board programme. | |

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

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

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

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

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|---|---|
| **Title of report:** | IPC Board Assurance Framework update. Version 1.11 |
| **Presented to:** | WWL Board of Directors |
| **On:** | 1 February 2023 |
| **Presented by:** | [Rabina Tindale, Chief Nurse, Director IPC] |
| **Prepared by:** | [Cheryl Osborne, Lead Nurse IPC] |
| **Contact details:** | 01942 778798 cheryl.osborne@wwl.nhs.uk |

**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 IPC BAF version 1.11. See appendix 1 for the full BAF update.

**Gaps in Assurance and Mitigating Actions**

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- **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 WWL Way

- **The demand on the IPC workforce** has increased due to vacancies, sickness, the emergence of seasonal respiratory viruses. Support has been requested to secure funding for investment in the IPC Service. Risk assessments have been submitted for review.
- **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 (Flu) 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 57 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 and Q3. There is 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 ED without adaption of the environment.** Rapid PCR and Point of care/ LFD testing for COVID-19 is available within ED. In December, a 4 virus point of care testing kit was installed in ED. Staff are currently receiving training to implement the testing. This will support patient placement for patients with seasonal respiratory viruses.
- **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.
- **Mandatory IPC e-learning modules:** Trust compliance rates for December 2022 were 96% for Level 1 IPC, and 86% for Level 2 IPC. This is an increase on November figures for level 1 training, level 2 remains static. 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 Q4.
- **Hand hygiene compliance** has decreased across the organisation, Trust compliance was 70% for December compared to 91% in November. There were several non-submissions in December which affected the overall compliance score.
- **Changes to the Emergency care delivery model:** The previous requirement for separate resuscitation areas is no longer operational. The increased demands on the emergency floor and operational flow pressures have required 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 have not increased, we have seen in the months of November and December an increase in seasonal respiratory viruses such as Flu. 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.

**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 updated December 2022:**

| **1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users** | | | |
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| **Key lines of enquiry** | **Evidence** | **Gaps in Assurance** | **Mitigating Actions** |
| **A respiratory plan incorporating respiratory seasonal viruses that includes:**<br>▪ 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.<br><br>POCT testing for seasonal respiratory viruses, is available for Paediatric pathways.<br>Testing arrangements are in line with NHSE/ UKHSA Guidance published on 31.8.2022.<br><br>Pause in asymptomatic patient and staff testing in line with current NHSE/ UKHSA guidance published on 31.8.2022. | POCT testing for other seasonal respiratory viruses is not currently in place in the emergency dept. | 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.<br>There is a plan in place to introduce 4 virus testing from December 2022. |

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| ▪ Segregation of patients depending on the infectious agent taking into account those most vulnerable to infection e.g., clinically immunocompromised | Patients known to be clinically immunocompromised are prioritised for side room allocation.<br><br>Dedicated COVID-19 and Flu ward areas continue to be operational.<br><br>The Trust continues to experience an increased demand on bed capacity and isolation capacity. | Limited options for segregation within the ED Department if the two resuscitation areas are consolidated into one area. | Options appraisal and support with approval for segregation/ ventilation within the ED Department. |
| ▪ A surge/ escalation plan to manage increasing patient/ staff infections | Winter Planning Meetings are operational within the Trust, surge/escalation plans for increasing patient/staff infections are discussed at this meeting. | Lack of isolation rooms across the Trust. | Risk assessment in place.<br><br>Regular review of side room occupancy performed by IPCT as required.<br>Flu planning meeting was held in November with Operations team and Head of emergency planning. |
| ▪ A multidisciplinary team approach is adopted with hospital leadership, operational teams**,** estates & 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 | Planning options are being considered by multi-disciplinary team for the patients receiving care in the resuscitation area of the ED department, with a focus on segregation of respiratory and non-respiratory patients and ventilation because of plans to consolidate two resuscitation areas into one area.<br><br>External Ventilation specialist review and plans for resus area requirements undertaken, with further input requested. | High volume of patients requiring admission.<br>The inability to create cohort areas in periods of high prevalence or new emerging infections.<br><br>Unknown COVID-19 status of staff and patients (asymptomatic) may lead to | Patient placement/ isolation priority managed in collaboration with Operations Team, IPC Team, and Estates/ Facilities.<br><br>Cohort areas are identified when required for patients positive with the same pathogen. |

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| | Peer review of Resus area requirements undertaken.<br>Support requested from NHSE IPC Lead | increase in COVID-19 transmission if IPC Measures not optimal. | |
| **Organisational /employers risk assessments in the context of managing infectious agents are:**<br>▪ Based on the measures as prioritised in the hierarchy of controls<br>▪ Applied in order and include elimination. substitution, engineering, administration and PPE/RPE<br>▪ Communicated to staff<br>▪ Further reassessed where there is a change or new risk identified e.g., changes to local prevalence | Measures consistent with the hierarchy of control are consistently reviewed in line with current UKHSA Guidance**.**<br><br>PPE/ RPE requirements in line with Trust Policies and SOPs and the National IPC Manual.<br>The use of FFP3 masks by staff continues in COVID-19 positive areas.<br><br>The NHS: National IPC Manual updated: September 2022<br><br>Reporting to the Trust Board, ETM and Chief Nurse.<br><br>Input to and collaboration with operational flow and bed capacity with joint working between IPC, Bed Management and Operations Teams continues.<br><br>Global/ IPC communications shared with all staff<br><br>Wearing of face masks continues in all clinical/ patient facing areas, including corridors<br>Mask fit Testing programme continues, with access available to staff to attend. | None | N/A |

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| | Updates are provided to staff via Global communications.<br><br>Changes in local prevalence of infection rates are closely monitored. Updates on National Guidance sought daily. | | |
| ▪ The completion of risk assessments has been approved through local governance procedures, for example Integrated Care Systems | Trust Risk Assessment tools approved through Trust Governance process<br>Risk assessments completed by Ward Leaders/ Managers and Recruitment Team with support available from OH Team.<br>Process for repeat/ update of risk assessments in line with UKHSA Guidance.<br>DIPC presents to the Board through the performance report or specific agenda items.<br>IPC Committee and Quality and Safety committee review quarterly IPC reports. | 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 | Risk assessments in relation to infectious agents are carried out in conjunction with specialists in IPCT, Health & Safety, Microbiology, and specialists in Ventilation and water safety, in line with National Guidance. | None | N/A |
| ▪ Ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons | This is adopted whenever possible and practicable in conjunction with IPC, Bed Management and Operations Teams. | Limited Isolation capacity.<br>High volume of patients requiring admission.<br>The inability to create cohort areas | Transfers of infectious patients between care areas are carried out based on clinical need and the requirement for Specialist care. |

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| | An IPC Team member attends the daily bed meetings to support appropriate patient placement. | in periods of high prevalence or 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.<br><br>The visits extend to include multiple areas of care, leadership, management, learning, staff wellbeing and development.<br><br>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. | None | N/A |
| ▪ The application of IPC practices within the NIPCM is monitored e.g., 10 elements of SICPs | Trust IPC Mandatory training covers all elements of SICPs. IPC audits monitor compliance.<br><br>Audit of the 10 elements of SICP's forms part of the IPC audits carried out as per schedule.<br><br>Audits and action plans are provided to the clinical area with a | None | N/A |

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| | requirement to complete a return for assurance.<br><br>1. Patient assessment for infection risk – patients are assessed on admission for signs and symptoms of infection. Patients known to be colonised with specific organisms i.e., MRSA, VRE, CPE have alerts visible on the HIS banner.<br>2. Hand hygiene – Monthly audits in place in all clinical areas.<br>3. Respiratory and cough hygiene – signage available throughout Trust premises<br>4. Personal protective equipment (PPE) – Regular audits of practice carried out by IPCT.<br>5. Safe management of equipment<br>6. Safe management of environment<br>7. Safe management of blood and body fluids<br>8. Safe management of linen<br>9. Safe disposal of waste (including sharps)<br>10. Occupational safety & Exposure | | |
| ▪ The IPC Board Assurance Framework (BAF) is reviewed, and evidence of assessments are made available and discussed at Trust board level | The IPC BAF has been reviewed consistently to date.<br>Reviewed with opportunity for discussion at Executive/ Board Meetings.<br>Report presented by DIPC. | None | N/A |
| ▪ The Trust Board has oversight of incidents/outbreaks and associated action plans | StEIS Concise Investigation Reports inclusive of Action Plans are reviewed at several Executive level and clinical meetings, Safety | None | N/A |

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| | Committee, including external scrutiny.<br><br>Quarterly Quality and Safety reports are submitted with opportunity for review at Executive meetings.<br><br>Outbreak updates, email cascades include Trust Board members/ Senior Leadership Team.<br><br>IPC activity reports through IPC Committee up to Quality and Safety and monthly Performance reporting to the Trust Board.<br><br>Action plans and IPC Committee documentation are available for review and included in reports. | | |
| ▪ 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.<br><br>There are currently 5 makes and model of mask used by the Trust.<br>1. Drager 1730+<br>2. Kolmi (Small & Medium)<br>3. GVS31000<br>4. 3M1863+ / 3M9330+<br>5. Handanny | 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.<br><br>The Department of Health and Social Care (DHSC) PPE Portal continues to supply the Trust with FFP3 masks however, this is | 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.<br><br>Full Support, a former supplier of FFP3 masks to the Trust, with great mask fit test results |

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| | | anticipated to cease in March 2023.<br><br>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 confirmed by the buyers | pre-pandemic, also being approached to re-establish supply chain.<br><br>A response from the National NHS Buyers is outstanding regarding the manufacturing location of each mask. |

| **2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections** | | | |
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| **Key lines of enquiry** | **Evidence** | **Gaps in Assurance** | **Mitigating Actions** |
| **Systems and processes are in place to ensure that:**<br>▪ 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 | The Trust has implemented the NSHC this is evidenced by the appropriate auditing of the clinical areas. | None | N/A |
| ▪ The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/room | All clinical areas have been assessed for the level of risk, and frequency of cleaning in line with the revised changes to the standards of Health care cleanliness.<br>The Operations team, in collaboration with IPCT designate and communicate the functionality of in-patient areas and isolation rooms. | None | N/A |

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| ▪ Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment | Cleaning standards and frequencies are monitored by trained auditors in all clinical areas using an approved electronic system.<br><br>Frequency of audit is dependent on risk.<br>FR1 – Weekly FR2 – Monthly<br>FR3/FR4 – Monthly and reported through IPC Group. | 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.<br>Compliance issues relating to Nurse cleaning and Estates issues are escalated to the appropriate teams.<br>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 | Enhanced domestic and nursing cleaning is initiated on request of the IPCT for patients with known or suspected infections. | None | N/A |
| Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products | The Trust follows manufactures guidance and contact time for all cleaning and disinfectant cleaning solutions. | None | N/A |
| For patients with a suspected/known infectious agent the frequency of cleaning should be increased particularly in:<br><br>➢ Patient isolation rooms<br>➢ Cohort areas<br>➢ Donning & doffing areas – if applicable<br>➢ 'Frequently touched' surfaces e.g., door/toilet handles, chair handles, patient call bells, over bed tables and bed/ trolley rails | The Trust has an enhanced cleaning process in place for all wards and clinical areas incorporating Frequently Touched Surfaces (FTS) and toilets in addition to the standard daily clean. | None | N/A |

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| ➢ Where there may be higher environmental contamination rates, including:<br>➢ Toilets/commodes particularly if patients have diarrhoea and/or vomiting | Enhanced cleans are instigated on request of the IPCT where there is an increased incidence of infection and during outbreaks.<br><br>Nurse cleaning is also increased in isolation rooms and during outbreaks. This is reiterated in care pathways and checklists i.e., MRSA, c. difficile. | | |
| 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 | Domestic staff have defined responsibilities and duties which is outlined as part of their training package.<br><br>Nurse/housekeeper cleaning schedules are in place in each clinical area. Ward/Dept. Leaders are responsible for monitoring the standards of cleanliness in their areas. | None | N/A |
| **A terminal clean of inpatient rooms is carried out:**<br><br>➢ When the patient is no longer considered Infectious<br>➢ When vacated following discharge or transfer (This includes removal and disposal/or laundering of all curtains and bed screens)<br>➢ 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) | The Domestic Response Team are responsible for the Terminal Infected Cleaning regime for all areas vacated by patients with known infections.<br><br>Disposable curtains, where applicable are replaced as part of this process.<br><br>HPV Decontamination Cleaning (Bioquell) process is also undertaken when applicable. Steam cleaning is also used as a methodical technique in decontamination and sanitisation. | None | N/A |

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| | Responsibilities for the decontamination of equipment between use are clearly defined and communicated via Trust training packages. Cleanliness is monitored and audited by dedicated staff and IPCT.<br><br>Staff are aware of specific downtime required following AGP. | | |
| ▪ **Reusable non-invasive care equipment is decontaminated:**<br>➢ Between each use<br>➢ After blood and/or body fluid contamination<br>➢ At regular predefined intervals as part of an equipment cleaning protocol<br>➢ Before inspection, servicing, or repair equipment | All patient equipment is cleaned between use by clinical staff and follow Trust processes and SOP. | None | N/A |
| ▪ Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment | The Trust has designated auditors who monitor the standard of cleanliness of the clinical environment in line with the NSHC.<br><br>IPCT also audit cleanliness as part of the scheduled audit process. | None | N/A |
| ▪ 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/<br>▪<br>▪ 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<br>▪ Where possible air is diluted by natural ventilation by opening windows and doors where appropriate | The latest version of HTM 03-01 is dated 2021 – WWL's ventilation systems designed and installed in late 2021 and into 2022 will generally be compliant with HTM 03-01 (2021) - any derogations will be clearly recorded.<br><br>The earlier version of HTM 03-01 was dated 2007 - WWL's ventilation systems designed and installed post 2007 will generally be compliant | 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. | 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 |

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| | with HTM 03-01 (2007) - any derogations should be clearly recorded.<br><br>HTM 03-01 replaced HTM 2025 that guidance was first published in 1994 (reprinted in 1998) - WWL's ventilation systems designed and installed post 1994 will generally be compliant with HTM 2025.<br><br>Many clinical areas across WWL predate the current HTM and preceding HTM guidance documents and have not been upgraded since the original design / installation. "Critical" areas such as Theatres, Treatment Rooms, Cardiac Catheter Laboratories, ICU Isolation Rooms, PPVL Isolation Room etc are inspected and verified annually.<br><br>That verification process checks that the ventilation system is operating correctly and determines the number of air changes. Those results are reported through the ventilation Working Group and to the Infection Prevention & Control Group. HTM 03-01 / HTM 2025 is generally used as the gauge for compliance purposes.<br><br>Endoscopy at RAEI & Leigh have been included within a GM programme where "HEPA / UV-A | 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).<br><br>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 and IP&C Committee were updated with the findings and actions. | dynamically measured.<br>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. |

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| | air scrubbers" have been deployed and used to reduce "Fallow Time" between patients. | | |
| **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:**<br>▪ Arrangements for antimicrobial stewardship (AMS) are maintained and a formal lead for AMS is nominated | The Trust employs a nominated AMS Lead in pharmacy. | There is currently no Microbiologist/ Infection Control Doctor in post to support AMS. | Risk assessment is in place. |
| ▪ NICE Guideline NG15 https://www.nice.org.uk/guidance/ng15 is implemented - Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use | Trust Antimicrobial Prescribing Guidelines, and use of Microguide within the Organisation | None | N/A |
| ▪ The use of antimicrobials is managed and monitored:<br>➢ To optimise patient outcomes<br>➢ To minimise inappropriate prescribing<br>➢ To ensure the principles of Start Smart, Then Focus https://www.gov.uk/government/publications/antimicrobialstewardship-start-smart-then-focus are followed | Daily checks of Therapeutic Drug Monitoring antibiotics, Thrice-weekly ICU antimicrobial reviews, quarterly work on AMS ward rounds<br><br>Bi-annual Trust point prevalence audits, annual division-specific audits, quarterly AMS activity summaries, enrolment in relevant NICE CQUINs | 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:<br>➢ Total antimicrobial prescribing.<br>➢ Broad-spectrum prescribing.<br>➢ Intravenous route prescribing.<br>➢ adherence to AMS clinical and organisational audit | Use of Microguide within the Organisation, use of an on-call Microbiologist service, education provisions to healthcare staff, quarterly work on AMS ward rounds | None | N/A |

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| standards set by NICE: https://www.nice.org.uk/guidance/ng15/resources | | | |
| ▪ 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 | There is currently no Microbiologist/ Infection Control Doctor in post to support the IPC Nursing Service and lead on specific IPC Doctor role, i.e., IPC Group (formerly Committee, Policy, Decontamination, Ventilation, antimicrobial stewardship role. | Two IPC Risk Assessments currently subject to the review process: *Lack of Microbiology support to IPC Nursing Service* and *IPC Service unable to deliver service due to lack of specialist staff*. Both awaiting review at Risk Management Group. |

**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 |
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| **Systems and processes are in place to ensure that:**<br>▪ 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<br>▪ 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 | In-patient/Departmental Visiting Policy updated September 2022 – maximum of two visitors at any one time.<br><br>Trust external Intranet provides advice for visitors.<br><br>Recorded message on Trust telephone system provides current advice for visitors, including not to visit if feeling unwell or displaying any respiratory symptoms.<br><br>Facemasks & hand gel available at all entrances | None | N/A |

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| | Waste disposal for facemasks available at all entrances. | | |
| ▪ 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. | In-patient/Departmental Visiting Policy updated September 2022 – maximum of two visitors at any one time. | 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 | In-patient/Departmental Visiting Policy updated September 2022. | 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 | Restrictions on visiting may be Implemented following multidisciplinary discussion at outbreak meetings as indicated in *In-patient/Departmental Visiting Policy* updated September 2022. Visitors are advised accordingly.<br><br>Risk assessment in place. The utilisation of the Visiting decision tree is currently in place allowing visiting in exceptional circumstances. | 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. | Hospital policy for continued use of facemasks in all clinical areas. Hand gel and masks available at all entrances.<br>Masks available at all hospital entrances and entrance to clinical areas. | Low compliance with mask wearing since the lifting of COVID restrictions nationally. | Options paper submitted to ETM to explore the reduction of the use of facemasks. |

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| ▪ 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 | Mask wearing continues.<br><br>Ward staff are advised by IPCT if visitors require additional PPE. | 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 | Entry to wards is via swipe which restricts unauthorised access.<br><br>Visible signage at entry points. Individual consideration and risk assessment by care area staff/ clinician<br><br>Additional PPE provided when required | 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 | Process in place with presence only following individual risk assessment on a specific patient basis: carer, child, guardian. | 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) | Review of all resources by IPC and Comms.<br>Several items have been used in internal and external comms.<br>Toolkit also shared with HR staff<br><br>Guidance will be reviewed where required if COVID-19 cases start to rise or a new strain emerges. | 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:**<br>▪ 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 | Patients attending the emergency department are triaged on arrival for signs and symptoms of infection. | Limited capacity to segregate within ED. IPC, Estates, Operations and ED Teams are | Options to be presented and discussed at ETM for approval. |

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| appropriate placement and actions are taken to mitigate identified infection risks (to staff and other patients) | Screening questions are in operation during triage for patients who may be at high risk of CPE.<br><br>Patients displaying respiratory symptoms are assessed and point of care testing is in place for COVID-19. Testing for other respiratory viruses is performed where required.<br><br>Patients with respiratory symptoms are encouraged to wear a Fluid resistant surgical mask where tolerated.<br><br>Patients who are known to be previously colonised with an alert organism such as MRSA/CPE/c.diff have an alert on the HIS banner. | collaborating to identify options to enable segregation/ Respiratory/ Non-Respiratory Pathways.<br><br>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) | Posters requesting patients to inform staff of any respiratory symptoms are in place at entrances to key areas such as A&E and urgent treatment areas, out-patient departments.<br><br>Patients are subject to screening questions and triaged in A&E. | 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 | The hospital Information system displays alerts on the banner for patients known to be colonised with alert organisms such as MRSA, CPE, VRE, CDT.<br><br>External website has clear information and advice. | None | N/A |

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| | Signage is available at all entry points<br><br>Suspected/Infection status is communicated verbally before the patient is transferred and then in writing via a transfer form when the patient is moved.<br><br>Discharge to assess process works to rapidly discharge patients to the most appropriate setting with a philosophy of home wherever possible reducing contact with others.<br><br>Patients are swabbed for COVID-19, 48 hours before discharge to nursing or care home. | | |
| ▪ 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. | Emergency patients are triaged for infectious illnesses, history of any known travel or contact with infectious individuals forms part of the initial assessment of the patient.<br><br>Care home outbreaks are communicated daily by Local public health teams and communicate to the Operations team and Emergency floor staff.<br><br>FRSM are offered to patients where required. | Limited capacity to segregate within ED. IPC, Estates, Operations and ED Teams are collaborating to identify options to enable segregation/ Respiratory/ Non-Respiratory Pathways. | Options to be presented and discussed at ETM for approval. |
| ▪ 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 | FRSM are offered to patients when required following risk assessment. Advice provided by IPCT as required. | None | N/A |

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| ▪ 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)<br>▪ 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 | Patients are assessed at triage and segregated appropriate to pathway and designated ward area.<br><br>Patients are asked to wear a mask unless clinically impossible or medically exempt.<br><br>Identified high risk/ symptomatic patients are prioritised for side rooms.<br><br>Included in SOP with mitigation.<br>Datix reporting for lack of isolation capacity.<br><br>An IPC Lead nurse attends daily bed meetings and are available on call to support patient placement decisions. | 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 | High risk patients are prioritised for side rooms.<br><br>Included in SOP with mitigation if no capacity.<br><br>Datix reporting for lack of isolation capacity.<br><br>An IPC Lead nurse attends daily bed meetings and are available on call to support patient placement decisions | 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 | Clinical assessment required to inform decision making.<br>Virtual consultation option to be considered. | | |

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| ▪ The use of facemasks/face covering should be determined following a local risk assessment | FRSM are required by all staff, to be worn Universally within all clinical areas in Trust settings in line with current UKHSA guidance.<br><br>RPE/ FFP3 masks are required in high-risk areas/ whilst undertaking AGPs and if indicated during respiratory outbreaks/ bay closures.<br><br>FRSMs are available in all clinical areas and at all entrances.<br><br>Visitors are requested to wear masks as they enter the hospital. Outpatients and visitors are requested to always wear, unless exempt.<br><br>IPC SOPs includes information on mask wearing. | Compliance with mask wearing has reduced amongst staff and visitors since COVID-19 measures have been removed for the General public. | Options paper submitted to ETM for mask wearing during low prevalence of infections. |
| ▪ Patients that attend for routine appointments who display symptoms of infection are managed appropriately, sensitively, and according to local policy | Patients attending routine appointments are advised not to attend if they are displaying signs and symptoms of infection.<br><br>Patients found to have symptoms following triage are advised accordingly. | None | N/A |
| ▪ Staff and patients are encouraged to take up appropriate vaccinations to prevent developing infection | Invitations for seasonal vaccinations (Flu, COVID-19) have been sent to all staff as part of the annual vaccination programme. | Staff compliance with Vaccination programme | |
| Two or more infection cases linked in time, place and person trigger an incident/outbreak investigation and are reported via reporting structures | Outbreaks are identified and monitored by the IPCT. Outbreaks | None | N/A |

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| | are reported via the NHS Outbreak APP. Daily outbreak meetings are instigated, IPCT co-ordinate bay/ward closures and actions to manage the outbreak. | | |

| **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** | | | |
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| **Key lines of enquiry** | **Evidence** | **Gaps in Assurance** | **Mitigating Actions** |
| **Systems and processes are in place to ensure that:**<br>▪ IPC education is provided in line with national guidance/recommendations for all staff commensurate with their duties<br>▪ Training in IPC measures is provided to all staff, including: the correct use of PPE | IPC education is mandatory for all staff via the Trust e-learning portal.<br><br>Content of the training package is in line with NIPCM which includes the appropriate use of PPE for standard and transmission-based precautions and appropriate use of respiratory protection as required.<br><br>IPC Level 1: Compliance reporting: December 2022 96%<br>IPC Level 2: Compliance reporting: December 2022 86%<br><br>IPC Team target support to ward areas during outbreaks and periods of increased incidence of COVID-19/Flu. | Staff access to training.<br>Face to face sessions limited due to the COVID-19 pandemic. | Face to face sessions to resume where possible.<br>Practical sessions to resume including during clinical induction/Cavendish sessions to focus on key areas of IPC and SICP's. |
| ▪ 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) | Hand hygiene technique posters are displayed at all clinical hand wash basins.<br><br>IPCT provide support for staff with hand hygiene training and the use of the light box to highlight areas frequently missed. | Limited capacity of the IPC Team in response to COVID-19, additional IPC priorities against a background of staffing vacancies, annual leave, and | Communication and reminders to staff for training completion.<br><br>Discussion with Finance/ Budget Lead to progress recruitment to Band 5/6 (within budget |

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| | Sessions on hand hygiene technique provided to Link workers.<br><br>Donning and doffing of PPE is included in Mandatory e-learning Practical assessments have been provided throughout the COVID-19 pandemic. Refresher sessions are provided in key areas if emerging infections are identified. | sickness within the Team. | 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<br>▪ 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<br>▪ Hand hygiene is performed:<br>➢ Before touching a patient<br>➢ Before clean or aseptic procedures<br>➢ After body fluid exposure risk<br>➢ After touching a patient; and<br>➢ After touching a patient's immediate surroundings | Compliance with correct technique reviewed, observed, and audited by the IPC Team during ward visits. Spot audits are undertaken by IPC Team and ward leaders.<br><br>Responsive audits are undertaken during episodes of Outbreaks, Bay closures and episodes of C. *difficile* infection.<br><br>PPE audit results are reported to IPCG, reviewed with action plans as indicated.<br><br>Audit results are included within quarterly report to Quality and Safety Committee<br><br>WHO 5 moments for hand hygiene posters are provided for all clinical areas. Auditing is carried out using this as a guide | PPE compliance is below expected standard in some ward areas.<br>Hand Hygiene compliance is below expected standard in some areas. | A refocus on IPC Compliance with "Back to Basics" approach will be adopted to support improved compliance and ownership.<br><br>Steering Group for the Gloves Off Campaign commenced meeting preparing for delivery of the campaign.<br><br>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 | Hand dryers are not in use in clinical areas.<br>Disposable hand towel dispensers in use in all areas. | None | N/A |

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| is located close to the sink but beyond the risk of splash contamination (NIPCM) | | | |
| ▪ Staff understand the requirements for uniform laundering where this is not provided for onsite | The laundering of staff uniforms is covered in the Mandatory e-learning package and the Trust Uniform policy. | None | N/A |

| **7. Provide or secure adequate isolation facilities** | | | |
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| **Key lines of enquiry** | **Evidence** | **Gaps in Assurance** | **Mitigating Actions** |
| **Systems and processes are in place to ensure:**<br>▪ 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 | Advice and guidance is provided to in-patients with respiratory viruses within the Trust with mask wearing, providing they can be tolerated and not detrimental to their (physical or mental) care needs. | 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 | For patients with a known or suspected infection whose treatment cannot be deferred, advice is provided for by the IPCT and Microbiologist and an appropriate plan is put in place to minimise the risk of transmission. | 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 | Patients with infections are prioritised for side rooms. Patients with confirmed COVID-19 are cohorted in dedicated wards/bays as appropriate. IPCT and Operations team, work in collaboration to prioritise isolation rooms. | 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 |

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| | Patient flow pathways were developed by the Microbiologist and shared within Divisions/ Clinical colleagues.<br><br>Patients continue to be appropriately placed if confirmed COVID-19 or Flu positive.<br><br>Collaboration between IPC Team, Operations Team, Bed Managers, and ward staff to inform patient placement.<br><br>Patients tracked through the Bed management team, the number of transfers and outbreak occurrences to minimise risk. This is monitored and supported by IPC<br><br>Designated side room capacity is utilised as available for incidence of infections, informed by risk assessment. This applies to clinical need, irrespective of infection as capacity allows and in collaboration with IPC and Bed management Teams. | | patients are unable to be isolated. And mitigating measures put in place to maintain safety. |

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| ▪ Standard infection control precautions (SIPC's) are applied for all, patients, at all times in all care settings<br>▪ Transmission Based Precautions (TBP) may be required when caring for patients with known / suspected infection or colonization | Standard IPC measures as per UKHSA/NHSE guidelines are in place in all care settings, training is provided via the Mandatory e-learning package.<br><br>Training is provided for appropriate use of PPE for patients with known infections. Posters are in place outside isolation rooms/cohort bays, displaying the level of PPE required. | Compliance with SICP's is below standard in some areas. | **See section 6** |

| **8. Secure adequate access to laboratory support as appropriate** | | | |
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| **Key lines of enquiry** | **Evidence** | **Gaps in Assurance** | **Mitigating Actions** |
| **There are systems and processes in place to ensure:**<br><br>▪ Laboratory testing for infectious illnesses is undertaken by competent and trained individuals<br>▪ Patient testing for infectious agents is undertaken promptly and in line with national guidance | The Laboratories used are UKAS accredited.<br><br>Testing is performed in line with national guidance. It is provided by Northern Care Alliance; monitoring of compliance is through contractual discussions (PAWS).<br><br>Trust guidance is in line with national guidance on testing for suspected COVID-19 cases and for other infections. | None | N/A |
| ▪ Staff testing protocols are in place for the required health checks, immunisations, and clearance | Staff are assessed by Occupational Health appointment to the Trust for immunisation status/health checks. | None | N/A |

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| ▪ 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 | Testing is provided through central laboratories at Northern Care alliance. Turnaround times are monitored by this service. | None | N/A |
| ▪ Inpatients who go on to develop symptoms of infection after admission are tested/retested at the point symptoms arise | Patients displaying signs and symptoms of infection are assessed by clinical teams and investigated as appropriate. Microbiology support is available 24 hours a day if required.<br><br>Hospital acquired infections are subject to an internal review process where any deficiencies in care are highlighted, action plans developed and any learning is shared where required. | None | N/A |
| **COVID-19 Specific**<br>▪ 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)<br><br>▪ For testing protocols please refer to:<br><br>COVID-19: testing during periods of low prevalence - GOV.UK (www.gov.uk)<br><br>C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk) | National guidance is followed for testing patients prior to discharge to care homes.<br><br>Patients and staff are only tested for COVID-19 if symptomatic in line with National guidance 31.08.2022. | Increased length of stay for patients who are asymptomatic but identified as COVID positive prior to discharge. | |

| **9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections** | | | |
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| **Key lines of enquiry** | **Evidence** | **Gaps in Assurance** | **Mitigating Actions** |

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| **Systems and processes are in place to ensure that:**<br>▪ 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)<br>▪ Staff are supported in adhering to all IPC and AMS policies | Regular audits of practice are undertaken by ward teams and IPC. This includes assessment of all external visitors to the Trust. Individual feedback and support is provided where required.<br><br>IPCT provide regular ward visits to monitor and support staff in adhering to IPC practice<br><br>Dedicated ward pharmacists monitor the use of Antimicrobials and advise accordingly. | 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 | Trust policies and SOPs are available via the intranet.<br><br>Surveillance by IPC Team identifies positive results, increased incidence, and identification of outbreaks in line with the recognised definition.<br><br>Outbreaks are managed by the IPC Team in collaboration with Microbiology, ward staff teams, Operations, bed managers.<br><br>Robust documentation of outbreaks is completed and informs reporting of outbreaks as incidents and completion of StEIS investigation. These are reviewed through Trust review and CCG systems/ National reporting systems. | None | N/A |

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| ▪ 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 | The procedure for handling infected clinical waste and linen is clearly defined in the Trust Standard Precautions and waste management SOP's. This is also reiterated in the Trust Mandatory IPC training.<br>Advice is sought where necessary from waste management and IPCT for higher risk waste and management. | None | N/A |
| ▪ PPE stock is appropriately stored and accessible to staff when required as per NIPCM | PPE is distributed to the wards daily. The main PPE store is on the RAEI site and is accessible 24/7. Opening times are highlighted in Trust communications.<br><br>PPE stores also at Leigh and Wrightington.<br>In Community settings, PPE store is well stocked and accessible to all teams | | |
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**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 |
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| **Systems and processes are in place to ensure that:**<br><br>▪ Staff seek advice when required from their occupational health department/ IPCT/ GP or employer as per their local policy<br>▪ Bank, flexible, agency, and locum staff follow the same deployment advice as permanent staff | Service level agreements (SLA) in place with external organisations and the Trust to provide an Occupational Health (OH) service and advice for staff. Occupational Health Policies as per organisation.<br><br>Dedicated OH/IPC email/ inbox for staff to contact OH/IPC Services. | None | N/A |

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| | A system of access and response available to all staff, operated by the OH staff team<br><br>Pre-employment/ Recruitment on-boarding available for the lifetime of employment within the Trust. | | |
| ▪ Staff understand and are adequately trained in safe systems of working commensurate with their duties | Staff are required to undertake Trust Mandatory training and familiarise themselves with policies and SOP's relevant to their area of work. | None | N/A |
| ▪ A fit testing programme is in place for those who may need to wear respiratory protection. | Fit testing programme is established and operational. | None | N/A |
| ▪ Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will:<br>➢ Lead on the implementation of systems to monitor for illness and absence<br>➢ **F**acilitate access of staff to treatment where necessary and implement a vaccination programme for the healthcare workforce as per public health advice<br>➢ Lead on the implementation of systems to monitor staff illness, absence, and vaccination<br>➢ Encourage staff vaccine uptake | Staff sickness/ COVID-19 absence monitoring within the Trust, Ward Leaders, Human Resources (HR). Data reported through Trust systems/ E-roster.<br><br>Data systems: Diagnostic codes, statistics, and analysis support reporting (HR and Business intelligence).<br><br>Staff sickness/ absence data and impact reported via Trust Senior Teams.<br><br>Outbreak reporting/ IPC Teams.<br>Access to antiviral treatment where required via general medical services/ routes (in-patients and Community). Signposting by OH Team.<br>Staff self-refer to OH Service and access is available to support.<br>Managers/ Ward Leaders refer staff to OH Services.<br><br>Pre-employment/ Recruitment on-boarding | None | N/A |

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| | available for the lifetime of employment within the Trust.<br><br>Trust local Induction provides information of access routes to OH Services and services available, available to all staff inclusive of nursing, medical, ancillary, estates/ facilities, bank, agency, and locum staff.<br><br>Staff Handbooks available to all staff; Matrons and Ward Leaders handbooks.<br><br>Dedicated Trust Vaccination Team provides vaccination for all Trust staff including: COVID-19 and Influenza.<br><br>Vaccination available to all staff across the Trust, Including, Agency and Bank.<br><br>Opportunistic vaccination by OH Team.<br>Vaccination uptake rates monitored within the Trust: Human Resources (HR) and reported via IPCC/ Board and IPC BAF, quarterly Q+S reporting and regional reporting.<br><br>OH Doctor provides dedicated input to vaccination across the Trust.<br><br>Mutual support by OH Team to support COVID-19/Flu vaccination across the Borough<br>Regular internal/ global communications are emailed to all staff (minimum weekly, with increased frequency if indicated).<br><br>Additional: Blogs, radio, Chief Exec Briefs and Blogs, Posters and constant reinforcement encouraging vaccination. | | |

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| ▪ 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 | Trust SOP'S and Policies.<br>Audit and monitoring of IPC Measures in line with national guidance.<br><br>Ward leaders support compliance with IPC Measures, SOP's, and Policies.<br>Support available from IPC and OH Teams.<br>National information provided at vaccination. | 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.<br>➢ A discussion is had with employees who are in the at -risk groups, including those who are pregnant and specific ethnic minority groups<br>➢ That advice is available to all health and social care staff, including specific advice to those at risk from complications<br>➢ Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff<br>➢ A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff | Risk assessments completed by Ward Leaders/ Managers and Recruitment Team with support available from OH Team.<br><br>Process for repeat/ update of risk assessments in line with UKHSA Guidance.<br><br>Risk assessments are completed for all staff including Bank, Agency and Locum staff across the Trust and all organisations within the Borough.<br><br>Input to process from OH, IPC, HR Teams, and Ward Managers/ Leaders.<br><br>Records of the outcomes from the self-declaration forms are logged and maintained within HR | **None** | **N/A** |
| ▪ Testing policies are in place locally as advised by occupational health/public health | Testing policies are in place when required for specific infectious organisms.<br>National guidance followed. | None | N/A |
| ▪ NHS staff should follow current guidance for testing protocols: C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk) | Flowsheet in place in line with National guidance for staff who develop symptoms of covid. | None | N/A |

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| 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 | Face fit testing is available across all acute sites and in the community and is co-ordinated by the Health and Safety (H+S) Team.<br>An RPE SOP has been developed and shared with all Testers.<br>For staff who cannot wear a close fitting FFP3 mask e.g., due to facial hair. A limited number of air powered hoods are available and issued to Wards and Departments with instructions for use. | None | N/A |
| ▪ Staff who carry out fit test training are trained and competent to do so | All mask fit testers have been trained in line with National legislation.<br><br>External contractor provides accredited Fit to Fit tester training to the Trust Face fit testers who then fit test WWLFT employees.<br><br>Database of Face Fit Testers maintained by H+S Team.<br>Refresher training required every 2 years. | None | N/A |
| ▪ Fit testing is repeated each time a different FFP3 model is used | Staff are instructed to be face fit tested for the mask they are using/have access to. | None | N/A |
| ▪ All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks | Face fit testing sessions continue with a plan in progress to achieve fit test to three models in high-risk areas and two models in all other areas for staff | None | N/A |

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| ▪ 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<br>▪ 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 | Process in place: Individuals have two attempts on six models. If all failed, the individual is trained in the use of a powered hood.<br><br>For staff who cannot wear a close fitting FFP3 mask e.g., due to facial hair. A limited number of air powered hoods are available and issued to Wards and Departments with instructions for use.<br><br>A decontamination process in line with manufacturer's instructions is in place for all powered hoods. | None | N/A |
| ▪ Members of staff who fail to be adequately fit tested: a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm<br>▪ 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 | Included within the Respiratory Protective Equipment Policy - Training Guidance SOP.<br><br>Line Managers are advised of all staff members/ individuals who fail a fit test to six models. A discussion is completed on available options including powered hoods.<br><br>If an individual was unable to be provided with alternative respirators and hoods, opportunity for discussion provided with Occupational Health and HR Teams/ colleagues with regards to redeployment.<br><br>The Trust has a designated Redeployment team who oversee staff skill mix, knowledge, and experience. | 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 | Trust Respiratory Protective Equipment Policy in place.<br><br>A centrally held mask fit database is maintained by the Health and Safety Team and is available | None | N/A |

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| ▪ 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. | Flow charts based on national guidance for COVID-19 outline the processes and time periods to follow and are on intranet. Staff are supported via managers during absence in accordance with all sickness absence.<br><br>**Flowcharts:** Ending Isolation early for COVID-19 Positive staff and Ending Isolation early for COVID-19 Contacts are available via the intranet and IPC Team.<br><br>HR advisors are available to staff and managers to seek advice and support where any individuals are concerned or have questions around returning to work or being absent due to COVID-19 and other infections. | Routine asymptomatic testing for COVID-19 has been paused in line with National Guidance 31.08. 2022.. Staff are required to only undertake a LFT if symptomatic. | Staff are advised to continue to access LFT via the Gov.uk website |

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

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| **Title of report:** | Standing Financial Instructions |
| **Presented to:** | Trust Board Meeting |
| **On:** | 1st February 2023 |
| **Presented by:** | Kelly Knowles Acting Chief Finance Officer |
| **Prepared by:** | Shirley Martland – Associate Director of Financial Services and Payroll |
| **Contact details:** | T: 01942 773786 |

**Executive summary**

The purpose of this paper is to request that the changes made to the Trust's Standing Financial Instructions (SFIs) and Budgetary Control and Delegation Arrangements, which were approved by Audit Committee on 23rd November 2022, are adopted by Trust Board.

**Link to strategy**

None.

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

There are no risks associated with this report.

**Financial implications**

This report has no direct financial implications.

**Legal implications**

There are no direct legal implications in this report.

**People implications**

There are no direct people implications in this report.

**Wider implications**

There are no wider implications in this report.

## Report

**Background**

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

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

**Introduction of non-compliance matrix**

The key changes this year include the addition of a non-compliance matrix. This can be found at the back of the SFI policy in Appendix A. The matrix has been reviewed and agreed with Staff Side, Local Negotiating Council (LNC) and the Executive Team.

Whilst the finance team monitor non-compliance of SFI's, this has until now been done informally. It has been recognised that to strengthen our governance processes and support employees in understanding their roles and responsibilities, a more formal approach should be taken.

In supporting the organisations 'just culture', the processes being put in place are aimed at supporting employees to fully understand their responsibilities and address issues where SFIs are not being followed because of inadequate processes and/or procedures, whilst at the same time ensuring appropriate actions are being taken to address issues where SFIs are not being followed without valid reason.

All areas for potential non-compliance of the SFI policy have been pulled together in a matrix which identifies how non- compliance within each of these areas will be monitored. Each area has been reviewed to ensure that an appropriate policy is in place to support the process.

Due to policies currently under review it has been agreed to temporarily defer monitoring of non-compliance around temporary staffing and patients' property. The finance team are liaising with the appropriate managers on these areas.

To support the process of monitoring, we have:

- Amended the procedure for new Oracle users – each user must now declare that they have read and understood their responsibilities within the SFIs before access is given.
- Produced a one-page summary SFI document which is issued to all employees as part of their new starter pack.
- Worked with HR colleagues to update Job descriptions and Terms and Conditions for new members to include a section on employee's responsibilities under SFIs.
- The finance training for budget holders has been updated to incorporate a section on SFIs.

**Other key changes**

The amendments to the SFIs also reflect changes due to the creation of the Greater Manchester Integrated Care System (GMICB). Changes to the Trust's internal business case process have been

reflected within the SFIs with an updated version of the approval matrix. This reflects that business cases for capital medical equipment (CME) under £0.5m do not require approval at ETM where this is within the delegated approval limit for CME and there are no revenue consequences (previously described as category 2 business cases). The waiver approval limits have also been amended with the minimum value increased from £5,000 to £10,000. A list of all changes made can be found in Appendix 1.

**Recommendation**

It is recommended that the above changes are adopted by the Trust Board.

## Appendix 1: Changes included to the Standing Financial Instructions

**Introduction purpose and scope *(page 6)***

**Amended SFI 1.4**

**From:** Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Finance Officer must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders (SOs).

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

**SFI 1.6 Added in:** Please refer to Appendix A for further information on compliance.

**Business planning, budgets, budgetary control, and monitoring *(page 12)***

**Amended SFI 3.1**

**From:** The appropriate Executive Director will compile and submit to the Board a Business Plan, which takes into account capacity and demand, and HR, estates and financial targets. The Business Plan will contain:

a) a statement of the significant assumptions on which the plan is based; and
b) details of major changes in workload, delivery of services, or resources required to achieve the plan.

The Business Plan will be submitted to NHS England in line with their deadlines, guidance and requirements.

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

(a) a statement of the significant assumptions on which the plan is based; and
(b) details of major changes in workload, delivery of services, or resources required to achieve the plan.

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

**Amended SFI 3.2 (b)**

**From:** accord with workload and manpower plans;

**To:** triangulate with workforce, activity and efficiency plans

**Amended SFI 3.3**

**From:** The Trust shall submit information in respect of its financial plans to NHS Improvement, once approved by the Board of Directors.

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

**Amended section 3.12** ***(page 13)***

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

(a) Monthly financial reports to the Board, including:

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

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

**Amended 3.13 (d)** ***(page 14)***

**From:** recruitment of a fixed term or permanent employee to a post, not covered by funded establishment, must be approved beforehand by following the Trust's current recruitment policy. Approval must be gained prior to engaging services of any and all agency workers.

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

**Added in:** (e) they remain within their funded establishment

**Amended SFI3.15** ***(page 14)***

**From:** The facility of virement is available to Divisional Chairmen and to budget holders/managers of other budgets. Virement can involve the following different types of transfers:

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

Job titles have been amended from Divisional Accountant to Divisional Finance Manager

**Non competitive waivers** ***(Page 20)***

**Amended SFI 7.11**

**From:** Requirements of a statutory nature, continued professional development and/or services provided by other public sector organisations that are sole suppliers are excluded from these tendering procedures and will not require a non-competitive waiver

**To:** Requirements of a statutory nature, and/or services provided by other public sector organisations that are sole suppliers are excluded from these tendering procedures and will not require a non-competitive waiver

**Added:**

**SFI 7.1** Continued professional development and / or training courses that are either sole supplier, provided by another public sector organisation or selected on the basis of geographical location will not require a non-competitive waiver.

**SFI 7.13** Contracts for the purchase or rental of land, existing buildings or other immovable property or concerning rights on such property are excluded from the Public Contract Regulations and as such will not require a non-competitive waiver.

**Authorisation of waivers *(Page 21)***

Amended authorisation limits as follows:

**From**:

| Amount | Authorisation |
|---|---|
| Less than £5,000 ex VAT | No waiver required |
| £5,000k - £25,000 ex VAT | Deputy Director of Operational Finance |
| Up to £50,000 ex VAT | Director of Operational Finance |
| Up to EU Threshold ex VAT | Chief Finance Officer |
| Up to and over EU Threshold ex VAT | Chief Executive (or Deputy) |

**To:**

| Amount | Authorisation |
|---|---|
| Less than £10,000 ex VAT | No waiver required |
| £10,001k - £50,000 ex VAT | Deputy Director of Operational Finance |
| £50,001 - £100,000 ex VAT | Director of Operational Finance |
| £100,001 to EU Threshold ex VAT | Chief Finance Officer |
| Up to and over EU Threshold ex VAT | Chief Executive (or Deputy) |

**SFI 11. Terms of Service, Allowances and Payment of Members of the Board of Directors and Executive Committee and Employees *(Page 34)***

**Added: SFI11.2 (a)** (iii) payable expenses and compensation payments; and

**SFI 17. Charitable Funds *(page 46)***

Replaced Charitable Trust Board with Charitable Trust Committee throughout the section.

**Amended SFI 17.22** ***(page 49)***

From: prepare annual accounts in the required manner, which shall be submitted to the Charitable Trust Board within agreed timescales.

To: prepare annual accounts in the required manner, which shall be submitted to the Charitable Trust Committee and Audit Committee within agreed timescales.

**SFI 22. Declaration of interests** ***(page 53)***

**Amended from:**

SFI 22.1 Staff at Band 8 & above, are required to declare on an annual basis, any interest, including partners or spouse, which may be relevant to the work of Wrightington Wigan and Leigh Teaching Hospitals NHS Foundation Trust or their work within the organisation. A declaration of interest must be submitted in the event where a relationship exists when entering into, or negotiating, the procurement of goods and services. Any disclosures not made and later discovered will be considered a breach of Trust Standing Financial Instructions, which could subsequently lead to disciplinary action being taken.

SFI 22.2 A declaration of interest must be submitted in the event where a relationship exists when entering into, or negotiating, the procurement of goods and services.

SFI 22.3 Where a new interest arises during the course of the year, then staff are required to declare that interest at the earliest opportunity and must notify their line manager that such an interest exists.

**To:**

To: SFI 22.1 All staff are required to declare interests which are relevant and material. Staff should declare interests on appointment and when there are any changes.

SFI 22.2 Staff members at Band 8d and above will be asked to confirm on an annual basis that their entry on the register of interests is accurate and provide updates as required.

SFI 22.3 A declaration of interest must be submitted by any grade of employee in the event where a relationship exists when involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices and/or equipment.

**SFI 23. Business case and tender process** ***(page 54)***

**Amended:**

**From:**

Introduction

SFI 23.1 The Trust's business case process has been established to ensure there is full involvement from any party within the organisation that could be affected by the intended direction

of travel. Auditability, governance and financial principles are critical to ensure there is no unforeseen service, quality or financial consequences from our investment decisions.

SFI 23.2 Revenue expenditure

SFI 23.3 *NHSI have stated that until further notice non-COVID-19 expenditure should not increase and Trust's should suspend all business cases seeking increased revenue spend.

SFI 23.4 In exceptional circumstances the Executive team may decide that a revenue business case can be considered. The standard business case template is still required, complete with all signatures.

SFI 23.5 Should the Trust approve it may also be necessary to seek NHSI's approval.

SFI 23.6 Capital expenditure

SFI 23.7 Capital schemes for the year have been categorised as follows:

Category 1: Strategic schemes requiring approval

Category 2: Strategic schemes with revenue implications

Category 2: Schemes already approved as part of the capital allocation

SFI 23.8 Business cases will approved in accordance with the following table:

| Type of Business Case | ETM | Finance and Performance Committee | Board of Directors |
|---|---|---|---|
| *Revenue only | £500k | £1m | >£1m |
| Capital - category 1 | £500k | £1m | >£1m |
| Capital - category 2 with revenue implications | £500k | £1m | >£1m |
| Capital - category 2 with no revenue implications | Not required | | |

SFI 23.9 Role of the approving entities

ECC, Finance and Performance Committee and the Board of Directors will take the decision to approve a business case taking into consideration strategic direction, priorities and affordability.

SFI 23.10 The business case process does not replace the Trust's tendering process which must be followed when purchasing goods or services.

**TO:**

**SFI 23. BUSINESS CASE AND TENDER PROCESS**

Introduction

SFI 23.1 The Trust's business case process has been established to ensure there is full involvement from any party within the organisation that could be affected by the intended direction of travel. Auditability, governance, and financial principles are critical to ensure there is no unforeseen service, quality, or financial consequences from our investment decisions.

SFI 23.2 All approved business cases must satisfy one of more of the investment criteria established by the Executive Team. Business cases must include key performance indicators for how the investment will be assessed or measured once implemented.

SFI 23.3 All business cases must have a reference number assigned by the finance department, referenced within the minutes of the meeting of the approving entity.

SFI 23.4 All revenue and capital investments must be submitted for a formal decision using the Trust's current business case process and template. Business cases for national funding should be on the appropriate NHSE template.

SFI 23.5 Should the Trust approve, it may also be necessary to seek approval from the Greater Manchester Integrated Care Board or NHS England.

SFI 23.6 Should the Trust approve, it may also be necessary to seek NHSI's approval.

SFI 23.7 Business cases will be approved in accordance with the following table:

| Type of Business case | Capital Medical Equipment Group | Executive Team Meeting | Finance and Performance Committee | Board of Directors |
|---|---|---|---|---|
| Capital medical equipment, within the delegated capital limit for Capital Medical Equipment and with no revenue implications. | £500k | N/A<br><br>(CME cases over £500k still require ETM endorsement before going to F&P) | £1m | >£1m |
| All other business cases | N/A | £500k | £1m | >£1m |
| *The value of a business case is defined as the total combined revenue and capital expenditure (calculated as total capital expenditure, plus recurrent revenue expenditure plus one-off revenue expenditure).* | | | | |

NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

# Standing Financial Instructions

Approved by the Board of Directors: 29 September 2021
Review date: September 2022

The WWL Way

**FOREWORD**

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

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

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

**CONTENTS**

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

The following policies are specifically referenced.

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

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

## SFI 1. INTRODUCTION

### Purpose and scope

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

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

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

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

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

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

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

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

### Terminology

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Responsibilities and delegation**

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

(a) formulating the financial strategy;

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

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

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

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

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

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

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

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

SFI 1.18 The Chief Finance Officer is responsible for:

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

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

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

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

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

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

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

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

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

(b) avoiding loss;

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

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

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

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

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

### Audit Committee

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

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

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

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

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

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

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

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

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

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

**Chief Finance Officer**

SFI 2.4 The Chief Finance Officer is responsible for:

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

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

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

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

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

(f) major internal financial control weaknesses discovered;

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

(h) progress against plan over the previous year;

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

(j) a detailed plan for the next year.

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

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

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

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

SFI 2.9 explanations concerning any matter under investigation.

**Role of internal audit**

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

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

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

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

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

(i) fraud and other offences;

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

(iii) poor value for money or other causes.

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

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

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

**External audit**

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

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

**Fraud, corruption and bribery**

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

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

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

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

**Security management**

SFI 2.20 Under the NHS Standard Contract, all organisations providing NHS services must put in place and maintain appropriate security management arrangements. In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance on NHS security management, and NHS Counter Fraud Authority Standards for providers.

SFI 2.21 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management. The Chief Executive has overall responsibility for controlling and coordinating security.

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

**Preparation and approval of plans and budgets**

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

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

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

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

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

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

(b) triangulate with workforce, activity and efficiency plans

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

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

(e) identify potential risks.

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

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

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

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

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

**Budgetary delegation**

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

(a) the value of the delegated budget;

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

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

(d) individual and group responsibilities;

(e) authority to exercise virement;

(f) achievement of planned levels of service; and

(g) the provision of regular reports.

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

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

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

**Budgetary control and reporting**

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

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

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

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

(iii) income and expenditure

(iv) movements in working capital;

(v) movements in cash and capital;

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

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

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

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

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

(d) Monitoring of management action to address variances.

(e) Arrangements for the authorisation of budget transfers.

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

SFI 3.13 Each budget holder is responsible for ensuring that:

(a) they remain within their budget allocation;

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

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

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

(e) they remain within their funded establishment;

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

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

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

**Budget transfer - virement**

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

(a) Transfers between non-pay budgets;

(b) Transfers between staff budgets; and

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

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

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

**Capital expenditure**

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

**Monitoring of performance**

SFI 3.19 The Chief Executive is responsible for ensuring that

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

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

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

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

**Emergency expenditure**

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

## SFI 4. ANNUAL ACCOUNTS AND REPORTS

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

(a) keep accounts, and in respect of each financial year;

(b) prepare annual accounts, in such form as NHS England and Department of Health and Social Care may, with the approval of the Treasury, direct;

(c) ensure that, in preparing annual accounts, the Trust complies with any directions given by NHS England and Department of Health and Social Care with the approval of the Treasury as to:

(i) the methods and principles according to which the accounts are to be prepared; and

(ii) the information to be given in the accounts.

(d) ensure that a copy of the annual accounts, and any report of the External Auditor on them, are laid before Parliament and that copies of these documents are sent to NHS Improvement; and

(e) submit financial returns to NHS England for each financial year in accordance with NHS Improvement's timetable.

SFI 4.2 The Trust's audited annual accounts must be presented to the Board for approval and received by the Council of Governors at a public meeting.

SFI 4.3 The Trust's annual accounts must be audited by an auditor appointed by the Council of Governors. The Trust's audited annual accounts must be presented at a public meeting and made available to the public.

SFI 4.4 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health and Social Care Group Accounting Manual.

## SFI 5. BANK AND GBS ACCOUNTS

### General

SFI 5.1 The Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts.

SFI 5.2 The Chief Finance Officer is responsible for negotiating the Trust's banking contracts, establishing any associated mandates and naming personnel to be signatories for banking transactions.

SFI 5.3 No employee may open or hold a bank account in the name and/or address of the Trust or of its constituent hospitals/departments. Any employee aware of the existence of such an account shall report the matter to the Chief Finance Officer.

### Bank and GBS accounts

SFI 5.4 The Chief Finance Officer is responsible for:

(a) bank accounts and Government Banking Service (GBS) accounts;

(b) establishing separate bank accounts for the Trust's charitable funds;

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Board of any external borrowing requirements; and

(e) ensuring that procedures are maintained that document all transaction processing relating to Trust bank accounts.

### Banking procedures

SFI 5.5 The Chief Finance Officer will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated;

(b) the limit to be applied to any overdraft; and

(c) those authorised to sign cheques or other orders drawn on the Trust's accounts.

SFI 5.6 The Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

**Banking tendering and review**

SFI 5.7 The Chief Finance Officer will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

SFI 5.8 Competitive tenders should be sought at least every five years, unless the Board determines otherwise. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

## SFI 6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

**Income systems**

SFI 6.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

SFI 6.2 Credit note authorisation will be determined for each manager depending on their role/responsibility and a list of managers who are set up to undertake such approvals is maintained within Oracle.

SFI 6.3 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

**Fees and charges**

SFI 6.4 The Trust shall follow NHS Improvement's guidance in setting prices for NHS Service contracts, where services are not covered by a mandatory National Tariff. The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by NHS England (such as Payment by Results National Tariffs), HM Treasury or by statute. Independent professional advice on matters of valuation shall be taken as necessary.

SFI 6.5 Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the NHS Commissioning Board – Standards of Business Conduct shall be followed.

SFI 6.6 All employees must ensure that an appropriate Service Level Agreement is in place in respect of all transactions which they may initiate or deal with that results in an income stream for the Trust. This will include but is not limited to contracts, leases, tenancy agreements, private patient undertakings. Employees must also ensure that an appropriate mechanism is in place for raising timely invoices to recover income due on such transactions.

**Debt recovery**

SFI 6.7 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

SFI 6.8 Income which is deemed due, but possibly uncollectable, should be dealt with in accordance with debt recovery procedures, and reported as a write-off loss (SFI 14.5) where appropriate.

SFI 6.9 Overpayments should be detected (or preferably prevented) and recovery initiated.

**Security of cash, cheques and other negotiable instruments**

SFI 6.10 The Chief Finance Officer is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

SFI 6.11 Trust cash shall not under any circumstances be used for private transactions such as the encashment of private cheques, bank to bank transfers or temporary loans.

SFI 6.12 Trust accounts should not be used for ad hoc temporary banking of employee funds or other monies unrelated to Trust business and income, except patients' monies held in trust.

SFI 6.13 Trust credit cards should not be used for personal expenditure, even if there is an intention to reimburse the Trust.

SFI 6.14 Trust credit cards should not be used to pay employee expenses without prior approval, as these should be reimbursed via Payroll.

SFI 6.15 All cheques, postal orders, cash etc. shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

SFI 6.16 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

SFI 6.17 During the absence (whether sickness or annual leave etc.) of the authorised safe key holder, the officer who acts in their place shall be subject to the same controls as the normal holder of the key. There shall be a written discharge of the safe and/or cash box contents on the transfer of responsibilities, with the discharge document authorised by the relevant senior officer and retained for audit inspection.

SFI 6.18 The opening of incoming post shall be undertaken by two officers except where authorised in writing by the Chief Finance Officer. All cash, cheques, postal orders and other forms of payment received shall be entered in an approved form of remittance register. All cheques and postal orders shall be crossed "Not Negotiable Account Payee Only – Wrightington, Wigan and Leigh NHS Foundation Trust". The remittance register should be passed to the cashier from whom a signature should be obtained.

SFI 6.19 All unused cheques and GBS orders will be held as controlled stationery and issued in accordance with controlled stationery procedures.

SFI 6.20 Any loss or shortfall in cash, cheques or other negotiable instruments shall be reported immediately. Where there is prima facie evidence of fraud, corruption and bribery it will be necessary to follow the Trust's Counter Fraud Corruption and Bribery Policy and Response

Plan. Where there is no evidence of fraud and corruption the loss shall be reported in line with losses procedures.

## SFI 7. TENDERING AND CONTRACTING PROCEDURE

### General

SFI 7.1 The procedure for making all contracts by, or on behalf of, the Trust shall comply with the Trust's Standing Orders and Standing Financial Instructions.

SFI 7.2 The approval of business cases prior to the procurement process is covered in SFI 23.

SFI 7.3 **In all instances, the intended expenditure should be reflective of the total life cycle costs of provision of the goods and / or services.**

### EU Directives governing public procurement

SFI 7.4 Directives by the Council of the European Union promulgated by the Department of Health and Social Care prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

### Competitive quotations

SFI 7.5 Competitive quotations are required where the intended expenditure or income is equal to, or is reasonably expected to exceed £5,000 but not exceed £50,000 ex VAT.

(a) Quotations should be obtained from at least three suppliers based on specifications or terms of reference prepared by, or on behalf of, the Trust.

(b) Quotations should be submitted by email or via electronic sourcing software, as deemed appropriate by the Procurement Department.

(c) All quotations should be treated as confidential and should be retained for inspection.

(d) The Chief Executive or his/her nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation (if payment is to be made by the Trust), or not the highest (if payment is to be received by the Trust), then the choice made and the reasons why should be recorded in a permanent record.

SFI 7.6 Contract and tendering procedures within these SFIs should be applied to quotations as best practice.

### Competitive tendering

SFI 7.7 Competitive tenders are required where the intended expenditure or income is equal to or is reasonably expected to exceed £50,000, but not exceed the relevant European Union threshold ex VAT.

SFI 7.8 The Trust shall ensure that competitive tenders are invited for:

(a) the supply of goods, materials and manufactured articles;

(b) the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);

(c) the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and

(d) disposals of Trust property or goods (unless specified in **Error! Reference source not found.**).

SFI 7.9 Formal tendering procedures need not be applied where:

(a) the estimated expenditure or income does not, or is not reasonably expected to exceed £50,000 excluding VAT;

(b) the supply is proposed under special arrangements negotiated by the DH, in which event the said special arrangements must be complied with;

(c) the Trust is disposing of Trust assets, as set out in SFI 7.71

(d) the requirement is covered by an existing contract (this includes contracts let by external agencies on behalf of the NHS e.g. NHS Supply Chain); or

(e) there is a national or regional sole supplier agreement in place.

**Non–competitive waivers**

SFI 7.10 In exceptional instances where competitive quotations and tenders are not deemed possible, Trust officers should seek the approval of the Trust to waive these requirements.

SFI 7.11 Requirements of a statutory nature, and/or services provided by other public sector organisations that are sole suppliers are excluded from these tendering procedures and will not require a non-competitive waiver.

SFI 7.12 Continued professional development and/or training courses that are either sole supplier, provided by another public sector organisation or selected on the basis of geographical location will not require a non-competitive waiver.

SFI 7.13 Contracts for the purchase or rental of land, existing buildings or other immovable property or concerning rights on such property are excluded from the Public Contract Regulations and as such will not require a non-competitive waiver

SFI 7.14 A waiver is not required where a repair is needed to equipment that is covered by an existing approved framework maintenance agreement, and the value of the repair is below £20,000 (ex VAT).

SFI 7.15 Quotation and tendering procedures may only be waived in the following circumstances:

(a) very exceptionally, where the Chief Executive decides that formal tendering procedures would not be appropriate, however in such instances the benefits and rationale must be clearly demonstrated;

(b) timescales - where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(c) sole supplier - where specialist expertise is required and is available from only one source;

(d) maintaining continuity – when there is a clear benefit to be gained from maintaining continuity with an earlier project and/or engaging a different supplier for the new task would be inappropriate. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering (financial evidence must be provided in support); or

(e) standardisation where the requirement is an addition to a previously tendered range of goods and services and clearly supports the Trust policy for standardisation.

SFI 7.16 The waiving of competitive quotation or tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

SFI 7.17 Where it is decided that a competitive quotation/ tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

**Authorisation of waivers**

SFI 7.18 Where competitive tendering or a competitive quotation process is to be waived, the authorisation limits stipulated are as follows.

| Amount | Authorisation |
|---|---|
| Less than £10,000 ex VAT | No waiver required |
| £10,001k - £50,000 ex VAT | Deputy Director of Operational Finance |
| £50,001 - £100,000 ex VAT | Director of Operational Finance |
| £100,001 to EU Threshold ex VAT | Chief Finance Officer |
| Up to and over EU Threshold ex VAT | Chief Executive (or Deputy) |

SFI 7.19 Expenditure exceeding the relevant European Union threshold may not be waived, unless specified in the European Regulations. The Trust Procurement Department will advise in these circumstances.

**Frameworks and approved supplier lists**

SFI 7.20 The Trust shall use contracts established by the Crown Commercial Service (CCS), NHS Supply Chain (NHSSC), Shared Business Service Collaborative Procurement Service (SBS) Health Trust Europe (HTE) or another applicable organisation with appropriate frameworks, for the procurement of goods and services unless the Chief Executive or nominated officers deem it inappropriate.

SFI 7.21 If the Trust does not use frameworks as mentioned in SFI 7.20, and where tenders or quotations are not required because expenditure is below £5,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Finance Officer.

SFI 7.22 The Trust shall ensure that the suppliers invited to tender for estates-related contracts (and where appropriate, quote) are among those on approved lists such as, ProCure22 or the latest DHSC framework providing design and construction services or those outlined in SFI 7.20.

SFI 7.23 All firms who have applied for permission to tender must satisfy the Trust as to their technical and financial competence. All suppliers must adhere, where appropriate, to the standard NHS Terms and Conditions.

**Exceptions to using approved contractors**

SFI 7.24 If, in the opinion of the Chief Executive and either the Chief Finance Officer or the Director with lead responsibility for clinical governance, it is impractical to use a potential contractor from the list of approved suppliers (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

**Contracting/tendering procedure**

SFI 7.25 The Trust has adopted an "e-tendering" system to issue and receive all tenders electronically.

SFI 7.26 All invitations to tender on a formal competitive basis shall state the date and time as being the latest time for the receipt of tenders, and no tender will be considered for acceptance unless submitted through the e-tender system, as instructed within the tender documentation.

SFI 7.27 Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

SFI 7.28 Every tender for goods and services shall embody the NHS Terms and Conditions and, as appropriate, the contract form required for the specific goods and services.

SFI 7.29 Where the Trust is tendering to undertake the provision of goods/services for another organisation then a full financial appraisal must be undertaken and approved by Executive Team Meeting (ETM) prior to any invitation to tender being submitted. Where approval has been granted a full business case must be completed and approved in accordance with the business case approval process during the period in which the contract is being agreed.

**Receipt and safe custody of tenders**

SFI 7.30 All tenders must be issued and managed via the Trust's, or other approved, electronic tendering systems e.g. Crown Commercial Services. No hard copy tenders will be accepted.

SFI 7.31 Electronic tenders will be held and locked electronically until the allocated time and date for opening.

**Opening tenders**

SFI 7.32 The electronic tendering system is a fully automated, auditable system which seals bids until the response deadline has passed. Therefore, the originating Contract Manager will be deemed authorised to access the electronic tenders and release them once the sealed date and time has passed.

SFI 7.33 A full electronic record of the tenders received will be available in accordance with the agreed parameters of the system.

**Admissibility of tenders**

SFI 7.34 In considering which tender to accept, if any, the designated officer(s) shall have regard to whether value for money will be obtained and whether the number of tenders received provides adequate competition.

SFI 7.35 Tenders received after the due time and date may be considered only if the tenders received on the due date have not been opened and the designated officer(s) decide that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, being satisfied that there is no reason to doubt the bona fides of the tenders concerned.

SFI 7.36 The Chief Executive or the Chief Finance Officer shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition.

SFI 7.37 Technically late tenders (i.e. those dispatched in good time but delayed through no fault of the tenderer) will be regarded as having arrived in due time.

SFI 7.38 Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders.

SFI 7.39 Where examination of tenders reveals errors, which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing their offer.

SFI 7.40 Necessary discussions with a tenderer regarding the contents of their tender, in order to elucidate before the award of a contract, need not disqualify the tender.

SFI 7.41 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the Chief Executive.

SFI 7.42 Where only one tender/quotation is received, the designated officer(s) shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

SFI 7.43 A tender other than the most economically advantageous tender shall not be accepted unless for good and sufficient reason and a record of that reason be created and approved by the Chief Executive and held with the appropriate tender documentation.

SFI 7.44 Where the form of contract includes a fluctuation clause, all applications for price variations must be submitted in writing by the tenderer and shall be approved by either the Chief Executive or the Chief Finance Officer.

SFI 7.45 All Tenders should be treated as confidential and should be retained for inspection.

**Acceptance of tenders**

SFI 7.46 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender.

SFI 7.47 The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless the Chief Executive determines that there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

SFI 7.48 It is accepted that the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach; and

(d) ability to complete the project on time.

SFI 7.49 Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

SFI 7.50 Post tender negotiations on price shall not be entered into without the specific prior approval of the Chief Finance Officer in writing and must be in accordance with UK and EU Procurement Regulations. Such approvals shall not be given without prior consultation with the Chairman of the Audit Committee or the Chairman of the Finance & Performance Committee. Such negotiations are to be carried out by a senior manager specifically designated by the Chief Finance Officer, witnessed by a second manager, and approved by the Chief Executive. The range and scope of the negotiations are to be determined by the Chief Finance Officer on each and every occasion.

SFI 7.51 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions, except with the authorisation of the Chief Executive.

SFI 7.52 The use of these procedures must demonstrate that the award of the contract was not in excess of the going market rate/price current at the time the contract was awarded, and that best value for money was achieved.

SFI 7.53 All tenders should be treated as confidential and should be retained for inspection.

**Signing of contracts**

SFI 7.54 In all instances, the Trust's Procurement Team must be engaged in the tender procurement process prior to an official order being raised.

SFI 7.55 SFI 7.54 to SFI 7.58 refers specifically to circumstances where a contract needs to be signed (see DHSC guidance document available on the www.gov.uk website).

SFI 7.56 Contracts should be approved as follows:

| Amount | Contracts on NHS T&Cs | Contract on Non-NHS T&Cs |
|---|---|---|
| Less than £5,000 ex VAT | Associate Director of Procurement | Associate Director of Procurement |
| £5,000k - £25,000 ex VAT | Associate Director of Procurement | Deputy Director of Operational Finance |
| Up to £50,000 ex VAT | Director of Operational Finance | Director of Operational Finance |
| Up to EU Threshold ex VAT | Chief Finance Officer | Chief Finance Officer |
| Over EU Threshold ex VAT | Chief Executive (or Deputy) | Chief Executive (or Deputy) |

**Tender reports to the Board of Directors**

SFI 7.57 Reports to the Board of Directors will be made on an exceptional circumstance basis only.

**Fair and adequate competition**

SFI 7.58 The Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and, unless not practicable, in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

**Expenditure to be within financial limits**

SFI 7.59 No tender or quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Chief Finance Officer.

**Reverse e-auctions**

SFI 7.60 Where appropriate, the Trust will use e-auctions, and partner organisations to conduct e-auctions on its behalf, and will determine throughout the year the most appropriate product areas that will achieve the best value by being managed through an e-auction.

SFI 7.61 The results of the e-auction will be made available for scrutiny and ratification using a similar process to that of electronic tenders, and a record will be kept of the submissions in full.

**Health care services**

SFI 7.62 Where the Trust elects to invite tenders for the supply of health care services, these Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure.

**Items which subsequently breach thresholds after original approval**

SFI 7.63 Items estimated to be below the limits set in these Standing Financial Instructions for which formal tendering procedures are not used, which subsequently prove to have a value above such limits, shall be reported to the Audit Committee on a quarterly basis and be recorded in an appropriate Trust record.

**Authorisation of tenders and competitive quotations**

SFI 7.64 Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided in line with SFI 7.54.

SFI 7.65 In the case of authorisation by the Board of Directors, this shall be recorded in their minutes.

**Private finance for capital procurement**

SFI 7.66 When considering PFI funding the Trust should normally market-test. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) the Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;

(b) a business case must be referred to the Department of Health and Social Care, NHS Improvement, or as per current guidelines;

(c) the proposal must be specifically agreed by the Board of the Trust; and

(d) the selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

**Compliance requirements for all contracts**

SFI 7.67 The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) the Trust's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) any relevant directions including the Capital Investment Manual, Health Building Note 00-08: Estatecode and guidance on the Procurement and Management of Consultants;

(d) such of the NHS Standard Contract Conditions as are applicable; and

(e) appropriate NHS guidance regarding the form of contracts with foundation trusts.

SFI 7.68 Where appropriate, contracts shall be in, or embody, the same terms and conditions of contract as the basis on which tenders or quotations were invited.

SFI 7.69 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all available systems in place.

SFI 7.70 Commercial negotiations and the establishment of a contract management framework may only be undertaken by members of the Procurement Department, unless otherwise authorised by the Chief Executive or Chief Finance Officer.

**Disposals**

SFI 7.71 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his/her nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the relevant disposal policy of the Trust;

(c) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract; and

(d) land or buildings subject to compliance with DH guidance.

**In-house services and benchmarking**

SFI 7.72 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided in-house. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering. This will be undertaken adopting a two-stage process.

SFI 7.73 The process for undertaking the Best Value Review is set out below.

(a) Establish a cross-functional project team, to include senior representatives from the department which is the focus of the exercise, Finance, Procurement, staff-side and HR, with project management responsibility residing with the Associate Director of Procurement.

(b) The project team will be responsible for the scope and specifics of the departmental review. This should include quality targets and innovations, as well as cost analysis. Specific metrics would include the range of services offered, head count, and comparison of KPI data, with the aim of providing the Trust with a holistic view of the value received from the existing in-house service provider. For benchmarking, at least one comparator must be an external provider.

(c) The project team are responsible for the production of a report in which improvements/opportunities are identified. The department or service in question is

then given a period of 3 months to make any necessary improvements to the in-house service provision, to align itself to the 'best in class' targets. Where improvements are not achieved, escalation to a full 'market testing' exercise is an executive decision.

SFI 7.74 On the basis of the outcome of the benchmarking exercise, the Trust may determine that in-house services should be market tested by competitive tendering.

SFI 7.75 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) specification group, comprising the Chief Executive or nominated officer(s) and specialist;

(b) in-house tender group, comprising a nominee of the Chief Executive and technical support; and

(c) evaluation team, comprising normally a specialist officer, a Procurement officer and a representative of the Chief Finance Officer.

SFI 7.76 All groups should work independently of each other, and individual officers may be a member of more than one group, but no member of the in-house tender group may participate in the evaluation of tenders.

SFI 7.77 The evaluation team shall make recommendations to the Board.

SFI 7.78 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

**Applicability of SFIs on tendering and contracting to funds held in trust**

SFI 7.79 These Instructions shall equally apply to expenditure from charitable funds.

## SFI 8. NON-PAY EXPENDITURE

**Delegation of authority**

SFI 8.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

SFI 8.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

(b) the maximum level of each requisition and the system for authorisation above that level.

SFI 8.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

**Authorisation levels for approval of purchase orders**

SFI 8.4 The below table details the internal approval levels and limits applicable for the procurement of goods and services through the Trust's procurement order processing system (Oracle).

| Approval Level | Approval Level - Posts | Approval Limit |
|---|---|---|
| 1 | Chief Executive/Deputy Chief Executive/Chief Finance Officer | £1,000,000 |

| | | |
|---|---|---|
| 2 | Director of Operational Finance | £300,000 |
| 3 | Executive Director | £250,000 |
| 4 | Associate Director / Deputy Director | £150,000 |
| 5 | Head of Department or Service | £20,000 |
| 6 | Deputy Head of Department/Head of Service | £10,000 |
| 7 | Senior Department/Service Manager | £5,000 |
| 8 | Department/Service Manager | £2,500 |
| 9 | Department/Service Approver | £1,000 |
| 10 | Requestor Only | N/A |

SFI 8.5 In cases where expenditure is over £1,000,000, the Chief Executive's limit will be increased to allow electronic authorisation in instances where the business case has been approved by the Board and evidence can be shown of this.

SFI 8.6 The table below details the internal approval limits applicable within the Procurement Department for the approval of purchase orders once authorisation has been given to expenditure

| Position | PO Approval Limit |
|---|---|
| Associate Director of Procurement | £25,000,000 |
| Procurement Manager | £250,000 |
| Contracts Officers (Capital) | £100,000 |
| eProcurement Manager/Contracts Manager/Assistant Contracts Manager | £100,000 |
| Contracts/eProcurement Officer/Assistant | £50,000 |

SFI 8.7 The procurement process for goods, services or works depends upon whether expenditure is incurred from capital or revenue budgets, and refers to expenditure not already covered by existing NHS national or local contracts.

SFI 8.8 The limits below refer to whole life cost of the contract (i.e. an annual contract value of £70,000 over 3 years requires OJEU tender in respect of revenue) to incur non-pay expenditure (ex VAT):

SFI 8.8.1. Revenue expenditure

1. Below £5,000 — Purchase order
2. £5,001 to £49,999 — Official quotations
3. £50,000 to EU threshold for goods/services — Official tender exercise
4. Over current EU threshold for goods/services — OJEU tender exercise

SFI 8.8.2. Capital

| | | |
|---|---|---|
| 1. | Below £5,000 | Purchase order |
| 2. | £5,001 to £49,999 | Official quotations |
| 3. | £50,000 to EU threshold for goods/services | Official tender exercise |
| 4. | Over current EU threshold for goods/services | OJEU tender exercise |

**Choice, requisitioning, ordering, receipt and payment for goods and services**

SFI 8.9 *Requisitioning:* To ensure best value for money all purchases of goods and services must be made utilising the advice and services of the Trust's Procurement Department. Where this advice is not acceptable to the requisitioner, the Chief Finance Officer (and/or the Chief Executive) shall be consulted. All requisitions shall be priced and include the relevant financial code.

SFI 8.10 *System of payment and payment verification:* The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms or otherwise in accordance with national guidance.

SFI 8.11 The Chief Finance Officer will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained. Once approved, the thresholds should be incorporated in these SFIs and regularly reviewed;

(b) prepare procedural instructions or guidance within these SFIs on the procurement of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, with the only exceptions set out in SFI 8.12 below; and

(e) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for the following:

(i) A list of Directors/employees authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct; and
- the account is in order for payment.

(iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

SFI 8.12 *Prepayments:* Prepayments are only permitted where exceptional circumstances apply.

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages.

(b) The appropriate authorised staff member must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is, at some time during the course of the prepayment agreement, unable to meet their commitments.

(c) The Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold).

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

SFI 8.13 *Official orders:* Official orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Chief Finance Officer;

(c) state the Trust's terms and conditions of trade; and

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

They may be transmitted by a system of Electronic Data Interchange (EDI) approved by the Chief Finance Officer.

SFI 8.14 *Duties of managers and staff:* Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and the relevant staff must ensure that:

(a) all contracts (except as otherwise provided for in these SFIs), leases, tenancy agreements and other commitments which may result in a liability are notified to the Procurement Department in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care;

(d) all intellectual property (IP) benefits, such as copyright, patents, design rights, trademarks and confidentiality are protected and applied in all cases via the Trust's authorised representatives, (as established in the Trust's Intellectual Property Policy);

(e) discussions with suppliers in respect of commercial terms must not be undertaken other than by members of the Procurement Department;

(f) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;

(g) all goods, services, or works are ordered on an official order except purchases from petty cash and purchases from suppliers identified on the agreed list of non-PO suppliers/services maintained by Financial Services and Procurement.

(h) verbal orders must only be issued very exceptionally and be accompanied by a purchase order number - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(i) requisitions/orders/petty cash requests are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(j) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(k) changes to the list of employees and officers authorised to certify invoices are notified to the Chief Finance Officer;

(l) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer;

(m) petty cash records are maintained in a form as determined by the Chief Finance Officer; and

(n) the Conflicts of Interest Policy (incorporating) Gifts and Hospitality Policy must be adhered to at all times, with no orders issued to or business transacted contrary to this policy.

SFI 8.15 The Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with current guidance.

SFI 8.16 In the case of contracts for building or emergency works which require payment made on account during progress of the works, the Chief Finance Officer shall make payment upon receipt of a certificate from the appropriate technical consultant or works officer appointed to a particular building or engineering contract.

## SFI 9. STORES AND RECEIPT OF GOODS

### General position

SFI 9.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take; and

(c) valued at the lower of cost and net realisable value, or a weighted average in the case of Pharmacy.

**Control of stores, stocktaking, condemnations and disposal**

SFI 9.2 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of any pharmaceutical stocks shall be the responsibility of a designated pharmaceutical officer; the control of any fuel oil and coal shall be the responsibility of a designated estates manager.

SFI 9.3 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager. Wherever practicable, stocks should be marked as Trust property.

SFI 9.4 The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

(a) All goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification. A delivery note should be obtained from the supplier at the time of delivery/service and signed by the staff member receiving the goods/service.

(b) Particulars of all goods/services received shall be registered on the day of receipt, with unsatisfactory goods returned to the supplier within the set timescales.

(c) Stock shall only be issued/released upon receipt of an authorised requisition.

SFI 9.5 All stock records shall be in such form and shall comply with such systems of control as the Chief Finance Officer may require.

SFI 9.6 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

SFI 9.7 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

SFI 9.8 The designated manager/pharmaceutical officer shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI 14 Disposals and condemnations, losses and special payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

**Goods supplied by NHS Supply Chain**

SFI 9.9 For goods supplied via the NHS Supply Chain regional stores, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note ('priced advice note') before forwarding this to the Chief Finance Officer/Director of Operational Finance, depending on value, who shall satisfy him/herself that the goods have been received before accepting the recharge.

## SFI 10. CONTRACTING FOR PROVISION OF HEALTHCARE SERVICES

### Commissioner-related contracts

SFI 10.1 The Chief Executive is responsible for negotiating contracts for the provision of services to patients in accordance with the Business Plan, and for establishing the arrangements for providing extra-contractual services. In carrying out these functions, the Chief Executive should take into account the advice of the Chief Finance Officer regarding:

(a) costing and pricing of services;

(b) payment terms and conditions; and

(c) amendments to contracts and extra-contractual arrangements.

SFI 10.2 Contracts should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income. Contract prices should comply with NHS Improvement's and NHS England's National Tariff Guidance.

SFI 10.3 The Chief Finance Officer shall produce regular reports detailing actual and forecast contract income with a detailed assessment of the impact of the variable elements of income.

### Non commissioner-related contracts

SFI 10.4 Where the Trust enters into a relationship with a non-NHS body or another NHS organisation for the supply or receipt of other services, either clinical or non-clinical, or collaborative arrangements and non-financial contracts, the responsible contracting officer should ensure that an appropriate Service Level Agreement (SLA) is in place and has been signed by both parties. SLAs must be signed off as follows:

(a) For corporate SLAs, the Lead Executive (or nominated deputy)

(b) For divisional SLAs, the Divisional Director of Operations.

Plus, in all circumstances:

(c) Director of Operations and Performance (or nominated deputy)

(d) Chief Finance Officer (or nominated deputy)

(e) Either: Chief Nurse, or Medical Director (or nominated deputies)

SFI 10.5 This contract should incorporate:

(a) a description of the service and indicative activity levels;

(b) the term of the agreement including termination arrangements;

(c) the value of the agreement;

(d) the operational lead;

(e) performance and dispute resolution procedures; and

(f) risk management and clinical governance arrangements.

SFI 10.6 Non-commissioner contracts should be reviewed and agreed on an annual basis or as determined by the term of the agreement so as to ensure value for money and to minimise the potential loss of income.

SFI 10.7 Copies of signed SLAs should be retained on file by the contracting officer and, where the contract specifies financial information, a copy should be issued to the appropriate Divisional Management Accountant within Finance.

SFI 10.8 Electronic copies of the SLA and sign off schedule should be submitted to the Head of Legal Services with summary details of the SLA expiry date and any review dates which occur during the term of the SLA.

## SFI 11. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE BOARD OF DIRECTORS AND EXECUTIVE COMMITTEE AND EMPLOYEES

### Remuneration and terms of service

SFI 11.1 The Board shall establish a Remuneration Committee comprised of non-executive directors. Such Committee shall have clearly defined terms of reference which specify which posts fall under its remit as well as its composition and the arrangements for reporting.

SFI 11.2 The Committee will undertake the following:

(a) Decide the remuneration and allowances, and the other terms and conditions of office, of the executive directors and any other senior employees under its remit, including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) payable expenses and compensation payments; and

(iv) arrangements for termination of employment and other contractual terms.

(b) monitor and evaluate the performance of the executive directors and any other senior employees under its remit; and

(c) oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

SFI 11.3 When deciding the remuneration, allowances and the other terms of service of the executive directors and any other senior employees under its remit, the Committee shall ensure that they are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate.

SFI 11.4 The allowances paid to the non-executive directors shall be determined by the Council of Governors**.**

### Funded establishment

SFI 11.5 The manpower plans incorporated within the annual budget will form the funded establishment.

SFI 11.6 The funded establishment of any department may not be varied without the approval of the Chief Executive unless in accordance with an establishment control procedure approved by the Board.

SFI 11.7 All budget holders must remain within their funded establishment unless prior consent has been granted by the Board.

**Staff appointments**

SFI 11.8 No Director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive; or

(b) unless the changes are within the limit of their approved budget and funded establishment; or

(c) the change is temporary and within the delegated powers of the Workforce Expenditure Panel.

SFI 11.9 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

**Processing payroll**

SFI 11.10 The Chief Finance Officer is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates; and

(d) agreeing method of payment.

SFI 11.11 The Chief Finance Officer will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the current Data Protection Legislation;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque or bank credit to employees and officers;

(i) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) segregation of duties in preparing records and handling cash; and

(m) a system to ensure the recovery of sums of money and property, from those leaving the employment of the Trust, due by them to the Trust.

SFI 11.12 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Chief Finance Officer's instructions and in the form prescribed by the Chief Finance Officer; and

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employees or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Chief Finance Officer must be informed immediately.

SFI 11.13 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

SFI 11.14 Advances of pay may only be given to staff to ensure timely remuneration of pay earned or reimbursement of legitimate expenses incurred in advance of normal pay processing. Loans may not be made to staff even if against potential future earnings.

SFI 11.15 Expenses should only be reimbursed via payroll. There should be no reimbursement for Trust purchases via payroll.

**Contracts of employment**

SFI 11.16 The Board shall delegate responsibility to the Director of Workforce for:

(a) ensuring that all employees are issued with a contract of employment in a form approved by the Board and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment. Local pay variations require the written approval of the Director of Workforce.

SFI 11.17 The Chief Finance Officer will be responsible for maintaining up-to-date procedures, to ensure that assurance can be obtained from off-payroll workers to determine that the correct tax and NI contributions are being paid to HMRC.

## SFI 12. EXTERNAL BORROWING AND INVESTMENTS

**Public Dividend Capital**

SFI 12.1 On authorisation as a foundation trust, the public dividend capital (PDC) held immediately prior to authorisation continues to be held on the same conditions.

SFI 12.2 Additional public dividend capital may be made available on such terms the Secretary of State for Health (with the consent of HM Treasury) decides.

SFI 12.3 Draw down of additional public dividend capital will be authorised by the Chief Executive or Deputy Chief Executive, and by the Chief Finance Officer or the Director of Operational Finance.

SFI 12.4 The Trust shall be required to pay annually to the Department of Health and Social Care a dividend on its public dividend capital at a rate to be determined from time to time, by the Secretary of State.

**Commercial borrowing and investment**

SFI 12.5 The Chief Finance Officer will advise the Board concerning the Trust's ability to pay interest on, or repay principal on, borrowings held, and will advise the Board on any proposed new borrowing. The Chief Finance Officer is responsible for reporting periodically to the Board concerning all loans and overdrafts.

SFI 12.6 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Chief Finance Officer.

SFI 12.7 The Chief Finance Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

SFI 12.8 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short-term borrowing requirement in excess of one month must be authorised by the Chief Finance Officer.

SFI 12.9 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Finance Officer.

SFI 12.10 All long-term borrowing must be consistent with the plans outlined in the current Business Plan and be approved by the Board of Directors.

**Investments**

SFI 12.11 Temporary cash surpluses must be held only in such public or private sector investments as approved and authorised by the Board in line with the Trust's Treasury Management Policy.

SFI 12.12 The Chief Finance Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

SFI 12.13 The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

## SFI 13. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

**Capital investment**

SFI 13.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon Business Plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) shall ensure that capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

SFI 13.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(iii) appropriate project management and control arrangements; and

(b) that the Chief Finance Officer has certified professionally the costs and revenue consequences detailed in the business case.

SFI 13.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of Health Building Note 00-08: Estatecode.

SFI 13.4 The Chief Finance Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HMRC guidance.

SFI 13.5 The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall delegate to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender; and

(c) approval to accept a successful tender.

SFI 13.6 The Chief Finance Officer shall issue procedures for the regular reporting of capital expenditure and commitment against authorised capital expenditure.

**Asset registers**

SFI 13.7 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a rolling programme of physical checks of assets against the asset register.

SFI 13.8 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Department of Health and Social Care Group Accounting Manual and IFRS accounting standards.

SFI 13.9 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architects' certificates, suppliers' invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) lease agreements in respect of assets held under a finance lease and capitalised.

SFI 13.10 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

SFI 13.11 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

SFI 13.12 The value of each asset shall be depreciated using methods and rates as specified in the Department of Health and Social Care Group Accounting Manual.

SFI 13.13 The Chief Finance Officer shall calculate and pay public dividend capital charges as specified in the Department of Health Group and Social Care Accounting Manual.

**Security of assets**

SFI 13.14 The overall control of fixed assets is the responsibility of the Chief Executive.

SFI 13.15 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset; and

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

SFI 13.16 The up-to-date maintenance and checking of asset records shall be the responsibility of designated budget holders for all items for which the initial purchase or replacement is within their service area. All discrepancies revealed by the verification of physical assets to the fixed asset register shall be notified to the Chief Finance Officer.

SFI 13.17 Whilst each employee has a responsibility for the security of Trust property, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

SFI 13.18 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

SFI 13.19 The Chief Finance Officer shall be the authorised officer to be responsible for the disposal of assets surplus to requirements.

SFI 13.20 Where practical, assets should be marked as Trust property and have a bar coded tag correlating to the record held on the asset register.

## SFI 14. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

**Disposals and condemnations**

SFI 14.1 The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers.

SFI 14.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will notify the Chief Finance Officer to determine the asset's current valuation and the impact the disposal may have on the Trust's finances. Advice will be given as to the disposal procedure and obtaining the estimated market value of the item, taking account of professional advice where appropriate.

SFI 14.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer; and

(b) recorded by the condemning officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

SFI 14.4 The condemning officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

**Losses and special payments**

SFI 14.5 The Chief Finance Officer must prepare procedural instructions on the recording of, and accounting for, condemnations, losses, and special payments, with regard to HM Treasury's Managing Public Money, and NHS-specific guidance and directions.

SFI 14.6 Any employee discovering or suspecting a loss of any kind, other than fraud, corruption or bribery, must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Finance Officer, or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then inform the Chief Finance Officer and/or Chief Executive.

SFI 14.7 Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the police if theft or arson is involved.

SFI 14.8 Where property loss/damage is suspected, including theft of or criminal damage (including burglary, arson, and vandalism) to staff, patient or NHS property or equipment, the Chief Finance Officer must immediately inform NHS Protect.

SFI 14.9 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify the Board.

SFI 14.10 Any employee discovering or suspecting fraud, corruption or bribery, or anomalies which may indicate fraud or corruption, must inform the Trust's Local Counter Fraud Specialist (LCFS).

SFI 14.11 The LCFS and/or Chief Finance Officer must report all frauds in accordance with the provisions of the Trust's Local Protocol on the Conduct of Investigations and Application of Sanctions and Redress in Respect of Fraud and Corruption.

SFI 14.12 The Chief Finance Officer will

(a) refer any novel, contentious or repercussive cases to the Department of Health and Social Care for approval, including extra-statutory and extra-regulatory payments, in accordance with HM Treasury direction; and

(b) refer severance payments on termination of employment (not including Treasury-approved MAS scheme payments) to NHS Improvement, who will deal directly with HM Treasury to get the necessary approval.

NHS England and the general public are informed of specific individual losses and special payments which exceed £250,000 via the Annual Reports and Accounts process.

SFI 14.13 The delegated limits approved by the Board for the approval of losses are set out below:

| Category of loss | Approval delegated to: | Nominated deputy |
|---|---|---|
| **1. Losses of cash**<br>(a) Theft, fraud, arson etc.<br>(b) Overpayments of salaries, wages, fees and allowances<br>(c) Other causes, including un-vouched or incompletely vouched payments, overpayments other than those included under 1(b), loss of cash by fire (other than arson), physical losses of cash, cash equivalents and stamps other than those covered by 1(a)<br>**2. Fruitless payments and constructive losses** (including abandoned capital schemes, except where work is purely exploratory)<br>**3. Bad debts and claims abandoned**<br>(a) Private patients<br>(b) Overseas visitors<br>(c) Cases other than 3(a) and 3(b)<br>**4. Damage to buildings, their fittings, furniture and loss of equipment and property in stores and in use**<br>(a) Culpable causes e.g. theft, fraud, arson or sabotage, whether proved or suspected, neglect of duty or gross carelessness<br>(b) Stores losses<br>(c) Other causes e.g. weather damage or accidental fire | ≤ £25,000: Chief Finance Officer<br>≤ £50,000: Chief Executive<br>> £50,000: Audit Committee and Board of Directors | For Chief Finance Officer: Director of Operational Finance or Deputy Director of Operational Finance<br>For Chief Executive: Executive Director |

SFI 14.14 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in respect of bankruptcies and company liquidations. This shall include the requirement for parent company guarantees or banker's bonds in circumstances where a review of company financial credit ratings requires further guarantees to be made prior to awarding contracts.

SFI 14.15 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

SFI 14.16 The delegated limits approved by the Board for the approval of special payments are set out below:

| Category of special payment | Approval delegated to: | Nominated Deputy |
|---|---|---|
| **5. Compensation payments made under legal obligation** (such as court order or arbitration award for personal injury, property damage or unfair dismissal)<br><br>**6. Extra-contractual payments to contractors** (such as payments for non-contractual obligations which might arguably have been upheld in court) | ≤ £25,000: Chief Finance Officer<br><br>≤ £50,000: Chief Executive<br><br>> £50,000: Audit Committee and Board of Directors | For Chief Finance Officer:<br>Director of Operational Finance<br><br>or Deputy Director of Operational Finance<br><br>For Chief Executive:<br>Executive Director |
| **7. Ex-gratia payments**<br>(a) Loss of personal effects<br>(b) Clinical negligence (negotiated settlements following legal advice) where the guidance relating to such payments has been applied<br>(c) Personal injury claims involving negligence where legal advice is obtained and relevant guidance has been applied<br>(d) Other clinical negligence cases and personal injury claims<br>(e) Other employment payments<br>(f) Patient referrals outside the UK and EEA guidelines<br>(g) Other<br>(h) Maladministration, such as bias, neglect, or delay | ≤ £10,000<br><br>Legal Services Department<br><br>≤ £50,000 Chief Nurse<br><br>> £50,000 Audit Committee and Board of Directors | Not applicable |
| **8. Severance payments on termination of employment** (beyond contractual obligations and not including Treasury-approved MAS)<br><br>**9. Extra statutory and extra regulatory payments** | See SFI 14.12 | |

SFI 14.17 The Chief Finance Officer shall maintain a Losses and Special Payments Register, which is completed on an accrual's basis.

SFI 14.18 All losses and special payments must be reported to the Audit Committee each quarter, as a minimum.

## SFI 15. INFORMATION TECHNOLOGY AND GOVERNANCE

### Responsibilities and duties of the Chief Finance Officer

SFI 15.1 The Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware, for which the Chief Finance Officer is responsible, from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for current Data Protection Legislation;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system.

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment; and

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Chief Finance Officer may consider necessary are being carried out.

SFI 15.2 The Chief Finance Officer shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

### Responsibilities and duties of other directors and officers

SFI 15.3 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of trusts in the region wish to sponsor jointly) all responsible directors and employees will send to the Chief Finance Officer:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirements; and

(c) support arrangements for the system including business continuity and disaster recovery plans.

### Contracts for computer services with other health bodies or outside agencies

SFI 15.4 The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

SFI 15.5 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

**Risk assessment**

SFI 15.6 The Chief Finance Officer shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action is taken to mitigate or control risk.

**Requirements for computer systems, which have an impact on corporate financial systems**

SFI 15.7 Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) only appropriate staff have access to such data; and

(d) computer audit reviews are carried out, as considered necessary.

**Freedom of information**

SFI 15.8 The Trust shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

**Information governance "principle 7 compliance statement"**

SFI 15.9 The NHS holds the most sensitive and confidential information about individuals and is bound by current Data Protection Legislation. When sharing data with external parties or data processed by a third party, we must adhere to General Data Protection Regulations Article 5 (1) (f) which states that: " data must be processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures." Therefore, all data processors acting on behalf of the Trust or under instruction from the Trust must adhere to all current Data Protection Legislation and afford the appropriate security to the information they may hold/process where the Trust is the Data Controller. Measures include statements regarding information security; implementation of physical security and access controls, and business continuity measures; information governance training for staff; and incident reporting procedures. Failures may lead to the Trust seeking damages if a breach/data loss occurs.

## SFI 16. PATIENTS' PROPERTY

SFI 16.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

SFI 16.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are notified before or at admission that the Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

SFI 16.3 This notification is through:

(a) notices and information booklets;

(b) hospital admission documentation and property records; and

(c) the oral advice of administrative and nursing staff responsible for admissions.

SFI 16.4 The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of patient's money.

SFI 16.5 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

SFI 16.6 Patient lockers are available for use by patients, and those wishing to use these facilities may do so following an assessment of competence and capability. For patients who have property that needs to be handed in for safekeeping, and who are unable to use the lockers provided, a Patient Property Record, in a form determined by the Chief Finance Officer, shall be completed in respect of the following:

(a) property handed in for safekeeping by any patient (or guardian as appropriate); and

(b) property taken into safe custody having been found in the possession of:

(i) mentally ill patients;

(ii) confused and/or disoriented patients;

(iii) unconscious patients;

(iv) patients dying in hospital;

(v) patients found dead on arrival at hospital; or

(vi) patients severely incapacitated for any reason.

A record shall be completed in respect of all persons in category (b) including a nil return if no property is taken into safe custody.

SFI 16.7 The Patient Property Record shall be completed by a member of the hospital staff in the presence of a second member of staff and the patient or their personal representative, where practicable. The record shall then be signed by both members of staff and the patient, except where the latter is restricted by mental or physical incapacity.

SFI 16.8 Property and money handed over for safe keeping shall be placed immediately into the care of the cashier or designated member of the General Office staff except where there are no administrative staff available, in which case the property shall be placed in the care of the most senior member of nursing staff on duty.

SFI 16.9 Except as provided in SFI 16.10 and SFI 16.11 below, refunds of cash handed in for safe custody will be dealt with in accordance with written instructions from the Chief Finance Officer. Property other than cash that has been handed in for safe custody shall be returned to the patient as required. The return shall be receipted by the patient (or guardian as appropriate) and witnessed. The receipts are then retained by the hospital cashier for audit inspection.

SFI 16.10 The disposal of the property of deceased patients shall be effected by the hospital cashier, or the staff member who has had responsibility for its security. Particularly where cash and valuables have been deposited, they shall only be released after written authority given by the Chief Finance Officer. Such authority shall include details of the lawful kin or other persons entitled the deceased's property.

SFI 16.11 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

SFI 16.12 In respect of a deceased person's property, if there is no will and no lawful kin, the property vests in the Crown and the Chief Finance Officer shall notify the Duchy of Lancaster.

SFI 16.13 Any funeral expenses necessarily borne by the Trust are a first charge on a deceased person's estate. No other expenses or debts shall be discharged out of the estate of a deceased patient.

SFI 16.14 Where patients' property or income is received for specific purposes and held for safekeeping, the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

## SFI 17. CHARITABLE FUNDS

### The charity framework and the applicability of standing financial instructions to the Charity

SFI 17.1 The Trust's SFIs are equally applicable to the Trust's charitable funds with regards to procurement and transactions.

SFI 17.2 The Standing Financial Instructions state the Board of Directors responsibilities as a Corporate Trustee for the management of charitable funds and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, Corporate Trustee responsibilities must be discharged separately, and full recognition given to its accountabilities to the Charity Commission. The Trustee must ensure compliance with the Charity Commission's latest guidance and best practice, and charity law, including the Charities Act 2011.

SFI 17.3 The discharge of the Board of Directors Corporate Trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. The Charitable Trust Committee is a Committee of the Trust Board with delegated powers to administer charitable matters and authorise expenditure.

SFI 17.4 Within these Standing Financial Instructions, 'charitable funds' are defined as the total net assets of Wrightington, Wigan and Leigh Health Services Charity (also known as 'Three Wishes'), which is a registered charity in support of purposes relating to the National Health Service. These chiefly represent the cumulative cash donated and bequeathed to the Charity, net of charitable expenditure to date. Management of the funds is governed by charity legislation.

### Approvals

SFI 17.5 The Chief Finance Officer must prepare procedural guidance for raising, handling, and accounting for charitable income, and for the proper expenditure of charitable funds, and shall

ensure that each charitable fund is managed appropriately with regard to its purpose, the Charity Commission's latest guidance and best practice, and charity law.

SFI 17.6 No new fund or fundraising activity (except those 'for the general purposes of the Charity', and not undertaken during work time) shall be established without first obtaining the written approval of the Charitable Trust Committee.

SFI 17.7 As Corporate Trustee, the Committee has delegated limits for the approval of expenditure as follows:

| Type of charitable fund | Nominated Deputy |
|---|---|
| Divisional funds and restricted funds (such as appeal funds) | ≤ £20,000 including VAT and carriage<br>Divisional Fund Committee<br>> £20,000<br>Charitable Trust Committee |
| Fundraising expenditure | ≤ £5,000 including VAT and carriage<br>Associate Director of Financial Services and Payroll<br>≤ £20,000 including VAT and carriage<br>Chief Finance Officer<br>> £20,000<br>Charitable Trust Committee |
| The Charitable Trust Committee reserves the right to veto expenditure approved by Divisional Fund Groups and to recharge divisional funds for administrative, governance or other costs. | |

**Fund management and expenditure**

SFI 17.8 All Divisional Fund Committees shall be responsible for the management of funds held within their areas of responsibility including the implementation of initiatives to increase donations.

SFI 17.9 Divisional Fund Committees will be responsible for ensuring that all expenditure incurred through charitable funds meets the public benefit test as outlined in the Charity Act 2011; and that such expenditure is timely, without the unnecessary accumulation of funds.

SFI 17.10 All expenditure must be for 'appropriate charitable purposes', in accordance with the Charity's Expenditure Guidance policy document. Exceptionally, strategic and governance expenditure is approved by the Charitable Trust Committee.

SFI 17.11 In the first instance, it is the responsibility of a Divisional Fund Committee or equivalent to ensure that all commitments against a charitable fund represent the best available value for money in terms of direct patient benefit, and are consistent with 'appropriate charitable purposes' as defined by

(a) the fund's objectives;

(b) Charity policies; and

(c) patient benefit criteria set out in charity law.

SFI 17.12 Under no circumstances shall a fund be allowed to go into deficit. It is a responsibility of the Divisional Fund Committee to ensure this does not occur.

SFI 17.13 Where possible, the use of exchequer funds to discharge charitable fund liabilities should be avoided, and any indebtedness to exchequer should be discharged by the charitable fund at the earliest possible time.

**Income**

SFI 17.14 All charitable gifts, donations and fundraising activities are governed by the Charity's Fundraising and Income Guidance policy document. All charitable proceeds must be handed immediately to the Chief Finance Officer via an authorised Cash/General Office, to be banked directly to the Charity's charitable fund bank account. All gifts received shall be confirmed to the donor in the Trust's authorised form of receipt that will ensure the donor's wishes are observed without unnecessarily creating new trusts.

SFI 17.15 Gifts which are intended to personally and directly benefit staff, such as 'thank-you' presents, flowers or contributions to staff recreation are not charitable donations, as they have no link to public or patient benefit, but are, rather, gifts to individuals. As such, they are expected to be modest, and are covered by the Trust's Conflicts of Interest Policy.

SFI 17.16 Under no circumstances shall any income (cash, cheques, or other forms of payment) be retained on any Ward or Department, excepting when a Cash/General Office is closed. Where a donation occurs at night or at weekends, the income shall be retained in a secure environment, with an internal receipt given to the donor at the time the donation is made. In the event of this occurring, the income shall be deposited with a Cashier at the next earliest opportunity.

SFI 17.17 All gifts and income accepted shall be administered in accordance with the relevant fund's charitable objectives, subject to the terms of specific trusts. As the Charity can only accept cash or non-cash donations for all or any purpose related to the Health Service, officers shall, in cases of doubt, consult the Chief Finance Officer before accepting gifts of any kind.

SFI 17.18 In respect of legacies and bequests, the Chief Finance Officer shall be kept informed of all enquiries regarding legacies and bequests, which should be filed on a case-by-case basis. Where required, the Chief Finance Officer shall:

(a) provide assistance covering any approach regarding the wording of wills and the receipt of funds/other assets from executors; and

(b) where necessary, obtain grant of probate, or make application for grant of letters of administration.

**Banking**

SFI 17.19 The Chief Finance Officer shall be responsible for ensuring that appropriate banking services are available in respect of administering the charitable funds.

**Investment management**

SFI 17.20 The Chief Finance Officer shall be responsible for all aspects of the management of the investment of charitable funds as delegated under the terms of the Charity's approved Treasury Management Policy. The issues on which the Chief Finance Officer shall be required to provide advice to the Charitable Trust Committee include:

(a) the formulation of a Treasury Management Policy, which meets statutory requirements and Charity Commission guidance with regard to income generation and the enhancement of capital value;

(b) the appointment of advisers, brokers and, where appropriate, investment fund managers;

(c) pooling of investment resources in line with Charity Commission legislation;

(d) the participation by the Trust in common investment funds and the agreement of terms of entry and withdrawal from such funds; and

(e) the review of investment performance and of brokers and fund managers.

**Asset management**

SFI 17.21 Donated assets in the ownership of, or used by, the Trust as Corporate Trustee, shall be maintained along with the general estate and inventory of assets of the Trust. The Chief Finance Officer shall ensure that:

(a) appropriate records of all donated assets owned by the Trust are maintained, and that all assets, at agreed valuations are brought to account; and

(b) appropriate measures are taken to protect and/or to replace assets. These are to include decisions regarding insurance, inventory control, and the reporting of losses.

**Reporting**

SFI 17.22 The Chief Finance Officer shall:

(a) ensure that regular reports are made to the Charitable Trust Committee with regard to, inter alia, fund balances, investments, expenditure, expenditure approvals, and any policies in line with Department of Health and Social Care and Charity Commission guidance;

(b) prepare annual accounts in the required manner, which shall be submitted to the Charitable Trust Committee and Audit Committee within agreed timescales;

(c) prepare an annual Trustee's report and required returns for the Charity Commission for adoption by the Committee;

(d) prepare detailed procedural instructions concerning the receiving, recording, investment and accounting for charitable funds; and

(e) maintain such accounts and records as may be necessary to record and protect all transactions and funds of the charitable funds.

## SFI 18. ACCEPTANCE OF GIFTS HOSPITALITY AND COMMERICAL SPONSORHSIP BY STAFF

SFI 18.1 The Chief Finance Officer shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy, the Conflicts of Interest Policy, should follow the guidance contained in the NHS England model policy document. This policy guides officers and should be adhered to in all business dealings with organisations and people outside of the Trust.

SFI 18.2 The Trust will publish on its website, its Register of Interests and Register of Gifts and Hospitality on a bi-annual basis and Registers of Interests and Registers of Gifts and Hospitality will be discussed at each Audit Committee meeting.

SFI 18.3 Gifts to staff, including cash, intended to benefit individual staff members or teams, are not charitable donations to the Trust's charity.

SFI 18.4 Staff should not ask for or accept gifts, rewards or hospitality that may affect, or be seen to affect, their professional judgement. Gifts of cash or cash equivalent should always be declined.

SFI 18.5 Hospitality includes offers such as transport, refreshments, meals, accommodation etc, and should only be accepted where it is secondary to a business event i.e. there is a legitimate business reason. Hospitality must be appropriate and not out of proportion to the occasion i.e. subsistence only.

SFI 18.6 Commercial sponsorship agreements must always be declared. Before entering into a commercial sponsorship agreement written approval should be sought from the individual's line manager.

SFI 18.7 Sponsored post holders must not promote or favour the sponsor's products.

SFI 18.8 Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored post.

## SFI 19. RETENTION OF RECORDS

SFI 19.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health and Social Care guidelines NHS Records Management Part 1 and Part 2.

SFI 19.2 The records held in archives shall be capable of retrieval by authorised persons.

SFI 19.3 Records shall only be destroyed in accordance with latest Department of Health and Social Care guidance and a record shall be maintained of those records so destroyed, together with the date of their destruction.

## SFI 20. RISK MANAGEMENT AND INSURANCE

### Programme of risk management

SFI 20.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with NHS Improvement's Risk Assurance Framework, which must be approved and monitored by the Board.

SFI 20.2 The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) promotion among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including internal audit, clinical audit, and health and safety review;

(f) a clear indication of which risks shall be insured; and

(g) arrangements to review the risk management programme.

SFI 20.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement within the Annual Report and Accounts as required by Department of Health and Social Care Group Accounting Manual.

SFI 20.4 The Chief Finance Officer shall ensure that appropriate insurance arrangements exist in accordance with Department of Health and Social Care guidance. This will be a mixture of NHS Resolution cover and, in some instances, commercial insurance.

SFI 20.5 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

SFI 20.6 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, exceptions when trusts may enter into insurance arrangements with commercial insurers. The exceptions are:

(a) insuring motor vehicles owned by the Trust including insuring third party liability arising from their use;

(b) private finance initiative (PFI) contracts where the other consortium members require that commercial insurance arrangements are entered into;

(c) pressure vessels such as boilers and other associated risks; and

(d) income generation activities – if not related to normal business activity, these should normally be insured using commercial insurance. If the income generation activity is an activity normally carried out by the Trust for an NHS purpose, the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority.

SFI 20.7 All other commercial, or alternative insurance policies, are to be approved by the Chief Finance Officer.

**Arrangements to be followed by the board in agreeing insurance cover**

SFI 20.8 Where the Board decides to use the risk pooling schemes administered by NHS Resolution, the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

SFI 20.9 Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed to the Trust.

SFI 20.10 All the risk pooling schemes require scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

## SFI 21. INTELLECTUAL PROPERTY

### Intellectual property (IP)

SFI 21.1 The Trust has an approved Intellectual Property Policy.

SFI 21.2 It is appropriate therefore to include IP references in the Standing Financial Instructions.

### Definition of intellectual property

SFI 21.3 Intellectual Property can be defined as products of innovation and intellectual or creative activity and can include inventions, industrial processes, software, data, written work, designs and images. IP can be given legal recognition of ownership through intellectual property rights (IPR) such as patents, copyright, design rights, trademarks or "know how."

SFI 21.4 Examples of IP that may be developed in the NHS include: training manuals, clinical guidelines, books and journal articles, PowerPoint presentations, inventions, new or improved designs, devices, equipment, new uses for existing drugs, diagnostics tests, and new treatments.

### Ownership of intellectual property

SFI 21.5 Ownership of IP will, in most cases, rest with the Trust. This applies to all IP produced by Trust employees in the course of their employment, specifically when undertaken on Trust premises, using Trust equipment and in contact with Trust patients. IP developed by an employee outside the course of their employment, not utilising Trust assets or Trust patients will usually belong to the employee, subject to agreement.

SFI 21.6 This is in accordance with the Patent Act 1977, and the Copyright, Designs and Patent Act 1988.

SFI 21.7 IP ownership can vary according to the circumstances under which the IP was generated. Such circumstances include:

(a) joint/honorary appointments/trainees;

(b) externally funded work;

(c) commissioned work; and

(d) collaborative projects.

### Disputes of ownership

SFI 21.8 If the ownership of IP is disputed, dated written records relating to the IP in question will be assessed to establish the inventor(s), and their proportionate contribution. If such material is not available, the Chief Executive of the Trust will make a final decision, taking professional advice if necessary.

SFI 21.9 Persons covered by the Intellectual Property Policy include:

(a) all staff that are full time or part time employees of the Trust;

(b) full-time or part-time staff who are self-employed (e.g. private practice);

(c) trainee professionals (e.g. Specialist Registrars);

(d) staff seconded to other organisations; and

(e) staff with joint or honorary contracts with another organisation.

**Intellectual property management**

SFI 21.10 The Trust should use an appointed NHS Innovation Hub as its IP expert company to give advice and assistance in the protection, management and commercial opportunities of IP initiatives.

**Staff obligations**

SFI 21.11 All employees, including those covered by the Intellectual Property Policy, have an obligation to inform the Trust's R&D manager about identified or potential IP activities, and must not, under any circumstances, sell, assign, license, give or otherwise trade IP without the Trust's approval.

SFI 21.12 The Trust brand and logos should not be used unless in connection with Trust business.

**Monitoring intellectual property**

SFI 21.13 The Research and Development Manager will provide to the Board updates with regards to:

(a) the risks and rewards in respect of approving IP initiatives; and

(b) potential and ongoing IP initiatives.

## SFI 22. DECLARATION OF INTERESTS

**General**

SFI 22.1 All staff are required to declare interests which are relevant and material. Staff should declare interests on appointment and when there are any changes.

SFI 22.2 Staff members at Band 8d and above will be asked to confirm on an annual basis that their entry on the register of interests is accurate and provide updates as required.

SFI 22.3 A declaration of interest must be submitted by any grade of employee in the event where a relationship exists when involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices and/or equipment

**Bribery Act 2010**

SFI 22.4 Bribery is generally defined as giving or offering someone a financial or other advantage to encourage a person to perform certain activities and can be committed by a body corporate. Commercial organisations (including NHS bodies) will be exposed to criminal liability, punishable by an unlimited fine, for failing to prevent bribery.

SFI 22.5 The offences of bribing another person or being bribed carry a maximum sentence of 10 years imprisonment and/or a fine. In relation to a body corporate the penalty for these offences is a fine.

SFI 22.6 This Trust does not, and will not, pay bribes or offer improper inducements to anyone for any purpose; nor will it accept bribes or improper inducements. It is important that all employees, contractors and agents are aware of the standards of behaviour expected of them contained in this policy.

SFI 22.7 It is the duty of Trust employees, including all agency and contracted staff, who have the powers to enter into transactions on behalf of the Trust, not to influence or enter into negotiations or purchases with an individual or entity where a relationship with the other party

exists. For clarification relationships include, but are not limited to, spouse, parent, child, brother, sister (and relations of any of these). Relationships also include friendships, and are deemed to exist when the employee has any financial interest in the other party.

SFI 22.8 If in doubt, Trust employees and representatives must inform their line manager and in all circumstances should declare his/her interest by completing a declaration of interest form which can be found in the Trust's Code of Conduct Policy, and should not take any part in the negotiation process.

**Declaration of interest**

SFI 22.9 An annual completion of declarations of interest exercise will be undertaken as part of the Trust's annual accounts process and is mandatory for all staff on band 8 and above. Any disclosures not made and later discovered will be considered a breach of Trust Standing Financial Instructions, which could subsequently lead to disciplinary action being taken.

## SFI 23. BUSINESS CASE AND TENDER PROCESS

**Introduction**

SFI 23.1 The Trust's business case process has been established to ensure there is full involvement from any party within the organisation that could be affected by the intended direction of travel. Auditability, governance and financial principles are critical to ensure there is no unforeseen service, quality or financial consequences from our investment decisions.

SFI 23.2 All approved business cases must satisfy one of more of the investment criteria established by the Executive Team. Business cases must include key performance indicators for how the investment will be assessed or measured once implemented.

SFI 23.3 All business cases must have a reference number assigned by the finance department, referenced within the minutes of the meeting of the approving entity.

**Revenue and capital expenditure**

SFI 23.4 All revenue and capital investments must be submitted for a formal decision using the Trust's current business case process and template. Business cases for national funding should be on the appropriate NHSE template.

SFI 23.5 Should the Trust approve, it may also be necessary to seek approval from the Greater Manchester Integrated Care Board or NHS England.

SFI 23.6 Should the Trust approve, it may also be necessary to seek NHSI's approval.

SFI 23.7 Business cases will be approved in accordance with the following table:

| Type of Business case | Capital Medical Equipment Group | Executive Team Meeting | Finance and Performance Committee | Board of Directors |
|---|---|---|---|---|
| Capital medical equipment, within the delegated capital limit for Capital Medical Equipment and with no revenue implications. | £500k | N/A<br><br>(CME cases over £500k still require ETM endorsement before going to F&P) | £1m | >£1m |
| All other business cases | N/A | £500k | £1m | >£1m |
| *The value of a business case is defined as the total combined revenue and capital expenditure (calculated as total capital expenditure, plus recurrent revenue expenditure plus one-off revenue expenditure).* | | | | |

As an organisation that is publicly funded with stringent financial duties to achieve, it is essential for the Trust to have robust financial controls in place. This will ensure that we are providing value for money, that our colleagues are working within this guidance framework and that we do not become vulnerable to the risk of fraud. A strong financial governance and control framework will contribute toward the Trust managing its finances on an effective and sustainable basis.

The Standing Financial Instructions (SFI's) form a key role in the Trust's financial governance and control framework, and it is important that employees are aware of their responsibilities for financial governance by understanding and working within the guidance of this policy.

To support the Trust's governance and control framework, a monitoring and reporting process has been implemented to ensure that employees are following the SFI's correctly and that processes and procedures are working effectively.

The following matrix highlights the key areas of the SFI's, how monitoring of compliance will be undertaken and when issues or incidents arise, how these will be managed. In some cases, where there are repeated occurrences of issues or disregard for the framework that put the Trust at risk of Fraud, these will be escalated formally.

It is acknowledged that in the majority of instances staff will have acted in good faith, and there may be situations where further training or guidance is required to support staff to ensure they are working in line with the framework, however, it is important that the Trust does not leave itself open to the risk of fraud. Exploring and understanding issues or incidents that don't comply with this framework will allow for a review of the procedures and controls in place.

We aim to work collectively with staff to understand the root cause of issues and learn from these to prevent future incidents. Whilst our priority is to support staff in following this framework, careless disregard for the processes within this framework or fraud related matters are unacceptable and will be addressed via a formal process.

| Chapter of SFI | **Areas for potential non-compliance** ***(This list is not exhaustive)*** | **How it will be monitored** | **Applicable to** | | **Monitoring by** | **Point at which breach will be escalated for review under Trust disciplinary policy.** |
|---|---|---|---|---|---|---|
| **Audit fraud corruption bribery and security** | • All instances of fraud, corruption or bribery ***(Section 2)*** | Referrals to Local Counter Fraud Specialist | All employees | | Local Counter Fraud Specialist | **Immediately** |
| **Business planning budgets budgetary control and monitoring** | • Exceeding budgetary total, or virement limits set by the board ***(3.2.2)*** | Monthly monitoring of budget statements | Budget holders | | Management Accounts | Clinical divisions report on their performance via bi-monthly divisional assurance meetings (DAMs) which are chaired by an Executive Director.<br><br>An escalation process called RAPID (recovery, action, planning, implementation and delivery) has been introduced where performance metrics can trigger the DAM meeting to convert to a RAPID meeting to provide further scrutiny and support on the financial position. |
| | • Use of non-recurring expenditure to fund recurring budget expenditure without authority ***(3.2.4)*** | | | | | |
| | • Use of approved budget for a purpose other than as specially authorised ***(3.3.2, c)*** | | | | | |
| | • Engaging services of agency workers without approval ***(3.3.2, d)*** | Budget statements<br>Review of agency invoices | Budget holders | | Financial Services | **After 3rd Notification** |

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| **Bank and GBS Accounts** | • Opening a bank account in Trust name ***(5.1.3)*** | As and when the situation arises. | All employees | | Financial Services | **Immediately** |
| **Income fees and charges** | • Employees must report income due on transactions which they initiate/ deal with including all contracts, leases and tenancy arrangements ***(6.2.3)*** | As and when the situation arises. | Budget holders | | Management Accounts | **Immediately** |
| | • Use of Trust cash for private transactions, encashment of cheques bank to bank transfers and loans ***(6.4.2)*** | As and when the situation arises. | Cash office | | Financial Services | **Immediately** |
| | • Use of Trust Credit card for personal expenditure ***(6.4.4)*** | Via monthly reviews of credit card statements | Credit card holders | | Financial Services | **Immediately** |
| | • Use of Trust credit card for expenses which should be reimbursed through payroll without prior approval ***(6.4.5)*** | | | | | **After 2nd notification** |
| | • Holders of safe keys should not accept unofficial funds for depositing in their safes without sealed envelopes or locked containers ***(6.4.7)*** | Audits of Cash Office | Cash office | | Financial Services | **Immediately** |
| | • Failure to report losses of cash cheques and other negotiable instruments ***(6.4.11)*** | As and when the situation arises. | Cash office | | Financial Services | **Immediately** |

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| **Tendering and contracting procedure** | • Failure to obtain competitive quotes for expenditure expected to exceed £5,000 but not exceed £50,000 ***(7.3.1)*** | Requisition entered onto Oracle and checked by buyer | Oracle users | | Procurement | **After 2nd notification** |
| | • Failure to undertake competitive tendering exercise for expenditure that is equal to or reasonably expected to exceed £50,000 ex VAT ***(7.4.1)*** | Requisition entered onto Oracle and checked by buyer | | | | **After 2nd notification** |
| | • Waivers unsupported by procurement ( 7.6.1) | As and when the situation arises. | | | | **After 2nd notification** |
| | • Failure to involve procurement in the tender process ***( 7.14.1)*** | As and when the situation arises. | | | | **After 2nd notification** |
| | • Unauthorised approval of NHS and Non NHS Contracts ***(7.14.3)*** | As and when the situation arises. | | | | **After 2nd notification** |
| | • Failing to ensure that all items received under a prepayment agreement have been received ***(8.3.4,d)*** | As and when situation arises | | | | **After 2nd notification** |
| | • Failing to comply with requisitioning and ordering processes ***(8.3.6, a- n)*** | Monthly reviews of invoice process via Non PO route. | Oracle users | | Procurement | **After 2nd notification** |
| **Contracting for provision of healthcare** | • Failure to ensure that a SLA is in place for the supply or receipt of services either clinical or non- clinical ***(10.4)*** | | Legal Team | | Legal team | **Immediately** |

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| **Terms of services allowances and pay** | • Failure to remain within funded establishment without prior consent to changes ***(11.2.3)*** | Monthly monitoring of budget statements | Budget holders | | Management Accounts | Escalated through divisional internal reporting structure and review meetings with finance managers, Directorate Managers and Directors of Performance.<br><br>Ultimate outcome is representation at the divisional assurance review with members of the executive team and then Finance and Performance Committee.<br><br>Finance reports to include details of breaches." |
| | • Engagement, re-grade, hire of agency staff or changes to any employees remuneration unless authorised to do so ***(11.3.1)*** | Monthly monitoring of budget statements | Budget holders | | Management Accounts/Payroll | **Under review pending update to temporary staffing policy (Aug 2021)** |
| | • Late submission of time records to payroll ***(11.4.3,a)*** | Monitoring of payroll related information | Payroll authorised signatories | | Payroll | **After 3rd Notification** |
| | • Failure to submit termination forms to the payroll department immediately on | | | | | **After 2nd notification** |

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| | knowing the effective date of the an employee's resignation, termination or retirement ***(11.4.3, c)*** | | | | | |
| | • Changing an individual's pay outside of agenda for change terms and conditions without the appropriately authorised Local Pay Variation form ***(11.5.1)*** | | | | | **Controls in place to prevent this happening**. |
| | • Damage to premises, vehicles and equipment or any of equipment stores or supplies must be reported. ***(13.3.5)*** | As and when the situation arises. | All employees | | Financial Services | **After 2nd notification** |
| **Disposals and condemnations, losses and special payments** | • Failure to dispose of assets in accordance with disposal policies. ***(14.1.2)*** | As and when the situation arises. | Budget holders | | Financial Services | **After 2nd notification** |
| | • Any employee discovering or suspecting a loss of any kind, other than fraud, corruption or bribery must immediately inform their head of department. ***(14.2.2)*** | As and when the situation arises. | All employees | | Financial Services | **Immediately** |
| **Patients Property** | • Failure to complete patient property record in respect of patient property handed in for safekeeping ***(16.6)*** | As and when the situation arises. | Ward Staff | | Financial Services | **After 2nd notification** |

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| | • Failure to hand patient property into the Cash office ***(16.7)*** | | | | | |
| **Charitable Funds** | • Undertaking fundraising activity for the Trust Charity without appropriate approval ***(17.2.2*** | As and when the situation arises. | All employees | | Financial Services | **After 1st notification** |
| | • Commitment to expenditure which does not meet charitable purposes and public benefit test ***(17.3.2, 17.3.3)*** | Monthly review of expenditure purchases | Charitable Fund Managers | | Financial Services | **After 1st notification** |
| **Acceptance of gifts and hospitality** | • Failure to disclose commercial sponsorships & Gifts and Hospitality ***(18.6, 8.3.6.n, 17.4.2)*** | Gifts and hospitality register | All employees | | Local Counter Fraud Specialist/Company Secretary | **After 1st notification** |
| **Risk management and insurance** | • Entering in to commercial insurance arrangements without authorisation ***(20.1.6)*** | As and when the situation arises. | All employees | | Financial Services | **After 2nd notification** |
| **Intellectual property** | • Selling, assign license or trade IP without approval ***(20.1.6)*** | As and when the situation arises. | All employees | | Financial Services | **After 1st notification** |
| **Declarations of interest** | • Influencing or entering into negotiations or purchases with an individual or entity where a relationship with the other party exists ***(22.2.4, 22.2.5 & 22.3.1)*** | Via MES software | All employees | | Local Counter Fraud Specialist /Company Secretary | **After 1st notification** |
| **Business case and tender process** | Incurring expenditure where the business case process has not been followed. **(S23)** | Via monthly budget statements and capital to revenue approvals | Budget holders | | Management Accounts and Capital Accountant | **After 1st notification** |